UNDERSTANDING CONTRACEPTIVE BEHAVIORS AMONG LATINAS

A Dissertation

by

JOVANNI VERENICE REYES

Submitted to the Office of Graduate and Professional Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Chair of Committee,	Kelly Wilson
Committee Members,	Adam Barry
	E. Lisako McKyer
	Linda Castillo
Head of Department,	Melinda Sheffield-Moore

August 2018

Major Subject: Health Education

Copyright 2018 Jovanni Verenice Reyes

ABSTRACT

In the United States, Latinas account for one-fourth of unintended pregnancies with more than half becoming pregnant before they even turn 20 years old. Exploring influential factors that impact contraception behaviors could aid in understanding unintended pregnancy among this population. The aim of this dissertation was to assess reproductive autonomy beliefs, marianismo beliefs, and contraception behaviors among an exclusively Latina sample and explore the relationships between these constructs.

Participant survey data from 567 Latinas was used to run Structural Equation Models. Results indicated that aspects of reproductive autonomy influence contraception negotiation skills, in a monogamous relationship (est. = 0.582; p = 0.000) and while single (est. = 0.198; p = 0.000). Marianismo beliefs were seen to influence contraception negotiation skills in a monogamous relationship (est. = -0.349; p = 0.003) and current contraception use (est. = -0.516; p = 0.008). Mediation models also confirmed that marianismo beliefs partially mediated the relationship between certain reproductive autonomy beliefs and contraception negotiation skills in a monogamous relationship. Culturally tailored interventions are needed to reduce unintended pregnancy rates among Latinas.

DEDICATION

This dissertation is dedicated to Salvador G. Conchas and G. Juanita Conchas.

I love you, Pito and Tia Juani.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank God for the unconditional love He showed me throughout my entire life. I would also like to thank my family. To my mom, Evangelina Reyes, thank you for always believing in me even when I didn't believe in myself. To my dad, Luis Reyes, thank you for always reminding me to never quit. To my brothers Dominik and Demitruss Reyes, thank you always making me laugh during stressful times. Thanks also go to my friends for making my time at Texas A&M University a great experience. A special thanks to Dr. Aishia Brown and Dr. Gayle Gabriel for being my PhD tribe. Lastly, I would like to thank my committee members, Dr. Kelly Wilson, Dr. Adam Barry, Dr. E. Lisako McKyer, and Dr. Linda Castillo for their guidance and support throughout the course of my graduate school journey.

CONTRIBUTORS AND FUNDING SOURCES

Contributors

This work was supervised by a dissertation committee consisting of Dr. Kelly Wilson and Dr. Adam Barry of the Department of Health and Kinesiology, Dr. E. Lisako McKyer of the Department of Health Promotion and Community Health Sciences in the School of Public Health, and Dr. Linda Castillo of the Department of Educational Psychology.

The analyses depicted in this dissertation were conducted with the help of Yuhong Ji of the Department of Educational Psychology. All other work conducted for the dissertation was completed by the student independently.

Funding Sources

Graduate study at Texas A&M University was supported by the Office of Graduate and Professional Studies' Graduate Diversity fellowship and by the College of Education and Human Developments Strategic Research Award. Dissertation funding was supported by the College of Education and Human Developments 2015 CEHD Research Grant and 2016 CEHD Research's Scholars Award.

NOMENCLATURE

TGP	Theory of Gender and Power
RAS	Reproductive Autonomy Scale
DM	Decision-Making
CR	Freedom from Coercion
CM	Communication
MBS	Marianismo Beliefs Scale
FP	Family Pillar
VC	Virtuous and Chaste
SO	Subordinate to Others
SS	Silencing Self to Maintain Harmony
SP	Spiritual Pillar
NSR	Contraception Negotiation Skills in a Monogamous Relationship
NSS	Contraception Negotiation Skills with Someone You Just Met
CCU	Current Contraception Use
SEM	Structural equation modeling

TABLE OF CONTENTS

Page

ABSTRACT ii

DEDICATION iii

ACKNOWLEDGEMENTS iv

CONTRIBUTORS AND FUNDING SOURCES v

NOMENCLATURE vi

TABLE OF CONTENTS vii

CHAPTER I INTRODUCTION 1

- Conceptual framework for the study 3
- Purpose 4
- Procedures 4
- Significance and implications of the study 8
- Limitations of the study 9
- Organization of the study 10
- Definition of terms 11

CHAPTER II LATINA EMPOWERMENT: THE IMPACT OF REPRODUCTIVE AUTONOMY ON CONTRACEPTION BEHAVIORS 13

- Theory of gender and power and reproductive autonomy scale 17
- Methods 18
- Results 23
- Discussion 26

CHAPTER III CULTURE MATTERS: THE INFLUENCE OF MARIANISMO ON CONTRACEPTION BEHAVIORS OF LATINAS 31

- Theory of gender and power and marianismo beliefs scale 34
- Methods 36
- Results 41
- Discussion 44

CHAPTER IV EXPLORING THE RELATIONSHIPS BETWEEN MARIANISMO, REPRODUCTIVE AUTONOMY, AND CONTRACEPTION BEHAVIORS: EXAMINING A MEDIATION MODEL 48

Theory of gender and power 51
Methods 52
Results 58
Discussion 61

CHAPTER V CONCLUSIONS 65

Contributions to the literature & implications 70
Recommendations for future research 72

REFERENCES 73

APPENDIX A INITIAL ENGLISH CONSENT FORM 83

APPENDIX B INITIAL SPANISH CONSENT FORM 87

APPENDIX C INITIAL ENGLISH QUESTIONNAIRE 90

APPENDIX D INITIAL SPANISH QUESTIONNAIRE 111

APPENDIX E FINAL ENGLISH INFORMATION SHEET 133

APPENDIX F FINAL SPANISH INFORMATION SHEET 135

APPENDIX G FINAL ENGLISH QUESTIONNAIRE 137

APPENDIX H FINAL SPANISH QUESTIONNAIRE 149

APPENDIX I RECRUITMENT FLYERS (ENGLISH/SPANISH) 161

APPENDIX J DEMOGRAPHIC DESCRIPTIONS 171

APPENDIX K TABLES 173

APPENDIX L FIGURES 177

CHAPTER I

INTRODUCTION

According to the Census Bureau's latest estimates, the number of Latinos in the United States reached 58.6 million in 2017 (Krogstad, 2017). In the last two years, the United States population has grown by 2.2 million and Latinos accounted for half (1.1 million) of that growth. Since this growth, public health researchers have explored Latino health and whether they experience similar or different health issues compared to other race and ethnicities in the United States. One of the health issues seen among the Latino population is unintended pregnancy. Not only are unintended pregnancy rates in the United States higher than most developed countries, Latinas account for one-fourth of unintended pregnancy rates (Finer et al., 2016; NATPTUP; 2012). In the United States, more than half of Latinas become pregnant before they even turn 20 years old (Martin et al., 2017; Ventura et al., 2012). Exploring what influences contraception use, misuse, and non-use could help better understand unintended pregnancy among Latinas.

When using contraception, correct and consistent use is required for maximum effectiveness. However, as we know, this does not happen often. In the United States, the 68% women that are at-risk for unintended pregnancies use contraception correctly and consistently; this group is responsible for about 5% of unintended pregnancies (Guttmacher, 2016; Sonfield et al., 2014). More alarming is the 18% of at-risk women who use contraception inconsistently and incorrectly and the 14% of at-risk women who

do not use contraception. Those who misuse account for 41% of unintended pregnancies and those who do not use account for 54% of all unintended pregnancies. Understanding what influences contraception use could help researchers and practitioners address issues concerning unintended pregnancy. While unintended pregnancy has been studied, previous research has focused on demographics (i.e., age, income, race, ethnicity, education, etc.) as influential factors towards contraception use. Though demographic information is vital for foundational examination, research must explore other factors to advance the research agenda. Healthy People 2020 has specified goals to address this health disparity; this included increasing access to highly effective contraception and educating on correct and consistent use (Healthy People, 2017b). These goals identify contraception as a change agent for reducing the rate of unintended pregnancies. Researchers are now exploring other aspects such as culture and women's empowerment to see how these constructs could impact contraception use and overall, influence unintended pregnancy.

This study explored marianismo, an aspect of Latino culture, and reproductive autonomy beliefs, an aspect of women's empowerment, to see how they influence contraception negotiation skills and contraception use. Reproductive autonomy beliefs are an individual's perceived control over their sexual health decision. Typically, these beliefs are shaped by the environment someone lives in and relationships they have with others in that environment. Marianismo beliefs are traditional beliefs associated with Latina gender norms. This dissertation examined reproductive autonomy beliefs and

marianismo beliefs to understand how they influence contraception negotiation and contraception use among Latinas. While reproductive autonomy beliefs, marianismo beliefs, and contraception behaviors have been examined individually, no studies have explored the relationships between these three constructs.

Conceptual framework for the study

Conceptual framework for this study was derived from the Theory of Gender and Power. The Theory of Gender and Power (TGP), developed by Raewyn Connell, and emphasizes gender as a large-scale social structure and not just an aspect of personal identity (Connell, 1987). The three theoretical constructs include: sexual division of labor, sexual division of power, and the structure of cathexis. Sexual division of labor examines economic inequities favoring males, sexual division of power examines inequities and abuses in authority and control in relationships and institutions favoring males, and the structure of cathexis, examines social norms. Figure 1 (Appendix L) shows a visual representation of the theory. This theory focuses on the societal and institutional issues of gender and power and how they impact the individual level. The constructs explain the heterosexual relationship between women and men and how it influences the health of women. In public health, the theory of gender and power helps identify exposure and risk factors, as well as economic, physical, and social exposures that affect women's health (Depadilla et al., 2011; Panchanadeswaran et al., 2007: Rinehart et al., 2018)

Purpose

The purpose of this study was to assess reproductive autonomy beliefs, marianismo beliefs, and contraception negotiation skills and behaviors among Latinas and explore the relationships between these constructs.

Research Questions

1) Do reproductive autonomy beliefs influence contraception behaviors among Latinas?

2) Do marianismo beliefs influence contraception behaviors among Latinas?

3) Does marianismo beliefs mediate the relationship between reproductive autonomy beliefs and contraception behaviors among Latinas?

Procedures

This study received approval from the institutional review board (IRB) at Texas A&M University in College Station, Texas. The study included four phases: (1) development of a questionnaire with feedback from experts in the field, (2) conducting cognitive interviews, (3) pilot testing the questionnaire, and (4) dissemination of the final questionnaire.

Phase 1: With the help of a reference librarian, the literature was explored, and potential scales were found that could be used to measure reproductive autonomy beliefs, marianismo beliefs, and contraception negotiation skills and behaviors. With feedback from experts in health education, scales were determined, and the draft questionnaire was developed. Demographic items were taken from previous U.S. census and CDC

questionnaires and included items about age, employment, income, education, religion, health insurance, relationships status, race, ethnicity, birth country, and generational status. The marianismo beliefs scale, created by Castillo et al. (2010), includes 24 items that measured five subscales (family pillar, virtuous and chaste, subordinate to others, silencing self to maintain harmony, and spiritual pillar) that described beliefs on Latina gender roles. The reproductive autonomy scale was created by Upadhyay et al. (2014) and included 14 items that measure three subscales: decision-making, freedom from coercion, and communication, as they pertain to contraceptive use, pregnancy, and childbearing. The items used to measure contraceptive negotiation skills and behaviors were adapted from items previously used national surveys (BRFSS, OAH TPP performance measures, etc.). The initial questionnaire (Appendix C & D) was compiled, and items were evaluated by experts in health education, promotion, and behavior to assess relevance and clarity. This step was conducted to maximize item appropriateness.

Feedback was provided by experts and adaptations were made to the questionnaire. The reproductive autonomy beliefs and marianismo beliefs scales were previously translated in Spanish. The remaining questions went through a translation process, where they were translated and back-translated by two women who identified as Latina and were native Spanish speakers. Recruitment flyers (Appendix I), study consent forms (Appendix A & B), and drawing form were available for survey participants in English and Spanish.

Phase 2: Cognitive interviews with adult women living in Latino communities took place to evaluate relevance and clarity of the questionnaire items. Flyers were distributed in communities (clinics, recreation centers, grocery stores, etc.) and eFlyers were posted on social media outlets to recruit for the cognitive interviews. Eight participants were recruited to read through the entire questionnaire and discussed any items they found confusing with the interviewer. All eight cognitive interviews were completed over the span of ten days and lasted approximately one hour each. The participants identified issues regarding spelling and meanings of Spanish words, and questionnaire formatting. Revisions based on the feedback from the cognitive interviews were made to prepare the questionnaire for the pilot test phase. A major issue was the formatting of questions. The items that asked about contraception use (previous, current, and future) were identified as confusing and adjustments were made to make these questions more reader-friendly.

Phase 3: Flyers were distributed throughout the community (clinics, recreation centers, grocery stores, etc.) and eFlyers were posted on social media outlets to recruit for the pilot testing. The modified questionnaire was pilot tested on a sample of Latinas living in the Bryan and College Station, Texas (BCS) area. A convenience sample was used to avoid contamination with the final participant sample. The participants were recruited from a Latina sorority and at an annual event celebrating Hispanic heritage month. There were 42 participants who completed the questionnaire in approximately 15 minutes. The participants completed the questionnaire and identified misspelled words or confusing questions and commented on any issues regarding the flow or document formatting.

After the questionnaire was pilot tested, adjustments were made based on the feedback from the participants. Participants identified misspelled words, formatting concerns and gave comments on the flow of the questionnaire. Misspelled words were corrected, scales were reorganized to prevent question fatigue, and small adjustments were made to the formatting to make the questionnaire reader-friendly.

Phase 4: Participants were recruited using flyers and eFlyers distributed in November and December 2016. Flyers were distributed in Latino community sites (clinics, recreation centers, grocery stores, etc.) throughout Dallas, Texas and eFlyers were posted on social media outlets (Facebook, Twitter, Instagram, etc.). Over the span of two months, the post was shared a total of 189 times on Facebook.

The final questionnaire, available in English (Appendix G) and Spanish (Appendix H), was administered two ways: face-to-face using a paper-pencil questionnaire and online using a web-based questionnaire. Qualtrics, an online software program provided by Texas A&M University to faculty, staff, and students, was used to host the web-based questionnaire. Each survey was anonymous and did not contain any personal identifying information. Each participant was provided a study information sheet (Appendix E & F) and asked to read it before starting the questionnaire. The IRB suggested a waiver of documentation of consent due to sensitive subject matter, therefore, when participants started the questionnaire, they consented to taking part in the research study. The questionnaire contained 107 items that included two previously made scales,

contraception behavior questions adapted from items previously used national surveys (BRFSS, OAH TPP performance measures, etc.), and demographic questions. The items were arranged in a way that attempted to reduce the risk of question fatigue. On average, it took each participant 17 minutes to complete the entire survey.

Each participant who completed the survey had the option to submit their name into a drawing for an opportunity to win a gift card. There were thirty-six gift cards awarded: thirty $25 gift cards, five $50 gift cards, and one $100 gift card. Gift cards an incentive to increase the likelihood of participants completing the survey. The personal information needed from the participant to distribute gift cards was locked in the PI's office.

In order to be a representative sample, 200-300 completed questionnaires were needed to analyze the data using Structural Equation Modeling. There were 1,283 participants total and 567 of those completed the survey in its entirety. Participant data from 567 Latinas was used to run three different Structural Equation Models. Table 1 (Appendix K) describes the study sample.

Significance and implications of the study

This dissertation contributes to understanding unintended pregnancy by exploring influential factors that impact contraception behaviors among Latinas. By understanding how these factors influence contraception behaviors, tailored interventions that address

unintended pregnancy can be developed specifically for Latino communities. With unintended pregnancy disproportionately impacting the health of Latinas, it would make sense to see interventions tailored specifically for this population regarding the issues they face. This dissertation aims to identify reproductive autonomy beliefs and marianismo beliefs as influential factors that play a role in contraception negotiation skills and contraception use. Identifying these factors and addressing them in future family planning interventions could aid in the increase of contraception use and decrease unintended pregnancy among Latinas. The proposed research is innovative because it explores factors that are associated with contraceptive behaviors, which could help us understand the complex issue of pregnancy prevention and unintended pregnancy. The impact from this innovative research will identify new influential factors that could be included in sexuality education, contraception education, pregnancy prevention, and family planning programs.

Limitations of the study

This dissertation contributes to the body of knowledge that explores unintended pregnancy and factors that influence contraception use, specifically among a Latina sample. However, the findings from this study should not be generalized to other populations due to several limitations. This study is cross-sectional, and the findings represent a onetime snapshot that is not guaranteed to be representative. With no follow-up data, researchers cannot analyze any behaviors over time which means no causal effects can be determined. Data collected from this study was self-reported and is

limited, due to the inability to verification behaviors that were reported compared to behaviors that actually occur. The information provided by participants was taken at face-value. It is understood that certain biases could influence participants' answer choices. Some of these biases include; selective memory, telescoping, and exaggeration. Another limitation in this study was the participant's self-identification as Latina. There are many factors that contribute to how a person identifies their ethnicity and the only criteria for this study was that the participant self-identifies as a Latina.

Organization of the study

The document is separated into five distinct chapters. Chapter one, which you are currently reading, represents the Introduction of the dissertation and the study. Chapters two through four are written as individual manuscripts which will be submitted for publication in peer-reviewed journals. These chapters contain three quantitative manuscripts that assess reproductive autonomy beliefs, marianismo beliefs, and contraception negotiation skills and contraception use among Latinas and examine the relationship between these constructs. Chapter two, "Latina Empowerment: The impact of reproductive autonomy beliefs on contraception behaviors," examines reproductive autonomy beliefs and how they influence contraception behaviors. Chapter three, "Culture Matters: The influence of marianismo on contraception behaviors of Latinas," examines marianismo beliefs and how they influence contraception behaviors. The studies represented in Chapters two and three used structural equation modeling (SEM) to explore the influence of reproductive autonomy beliefs and marianismo beliefs on

contraception negotiation skills and contraception use. Chapter four, "Exploring the relationship between marianismo, reproductive autonomy, and contraception behaviors: Examining a mediation model," explores the relationships between reproductive autonomy beliefs, marianismo beliefs, and contraception negotiation skills and contraception use. In this chapter, a mediation model was used to understand what role marianismo beliefs play in the relationship between reproductive autonomy and contraception negotiation skills and contraception use. Finally, Chapter 5, Conclusions, embodies all the results and conclusions from this study. The last chapter reiterates all important findings, discusses the contribution to the literature and implications, and gives recommendations for future research.

Definition of terms

The following are definitions for terms used throughout the study and this dissertation:

Marianismo: female gender norm that are associated with being virtuous, humble, extremely spiritual, submissive to men, and endure sacrifice and suffering for the sake of their family (Castillo and Cano, 2007).

Machismo: male gender norm that are associated with aggression, antisocial and authoritative behaviors, and alexithymia (i.e., inability to process emotions) (Arciniega et al., 2008).

OBGYN: doctor of obstetrics and gynecology

Reproductive Autonomy: having the power to decide about and control matters related to contraceptive use, pregnancy, and childbearing" and is molded by the relationship with her partner, culture, and the environment she lives in (Upadhyay, 2014).

Structural equation modeling (SEM): statistical technique for building and testing statistical models.

Theory of Gender and Power (TGP): a theory developed by Raewyn Connell in 1987 that examines gender as a large-scale social structure.

CHAPTER II

LATINA EMPOWERMENT: THE IMPACT OF REPRODUCTIVE AUTONOMY ON CONTRACEPTION BEHAVIORS

In the United States, the unintended pregnancy rate is significantly higher when compared to other developed countries around the world (Singh, 2010). Out of the 6.1 million pregnancies in 2011, approximately 2.8 million were unintended, meaning that women did not want to get pregnant at that time or did not want to get pregnant at all (Finer et al., 2016; NCTPTUP, 2017). In the last three decades, the National Survey of Family Growth has data that shows no overall decline in unintended birth rates (Mosher et al., 2012). In the last decade, Latinas (20-29 years old) accounted for one-fourth of the unintended pregnancies with the most recent rate being 58 per 1000 births in 2011 (Finer et al., 2016; NATPTUP; 2012). There has been progress seen in unintended pregnancy among non-Hispanic white women but other groups, such as Hispanics, have not been as fortunate to see improvements with this health issue (Masinter et al., 2013).

Unintended births, especially among disproportionately affected groups such as Latinas, can be associated with negative health and economic outcomes for mother and child. Women who have unintended pregnancies are more likely to have delayed prenatal care, engage in risky health behaviors such as smoking or drinking during pregnancy, experience preterm delivery and low birth weight, and are less likely to breast-feed (American Academy of Pediatrics, 2012; Finer et al., 2016; Kost et al., 2015). Over 50%

of Latinas living in the United States become pregnant at least once before they turn 20 years old (Martin et al., 2017; Ventura et al., 2012), putting themselves and their children at higher risk for negative health and economic outcomes.

Children whose births are unintended are associated with an increased risk of physical and mental health issues growing up, as well as inferior behavioral and educational success compared to their counterparts that are born as a result of a planned pregnancy (Logan et al., 2007; NATPTUP, 2012). An unintended pregnancy directly affects the people involved (mother, father, child, etc.), as well as indirectly affecting the public with the high medical costs. In 2010, unintended births were estimated to cost the public approximately $21 billion dollars nationwide (Guttmacher, 2016). One way to address this problem is to increase the use of contraceptives among those populations disproportionately affected. Healthy People 2020 set family planning goals to address health disparities, such as unintended pregnancy. Their goals aim at reducing the number of unintended pregnancies by improving pregnancy planning and spacing (Healthy People, 2017). Some objectives include increasing the overall proportion of intended pregnancies, reducing the amount of repeat births (i.e., pregnancy within 18 months of previous birth), increasing the proportion of females (and partners) who used contraception the last time they had intercourse, and increasing the proportion of sexually active females who used multiple forms of contraception (ex., condom AND pill, condom and IUD, etc.) (Healthy People, 2017b).

Abstaining from sexual intercourse is the only way to avoid unintended pregnancy; however, abstinence is not for everyone. For people who choose to be sexually active and do not want a pregnancy, using a form of contraception consistently and correctly is vital. Even though the widespread recommendation among healthcare professionals is correct and consistent use, it is not always seen among women using contraception. In the United States, 68% of women that are at-risk for unintended pregnancies use contraception correctly and consistently and are responsible for 5% of unintended pregnancies (Guttmacher, 2016; Sonfield et al., 2014). More alarming is the 18% of at-risk women who use contraception inconsistently and incorrectly and the 41% of unintended pregnancies that are a product of contraception misuse. The most frightening concern is the 14% of at-risk women who do not use contraception at all and are responsible for 54% of all unintended pregnancies. Healthy People 2020 goals related to decreasing the rate of unintended pregnancy involves increasing access to highly effective contraception and more importantly, educating more correct and consistent use of contraceptive methods. To address these issues, researchers need to investigate what influences contraception use among women in the United States.

In the literature, studies have examined influential factors on contraceptive use, nonuse, and misuse; the focus of these studies were demographic variables and relationship characteristics (Frost et al., 2007; 2008;Wildsmith et al., 2012) These research studies fail to take into consideration other influential factors, such as power dynamics (partner influence, personal autonomy, gender empowerment, etc.), which have been seen to

affect other sexual health outcomes, like STI infection (Dworkin et al., 2009; Moreno, 2007). Two U.S. studies involving Latinos and two international studies in Africa identified partner influence, culture, and aspects of women's empowerment as factors that influence contraceptive use (Crissman, et al., 2012; Do & Kurimoto, 2010; Kerns et al., 2003; Moreno, 2007).

Factors such as partner influence, culture, and empowerment are seen in the complex construct of "women's empowerment." Women's empowerment encompasses several dimensions of empowerment such as, economic, sociocultural, legal, political, psychological, and familial/interpersonal (Malhotra, 2002). Specifically related to sexual health, familial/interpersonal empowerment is best described as a woman's control over sexual relations, her ability to make childbearing decisions, and her decision to use contraception. Reproductive autonomy, a relatively new construct, can be seen as part of the familial/interpersonal domain. It is defined as "having the power to decide about and control matters related to contraceptive use, pregnancy, and childbearing" and is molded by the relationship with her partner, culture, and the environment she lives in (Upadhyay, 2014). Exploring factors that are associated with an individual's relationship and autonomy in that relationship could help researchers understand contraceptive use and factors that influence that use.

Theory of gender and power and reproductive autonomy scale

In this study, the Theory of Gender and Power was the conceptual underpinning to explore the relationships between reproductive autonomy and certain contraception behaviors. The Theory of Gender and Power, developed by Raewyn Connell, emphasizes gender as a large-scale social structure and not just an aspect of personal identity (Connell, 1987). The three theoretical constructs are: sexual division of labor which examines economic inequities favoring males, sexual division of power which examines inequities and abuses in authority and control in relationships and institutions favoring males, and the structure of cathexis, which examines social norms. This theory focuses on the societal and institutional issues of gender and power and how they impact individual level behaviors. The constructs are distinct and work together to define and explain the heterosexual relationship between women and men and the influence on women's health. In public health, the Theory of Gender and Power helps identify exposure and risk factors, as well as economic, physical, and social exposures that affect women's health. This theory can be used to address women's issues and look more into gender-based inequalities and disparities in women's health. The theory of gender and power has been used to examine women's HIV exposure (Wingood et al., 2000). Others have used it to examine relationships between unbalanced gender, power structures, and control as it pertains to condom use and other sexual behaviors (Depadilla et al., 2011; Lopez et al., 2012; Wingood et al., 2000).

The Reproductive Autonomy Scale (RAS) (Upadhyay, 2014) is a 14-item scale that measures a persons' ability to have the power to make decisions and control matters associated with contraceptive use, pregnancy, and childbearing. Upadhyay (2014) drew from Connells' Theory of Gender and Power to develop the conceptual framework for this scale. Reproductive autonomy is measured through three subscales: (1) decision making, (2) freedom from coercion, and (3) communication. The analysis conducted examined reproductive autonomy, an aspect of sexual division of power, and explored how relationship power dynamics and personal autonomy play a role in women's sexual health decisions. The purpose of this study is to assess reproductive autonomy beliefs among Latinas and explore how these beliefs influence sexual health behaviors regarding contraception negotiation skills and contraception use.

Methods

Participants and Procedures

This study received approval from the institutional review board (IRB) at Texas A&M University in College Station, Texas. This study qualified for a waiver of documentation of consent. All participants were recruited through flyers that were posted on social media outlets (Facebook, Twitter, Instagram, Snapchat, etc.) and throughout the Dallas community (restaurants, barber shops, hair salons, tattoo shops, bakeries, bars, etc.). Participants either accessed the survey through an online link, or by contacting the researcher to complete the paper-pencil option. Participants were eligible to take part in

the study if they self-identified as Latina and were over the age of 18 years old. Data was collected in November and December 2016.

The questionnaire was available in English and in Spanish. Those participants who preferred the paper-pencil option were given a questionnaire in-person and were asked to read the information sheet. After reading the information sheet, participants could ask any clarifying question regarding the research study. Once completed, their questionnaire was sealed in an envelope until the data was entered into the database. Participants who selected the online option were directed to a Qualtrics link to complete an anonymous questionnaire. The first page of the online questionnaire included details about the research study and contact information. By starting the questionnaire, participants consented to participating in the research study.

The questionnaire comprised 107 items and took, on average, 17 minutes to complete. Participants who completed the questionnaire were given the opportunity to enter their personal information into a drawing that took place after all data was collected. There were 36 gift cards in the drawing: thirty $25 gift cards, five $50 gift cards, and one $100 gift card. Using gift cards was an incentive to increase the likelihood of participants to complete the survey. A total of 1,283 women who participated in the survey. Participants with missing data were removed resulting in a final sample of 567. The final number included women who completed the survey in its entirety.

Measures

Reproductive Autonomy. The RAS (Upadhyay, 2014) has 3 subscales which include: Decision-making (4 items), Freedom from coercion (5 items), and Communication (5 items). The decision-making subscale had the following answers choices: My sexual partner (1), Both me and my sexual partner (2), and Me (3). An example of an item from the first subscale includes: "Who has the most say about whether you use a method to prevent pregnancy?" The two other subscales, Freedom from coercion and Communication, had answers choices that ranged from Strongly Disagree (1) to Strongly Agree (4). Examples of items from those subscales include: "My partner has stopped me from using a method to prevent pregnancy when I wanted to use one", "My partner has pressured me to become pregnant", "My partner would support me if I wanted to use a method to prevent pregnancy", and "If I really did not want to become pregnant I could get my partner to agree with me." Overall the full RAS established high reliability with individual subscale reliability at 0.82, 0.74, and 0.65 for Freedom from coercion, Communication, and Decision-making subscales respectively (Upadhyay, 2014). Alphas in this present study include: Freedom from coercion ($\alpha = 0.8385$), Communication ($\alpha = 0.7632$), and Decision-making ($\alpha = 0.5867$).

Contraceptive Behaviors. Contraceptive behaviors were measured using three questions: (1) contraception negotiation skills in a monogamous relationship, (2) contraception negotiation skills with someone you just met, and (3) current contraception use. To measure negotiation skills in a monogamous relationship (NSR)

participants were given the prompt “Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you…” and were given 13 scenarios. Each scenario included different types of contraceptives including surgical procedures (i.e. tubes tied, vasectomy), implants, shots, rings, condoms (male and female), and even withdrawal. An example included: “Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you want to start using an IUD (intra-uterine device)? [Examples: Mirena, Paraguard, Skyla, Lileta]?” The response choices included (1) I definitely could not, (2) I probably could not, (3) I probably could, and (4) I definitely could. An average score, using the 13 items, was created for each participant ranging from 0 to 4; this average score represents the participant’s negotiation skills in a monogamous relationship. The higher the average score, the higher participants’ negotiation skills were within a monogamous relationship.

To measure negotiation skills with someone you just met (NSS) participants were provided the following hypothetical situation: “Imagine you are going to have sex with someone you just met. You feel it is important to use a method to prevent pregnancy. Could you tell that person you…” and asked if they could negotiate contraception methods with a person they just met. Six different contraction were provided: male condom, female condoms, foam/jelly/cream, diaphragm, family planning method, and withdrawal/pulling out. The response choices for each contraception type included (1) I

definitely could not, (2) I probably could not, (3) I probably could, and (4) I definitely could. An average score, using the six items, was created for each participant ranging from 0 to 4; this average score represented the participant's negotiation skills with someone they just met. The higher the average score, the higher the participant's negotiation skills were with someone they just met.

To measure current contraception use (CCU), participants were asked "What methods are you (or your partner) CURRENTLY using to keep you from getting pregnant?" The response choices included: Sterilization method (e.g., tubes tied or vasectomy), IUD (Mirena, Paraguard, Skyla, Lileta), Implant (Implanon, nexplanon), Shots (Depo-Provera), The Ring (Nuvaring), The Birth Control Patch, Birth Control Pill, Male Condoms, Female Condoms, Foam/jelly/cream, Diaphragm, Rhythm/family planning method (Not having sex at certain times), Withdrawal or Pulling out, or Nothing. Contraception use was coded as binary, with 0 indicated nonuse and 1 indicated current use.

Demographics. Items on the questionnaire asked the participant to identify demographic information regarding their age, current location, education status, current relationship status, number of children, religious affiliation and church attendance, race, ethnicity, Latino subgroup(s), generational status, country of origin, employment category and status, personal income and household income, health insurance status, and usual source of health services. Detailed descriptions can be found in Appendix J.

Data Analysis

Descriptive statistics, such as frequencies, means, and standard deviations of variables were calculated to describe the characteristics of the study sample. The SEM analysis was performed in two parts: (1) assessing the fit of the reproductive autonomy scale measurement model and (2) assessing the fit of the reproductive autonomy and contraception behaviors structural model. Model fit was assessed using the $\chi 2$ model fit index with non-significance indicating model fit. Goodness-of-fit (GFI) was used as an indicator of variance explained and for model comparison. Model fit was assessed by the following statistics and criteria: root mean error of approximation (RMSEA<0.08), comparative fit index (CFI>0.90), Tucker-Lewis index (TLI>0.90), and standardized root mean residual (SRMR<0.05). All analyses were performed using Stata 14.2 and MPlus Version 8.

Results

Demographics

Table 1 (Appendix K) presents the sample characteristics for Latina participants in this study. Among the 567 women, their average age was 29.57 (SD $\pm$ 6.015) and ranged from 19 to 40+ years old. When asked about education, most of the women either had their bachelor's degree (34%), master's degree (20%) or went to college but never received a degree (18.7%). Regarding relationship status, approximately one-third of the women were married and almost a quarter were currently in a monogamous relationship. For the relationship status, participants could choose multiple response choices to account for different types of relationships. Over half of the participants reported not

having children (59.3%). A quarter of the participants identified as not being part of any organized religion but were spiritual, while 38.8% identified Roman Catholic, and 19.6% identified as Christian–non-denominational. For church attendance, a third of the women went to church a few times a year (31.2%), while 23.1% of women stated that never went to church.

When asked to identify which Latino sub-group they identified with, over half of the participants identified as Mexican (54.5%), with Virgin Islanders and Puerto Ricans being the next big groups at 15.2% and 6.2%, respectively. Approximately 10% of the participants identified with 2 or more Latino subgroups. The participants were asked about their generational status and half (52.7%) of the sample identified as second generation, meaning they were born in the USA and either parent was born in another country. With that being said, approximately three-fourths of the participants were born in the United States and the next biggest group were born in Mexico (11.5%). Close to half of the participants (47.1%) identified as being employed full-time. Roughly 55% of participants had insurance that was provided through their current employer. When asked about a usual source for female health services, 39.3% said they went to a private OBGYN, 19% said they went to a general or family physician, and 12.9% said they did not have a usual course.

Reproductive Autonomy

RAS measured an individual's control over their sexual health. To measure this, participants were asked several questions about decision-making, freedom from coercion, and communication. The average mean for the Decision-making subscale was 2.57 (SD $\pm$ 0.3454). The average mean for the Freedom from Coercion subscale was 1.31 (SD $\pm$ 0.4672). The average mean for the Communication subscale was 3.52 (SD $\pm$0.4749).

Contraception Behaviors

Participants were asked about contraception behaviors by answering questions regarding contraception negotiation skills in a monogamous relationship, contraception negotiation skills with someone you just met, and current contraception use. The average score for contraception negotiation skills while in a relationship (NSR) was 3.702 (SD $\pm$ 0.4622). The average score for contraception negotiation skills with someone you just met (NSS) was 3.402 (SD $\pm$ 0.7141). The average score for current contraception use (CCU) was 0.865 (SD $\pm$ 0.3409).

Confirmation factor analysis and SEM model

Confirmatory factor analysis (CFA) was performed to confirm the original factor structure of the reproductive autonomy scale (Upadhyay, 2014). The initial measurement model attempted to include the second order latent variable reproductive autonomy, but the model failed to converge. Researchers performed CFA for the three first order latent

variables decision-making (DM), freedom from coercion (CR), and communication (CM) separately and saw successful results. Overall, the three measurement models had good fit (Appendix K, Table 2). Figure 2, 3, and 4 (Appendix L) displays the three measurement models, which specifies the latent variables are caused by the observed variables. Figure 5 (Appendix L) displays the reproductive autonomy and contraception behaviors structural model. DM, CR, and CM are the independent latent variables, while NSR, NSS, and CCU are dependent variables. The final structural model had fair fit (RMSEA = 0.050; CFI = 0.942; TLI = 0.931; SRMR = 0.052). Table 3 (Appendix K) shows the fit statistics of the final structural model. The model shows significant results with contraception negotiation skills in a monogamous relationship (NSR) being influenced by freedom from coercion (est. = 0.089; p = 0.033) and communication (est. = 0.582; $p < 0.000$). Contraception negotiation with someone you just met (NSS) was only seen to be influenced by communication (est. = 0.198; $p < 0.000$). To further explain, for every one-point increase in reproductive autonomy beliefs pertaining to freedom from coercion and communication, an individual's contraception negotiation skills in a relationship score goes up 0.089 and 0.582 points, respectively.

Discussion

The purpose of this study was to assess reproductive autonomy beliefs among Latinas and explore how those beliefs influence contraception behaviors. The results show that contraception negotiation skills, when the participant was in a relationship or with someone they just met, are influenced by their individual level of belief in certain

aspects of reproductive autonomy. Contraception negotiation skills in a relationship are significantly influenced by reproductive autonomy beliefs concerning freedom from coercion and communication. So, if an individual can communicate their sex life with their partner and does not experience sexual coercion in a relationship, then they have a greater chance of being able to negotiate contraception in their current relationship. Contraception negotiation skills with someone they just met was only influenced by reproductive autonomy beliefs specifically about communication. In this study, if a Latina feels like they have more autonomy in their sexual communication, then they have a better chance negotiating contraception with someone they just met. Communication is important when negotiating contraception and unfortunately it is often a construct that is overlooked when discussing unintended pregnancy.

The more women believe they can confidently communicate with their partner(s) about their sexual health, the better they will be at negotiating contraception. The better women can properly negotiate contraception, the better they will be at using contraception consistently, and they can better avoid unsafe sexual activity and successively avoid unintended pregnancies. This also pertains to reproductive autonomy when discussing freedom from coercion. In a relationship, if a woman believes they have control over sexual coercive situations, the better they can negotiate contraception with their partner(s). If women can control these situations and still be able to negotiate contraception, they decrease their risk of unprotected sex. In a recent study, greater

sexual relationship power had a greater influence on condom use when safer sexual communication was added in the model (Li & Samp, 2017).

These results give us an insight into what influences contraception negotiation among Latinas. This study can influence the development of tailored interventions that focus on (1) increasing sexual communication and refusal skills, (2) practicing contraception negotiation skills, and (3) teaching medically accurate sexual health information, including the importance of correct and consistent contraception use. Including these aspects in interventions help educate Latinas with new knowledge and skills they can use to communicate confidently with their sexual partner(s), which could lead to correct and consistent contraception use and overall, decrease unintended pregnancies. Other researchers are also seeing the importance of sexual communication and how it influences safer sex. There are new interventions being made that specifically focus on sexual communication skills, including a web-based program called ProjectHeartForGirls.com designed to increase sexual communication skills in adolescent girls (Widman et al., 2016). Programs like this can help vulnerable populations that are most affected by unintended pregnancy.

A major strength of this study was its use of SEM to assess the measurement of reproductive autonomy among a Latina sample and then to examine its relationship with certain contraception behaviors. Currently, there are no published studies that have used SEM to look at how reproductive autonomy influences certain contraception behaviors

among Latinas. However, this study has limitations worth discussing. This is a cross-sectional study with findings that are only a snapshot and not guaranteed to be representative. Without any follow-up data, the researchers are unable to analyze any behaviors over time which means no causal effects can be determined. Data collected from this study was self-reported and is limited due to lack of proper verification. The information that was given is to be taken at face-value and it is to be understood that certain biases could influence participant's responses. Some of these biases include, selective memory, telescoping, and exaggeration. Another limitation in this study is the participant's self-identification as Latina. There are many factors that contribute to how a person chooses to identify and the only criteria for this study was the participants self-identify as a Latina. Therefore, the results stated in this study should be interpreted with caution.

In conclusion, this research is an important step towards identifying additional influential factors that contribute to understanding contraception negotiation skills and contraception use among Latinas. Unintended pregnancy is influenced by many factors, many which have been overlooked. In this study, we looked at how aspects of reproductive autonomy influenced certain contraception behaviors. The results gave support to the use of SEM to examine reproductive autonomy (i.e., decision-making, freedom from coercion, and communication) and how it effects certain contraception behaviors (contraception negotiation in a relationship, contraception negotiation with someone you just met, and current contraception use). Results indicate that contraception

negotiation skills could be influenced by an individual's autonomy beliefs regarding freedom from coercion and communication. This information is vital to moving the sexual health field forward. These identified influential factors can be used to develop tailored family planning interventions that can be used in Latina populations to decrease unintended pregnancy.

CHAPTER III

CULTURE MATTERS: THE INFLUENCE OF MARIANISMO ON CONTRACEPTION BEHAVIORS OF LATINAS

Although unintended pregnancy rates in the United States have decreased since the 1990's, progress has been among non-Hispanic white women. Other groups are still struggling with unintended pregnancy, including Latinas (Masinter et al., 2013). Half of the pregnancies in the United States are unintended and Latinas (20-29 years old) account for 25% with the most recent rate being 58 per 1000 births (Finer et al., 2016; NATPTUP; 2012; NCTPTUP, 2017). In the United States, over half of Latinas become pregnant before they turn 20 years old (Martin et al., 2017; Ventura et al., 2012). Negative and economic outcomes for mother and child are associated with unintended births, especially in disproportionately groups like Latinas (American Academy of Pediatrics, 2012; Finer et al., 2016; Kost et al., 2015; Logan et al., 2007; NATPTUP, 2012). The U.S. Department of Health and Human Services has established family planning goals according to Healthy People 2020 that address unintended pregnancy. The goals include improving the rate of planned pregnancies and birth spacing, which is the time between births (Healthy People, 2017). This includes increasing the rates of intended pregnancies, reducing repeat births (i.e., pregnancy within 18 months of previous birth), increasing contraception use the last time of sex, and increasing multiple contraception use (ex., male condom and hormonal birth control pill) (Healthy People, 2017b).

For sexually active individuals who do not intend to get pregnant, using contraception consistently and correctly is key. Realistically, this not a common practice among woman currently using contraception. One-third of at-risk women use contraception inconsistently and incorrectly or do not use contraception at all; these women account for 95% of unintended pregnancies (Guttmacher 2016; Sonfield et al., 2014). Healthy People 2020 goals associated with decreasing unintended pregnancy includes increasing access to effective contraception and more importantly, educating more correct and consistent use of contraceptive methods. In order to for these goals to succeed, it is essential that researchers further explore what influences contraception use, especially among Latinas.

Previous studies have examined contraception influential factors and found that the focus was predominately demographics and relationships characteristics (Frost et al., 2007; 2008; Wildsmith et al., 2012). Previous studies have associated culture with contraception use (Crissman, et al., 2012; Moreno, 2007). Cultural research on Latino health has grown in the last two decades since this population is responsible for more than half of the population growth from 2000 to 2010 (Ennis, 2011). Previous studies have examined teen pregnancy, HIV/AIDS, intimate partner violence, and mental health among Latino populations (Denner et al., 2001; Moreno, 2007; Ojeda and Pina-Watson, 2013; Pina-Watson et al., 2013, 2015; Villareal et al., 2017). Cultural values not only influence an individual's person decisions but also have an influence in the community that individual lives in. Prior research has examined cultural values that revolve around

the constructs of family and respect, but limited research has studied gender norms and how they influence health.

Gender norm beliefs are socially constructed values and attitudes a person has towards how they think a man or woman should normally act (WHO, 2015). In Latino culture, machismo and marianismo describe the societal gender norms. Machismo is the name for the Latino (i.e., male) gender norm, which is associated with aggression, antisocial and authoritative behaviors, and alexithymia (i.e., inability to process emotions) (Arciniega et al., 2008). On the other side and what we will be focusing on is Marianismo, which is the name for the Latina (i.e., female) gender norm. Marianismo is associated with being virtuous, humble, extremely spiritual, submissive to men, and endure sacrifice and suffering for the sake of their family (Castillo and Cano, 2007). These terms stem from prominent Latino cultural values such as, familismo, respeto, and simpatia (Flores et al., 1998; Raffaelli and Ontai, 2004; Triandis et al., 1984).

Cultural values have been associated with positive and negative effects on health issues. Previous studies have associated certain Latino cultural values as protective factors against sexual risk behaviors (De Santis et al., 2016; Ma et al., 2014). There have been other studies where Latino cultural values were associated with certain risk factors. Ma and Malcolm (2016) examined HIV testing among Latino youth and saw that individuals who had higher familismo scores were less likely to get tested for HIV. With men who have sex with men, Surace, Levitt, and Horne (2017) saw that higher familismo and

machismo scores were associated with higher levels of ASWC (the appeal of sex without condoms). Since there have been unclear findings for how culture influences sexual health, exploring factors that are associated with culture could aid in a better understanding of Latina contraception use.

Theory of gender and power and marianismo beliefs scale

The conceptual underpinning of this study was derived from the Theory of Gender and Power. The Theory of Gender and Power was created in 1987 by Raewyn Connell. This theory explains how gender is a large-scale social structure and not just a personal identifier (Connell, 1987). This study used this theory to explore the relationships between marianismo beliefs and certain contraception behaviors. The three theoretical constructs in this theory are sexual division of labor, sexual division of power, and cathexis. Sexual division of labor examines economic inequities that favor males. Sexual division of power examines inequities and abuses in authority and control in relationships and institutions that favor males. Cathexis examines social norms, cultural values, and gender biases. The focus of this theory is on societal and institutional issues regarding gender and power and how it impacts individual behaviors. These three constructs work together to define and explain heterosexual relationships and how certain aspects play a role in women's sexual health decision making. This theory helps identify risk factors that affect women's sexual health; the theory can be used to address women's health issues pertaining to gender-based inequalities. Previously, women's HIV exposure has been examined using the theory of gender and power (Wingood et al.,

2000). Other researchers have also used the theory to examine relationships between unbalanced gender, power structures, and control in regard to condom use and other sexual behaviors (Depadilla et al., 2011; Lopez et al., 2012; Wingood et al., 2000).

The Marianismo Beliefs Scale (MBS) (Castillo et al., 2010) was created with the intention of exploring the influence of marianismo on health outcomes. Initial development of this scale was based on interdisciplinary literature regarding Latino values, Latino gender role socialization, marianismo, and aspects of acculturation and enculturation. The MBS is measured through five subscales: (1) Family Pillar, (2) Virtuous and Chaste, (3) Subordinate to Others, (4) Self-Silencing to Maintain Harmony, and (5) Spiritual Pillar. Marianismo is a multidimensional construct and has previously been used to examine several health issues including HIV/AIDS, intimate partner violence, sexual health, domestic violence, and depression (Moreno, 2007). The theory of gender and power was chosen to aid in the exploration and understanding of factors that influence unintended pregnancy. In this study marianismo beliefs, an aspect of cathexis (i.e., cultural norms, gender norms) is examined to determine its influence on contraception negotiation skills and contraception use. The purpose of this study was to assess marianismo beliefs among Latinas and explore how these beliefs influence sexual health behaviors regarding contraception negotiation skills and contraception use.

Methods

Participants and Procedures

This study was approved from Texas A&M University's institutional review board (IRB) in College Station, Texas. The study qualified for a waiver of documentation of consent from IRB. Participant recruitment occurred via flyers posted on social media outlets (Facebook, Twitter, Instagram, Snapchat, etc.) and throughout the Dallas community (restaurants, barber shops, hair salons, tattoo shops, bakeries, bars, etc.). Participants accessed the survey online, or by paper-pencil. Study eligibility included self-identification as Latina and participants being over the age of 18 years old. November and December 2016 are when data was collected.

Participants were given the option of taking an English or Spanish questionnaire. Participants preferring paper-pencil option were given a questionnaire in-person and asked to read the information sheet. Then, participants could ask clarifying questions about the study. After completion, the questionnaire placed in a sealed envelope until data entry. For those participants who chose to take the questionnaire online, a Qualtrics link was given to them to complete the anonymous questionnaire. The link took the participants to an introductory page that included details about the research study and contact information. Participants consented to taking part in the research study by starting the questionnaire.

There were 107 items on the questionnaire and participants took, on average, 17 minutes to complete. There was an optional drawing that took place after data collection for all participants who completed the questionnaire. A total of 36 gift cards were in the drawing: thirty $25 gift cards, five $50 gift cards, and one $100 gift card. This was used as an incentive to increase survey participation. Total survey participation was 1,283 women. The final sample was 567 once participants with missing data were removed. The final sample included participants who answered all items on the questionnaire.

Measures

Marianismo beliefs. The MBS (Castillo et al., 2010) is a 24-item scale that measures the extent someone believes a Latina should enculturate and maintain the cultural values from the Latina female gender role construct, marianismo. This scale comprises five subscales which include: Family Pillar (5 items), Virtuous and Chaste (5 items), Subordinate to others (5 items), Self-Silencing to Maintain Harmony (6 items), and Spiritual Pillar (3 items). Participants had the chance to choose an answer from a four-point scale ranging from strongly disagree (1) to strongly agree (4). An example of an item includes: "A Latina…" "must be a source of strength for her family," "should (should have) remain(ed) a virgin until marriage," "should satisfy her partner's sexual needs without argument,", "Should not discuss birth control," and "is responsible for the spiritual growth of the family." The scores for the MBS are computed for each subscale; higher scores on each subscale indicates a higher incorporation of marianismo beliefs in daily lives. The MBS had established adequate reliability, convergent validity, and

discriminant validity among college students (Castillo et al., 2010). Alphas in this present study include: Family Pillar (α = 0.7456), Virtuous and Chaste (α = 0.8394), Subordinate to others (α = 0.7237), Self-Silencing to Maintain Harmony (α = 0.8587), and Spiritual Pillar (α = 0.8700).

Contraceptive Behaviors. Three questions measured contraception behaviors: contraception negotiation skills in a monogamous relationship, contraception negotiation skills with someone you just met, and current contraception use. For contraception negotiation in a monogamous relationship, participants were prompted with the scenario: "Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you…" and were given 13 responses to choose from. Responses included different contraceptive methods including surgical procedures (i.e. tubes tied, vasectomy), implants, shots, rings, condoms (male and female), and even withdrawal. An example read: "Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you want to start using an IUD (intra-uterine device)? [Examples: Mirena, Paraguard, Skyla, Lileta]?" The responses included (1) I definitely could not, (2) I probably could not, (3) I probably could, and (4) I definitely could. Using the 13 items, an average score was created for each participant ranging from 0 to 4; this average score signifies the participant's negotiation skills in a

monogamous relationship. The higher the average score, the higher the participant's negotiation skills within a monogamous

For negotiation skills with someone you just met (NSS), participants were given a hypothetical scenario: "Imagine you are going to have sex with someone you just met. You feel it is important to use a method to prevent pregnancy. Could you tell that person you…" and asked how well they could negotiate various contraceptives with an acquaintance. The methods of contraception included male condom, female condoms, foam/jelly/cream, diaphragm, family planning method, and withdrawal/pulling out. Responses included (1) I definitely could not, (2) I probably could not, (3) I probably could, and (4) I definitely could. Using the six items, an average score was created for each participant ranging from 0 to 4; this average score signifies the participant's negotiation skills with someone they just met. The higher the average score, the higher the participant's negotiation skills with someone they just met.

For current contraception use (CCU), the following question was asked "What methods are you (or your partner) CURRENTLY using to keep you from getting pregnant?" The responses included: Sterilization method (e.g., tubes tied or vasectomy), IUD (Mirena, Paraguard, Skyla, Lileta), Implant (Implanon, nexplanon), Shots (Depo-Provera), The Ring (Nuvaring), The Birth Control Patch, Birth Control Pill, Male Condoms, Female Condoms, Foam/jelly/cream, Diaphragm, Rhythm/family planning method (Not having

sex at certain times), Withdrawal or Pulling out, or Nothing. This item was coded as binary with nonuse and current use represented by 0 and 1, respectively.

Demographics. Many items on the questionnaire collected demographic information about age, current location, education status, current relationship status, number of children, religious affiliation and church attendance, race/ethnicity, Latino subgroup(s) the participant identified with, generational status, country of origin, employment category and status, personal income and household income, health insurance status, and usual source of health services. In Appendix J, detailed descriptions for each item can be found.

Data Analysis

Descriptive statistics, such as frequencies, means, and standard deviations of variables, used to describe the characteristics of the study sample were calculated. The SEM analysis was performed in three parts: (1) assessing the fit of the marianismo beliefs scale measurement model, (2) assessing the fit of the marianismo beliefs and contraception behaviors structural model, and (3) separating marianismo into its five sub-constructs and assessing the fit of the detailed structural models. Model fit was assessed using the $\chi 2$ model fit index with non-significance indicating model fit. Goodness-of-fit (GFI) was used as an indicator of variance explained and for model comparison. Model fit was assessed by the following statistics and criteria: root mean error of approximation (RMSEA<0.08), comparative fit index (CFI>0.90), Tucker-

Lewis index (TLI>0.90), and standardized root mean residual (SRMR<0.05). All analyses were performed using Stata 14.2 and MPlus Version 8.

Results

Demographics

The sample characteristics for 567 Latinas participants in this study are represented in Table 1 (Appendix K). The average age for all participants was 29.57 (SD $\pm$ 6.015). For educational status, the participants either had their bachelor's degree (34%), master's degree (20%) or had gone to college but never received a degree (18.7%). One-third of the women were married and almost a quarter were currently in a monogamous relationship. Participants had the option to select multiple answer choices to account for diverse relationships. Almost 60% of the participants reported not having children. One-quarter of the participants identified as not being part of any organized religion but were spiritual, while 38.8% identified Roman Catholic, and 19.6% identified as Christian–non-denominational. One third of the women stated they attended church a few times a year (31.2%), while 23.1% of women stated that they never attended church.

Over half of the participants identified as Mexican (54.5%), with Virgin Islanders and Puerto Ricans being following at 15.2% and 6.2%, respectively. Roughly 10% of the participants identified with 2 or more Latino subgroups. A little over half (52.7%) of the sample identified as second generation, meaning they were born in the USA and either parent was born in another country; three-fourths of the participants were born in the United States and the next biggest group were born in Mexico (11.5%). Roughly half of the participants (47.1%) identified as being employed full-time. Half of the participants

reported that their insurance was provided through their current employer. When asked about a usual source for female health services, 39.3% said they went to a private OBGYN, 19% said they went to a general or family physician, and 12.9% said they did not have a usual course.

Marianismo beliefs

MBS measured the extent someone believes a Latina should enculturate and maintain the cultural values from the Latina female gender role construct. The five subscales were Family Pillar, Virtuous and Chaste, Subordinate to Others, Self-Silencing to Maintain Harmony, and Spiritual Pillar. The average mean for the Family pillar (FP) subscale was 3.108 (SD $\pm$ 0.5313). The average mean for the Virtuous and Chaste (VC) subscale was 2.358 (SD $\pm$ 0.6577). The average mean for the Subordinate to Others (SO) subscale was 1.501 (SD $\pm$ 0.5317). The average mean for the Silencing Self to maintain Harmony pillar (SS) subscale was 1.393 (SD $\pm$ 0.4807). The average mean for the Spiritual pillar (SP) subscale was 2.213 (SD $\pm$ 0.7527).

Contraception Behaviors

Contraceptive behaviors were measured by prompting participants with scenarios regarding contraception negotiation skills in a monogamous relationship, contraception negotiation skills with someone you just met, and current contraception use. Average score for Negotiation Skills while in a Relationship was 3.702 (SD $\pm$ 0.4622). The

average score for Negotiation Skills while single was 3.402 (SD $\pm$ 0.7141). Average score for Current Contraception Use was 0.865 (SD $\pm$ 0.3409).

Confirmation factor analysis and SEM model

Confirmatory factor analysis (CFA) as performed to confirm the original factor structure of the marianismo beliefs scale (Castillo et al., 2010). The initial measurement model attempted to use the first order latent variables found in marianismo beliefs, but the model failed to converge. Researchers performed CFA for the second order latent variable marianismo beliefs (MBS) and saw successful results. Overall, the measurement model had fair fit (Appendix K, Table 4). Figure 6 (Appendix L) displays the measurement model, which specifies that the latent variables are caused by the observed variables. Figure 2 (Appendix L) displays the marianismo beliefs (MBS) and contraception behaviors structural model. MBS is the independent latent variable, while NSR, NSS, and CCU are dependent variables. The final structural model had fair fit (RMSEA = 0.046; CFI = 0.938; TLI = 0.930; SRMR = 0.076). Table 5 (Appendix K) shows the fit statistics of the final structural model. The model shows significant results with contraception negotiation skills in a monogamous relationship (NSR) being influenced by marianismo beliefs (est. = -0.349; p = 0.003). Current contraception use was also influenced by marianismo beliefs (est. = -0.516; p = 0.008). For example, for every one-point increase in marianismo beliefs, an individual's negotiation skills in a relationship and current contraception use score was affected by -0.349 and -0.516 points, respectively.

Additional analyses were done to see which individual MBS sub-constructs influenced contraception behaviors. Out of the fifteen detailed models, seven of them showed statistically significant results (Appendix K, Table 6). Contraception negotiation skills in a monogamous relationship (NSR) was influenced by marianismo subconstructs virtuous and chaste (est. = -0.074; p = 0.009), subordinate to others (est. = -0.165; *p = 0.000*), silencing self to maintain harmony (est. = -0.259; *p = 0.000*), and spiritual pillar (est. = -0.100; p = 0.002). Contraception negotiation with someone you just met (NSS) was influences by silencing self to maintain harmony (est. = -0.091; *p = 0.000*). Current contraception use was influences by virtuous and chaste (est. = -0.137; p = 0.006) and SO (est. = -0.129; p = 0.047). Figure 8 (Appendix L) displays a simplified version of the detailed MBS models.

Discussion

The purpose of this study was to assess marianismo beliefs among Latinas and explore how these beliefs influence sexual health behaviors regarding contraception negotiation skills and contraception use. The results indicate that contraception negotiation skills in a relationship and current contraception use were influenced by marianismo beliefs. Within this sample of Latinas, increased levels of marianismo beliefs led to decreased scores in contraception negotiation (in a relationship) and current contraception use. In this study, if an individual identified more with traditional Latina gender norms, then she had a lower score in contraception negotiation skills (in a relationship) and current contraception use.

Results from the detailed models show dependent variables specifically influenced by certain marianismo sub-constructs. Contraception negotiation skills in a monogamous relationship was primarily influences by the four sub-constructs: virtuous and chaste, subordinate to others, silencing self to maintain harmony, and spiritual pillar. The most influential being silencing self to maintain harmony. Contraception negotiation skills with someone you just met was primarily influences by the sub-construct: silencing self to maintain harmony. And last, current contraception use was influences by the two sub-constructs, virtuous and chaste and subordinate to others, with the most influential being virtuous and chaste.

These results give an insight to what influences contraception negotiation and current contraception use among Latinas. The results from this study can help understand how culture plays a role in sexual health and allows researchers to think about what steps need to take place to address culture in intervention development. More sexual health researchers and practitioners can use the results from this study to advocate for new culturally tailored interventions that focus on discussing Latino cultural values. Developing interventions helps educate Latinas with knowledge and skills they can use to confidently communicate with their sexual partner(s), leading towards correct and consistent contraception use and overall, decrease pregnancies that are unintended. There is a culturally tailored program called "¡Cuídate! (Take Care of Yourself)" that was specifically designed for Latino youth (DHHS, n.d.). Although "¡Cuídate!" targets youth, it is important to recognize how the program takes Latino cultural values and

reframes their meaning to teach abstinence and condom use as ways to prevent unintended pregnancy and STD/HIV. The curriculum concentrates on increasing youth confidence and self-efficacy by having lessons that focus on partner communication and negotiation skills. The reframing of cultural norms in a positive way can spark a paradigm shift in Latino communities. A recent study saw positive program outcomes that included increased self-efficacy regarding condom communication and consistent condom use (Bartlett et al., 2018). Developing similar programs for Latinos across several age ranges and backgrounds can push forward efforts to reduce the rates of unintended pregnancy.

Limitations

One strength of this study was use of SEM to assess the measurement of marianismo beliefs and then to examine its relationship with certain contraception behaviors. Currently, there are no published studies that have used SEM to look at how marianismo beliefs influences contraception negotiation behaviors among Latinas. However, this study has limitations worth discussing. This is a cross-sectional study with findings that cannot guaranteed to be representative. Without additional follow-up data, researchers cannot examine any behaviors over time, meaning no causal effects can be determined. All data collected was self-reported and is limited due to lack of proper verification. The information that was given is to be taken at face-value and it is to be understood that certain biases could influence participants answer choices. Some of these biases include, selective memory, telescoping, and exaggeration. Another limitation in this study is the

participant's self-identification as Latina. Many factors contribute to personal identification and the only criteria for this study was that the participant self-identify as a Latina. Therefore, the results stated should be interpreted with caution.

In conclusion, this research is important because it recognizes influential factors that play a role in contraception negotiation. In this study, we looked at how marianismo beliefs influenced certain contraception behaviors. These results displayed the use of SEM to examine marianismo beliefs and how it affected certain contraception behaviors (contraception negotiation in a relationship and current contraception use). Results indicated that cultural values (i.e. marianismo beliefs) play a role in sexual health and future interventions should tailor their efforts to fit the need of the populations most affected. Future research endeavors should include examining the influence of demographic information, separating "Latinas" into various subgroups (i.e., Mexican, Puerto Rican, Salvadorian, etc.) or geographical locations, and modified to use with people in same-sex relationships.

CHAPTER IV

EXPLORING THE RELATIONSHIPS BETWEEN MARIANISMO, REPRODUCTIVE AUTONOMY, AND CONTRACEPTION BEHAVIORS: EXAMINING A MEDIATION MODEL

Half of all pregnancies in the United States are unintended. In 2011, approximately 2.8 million out of 6.1 million pregnancies were unintended, meaning that the women did not want a pregnancy at that time or did not want a pregnancy at all (Finer et al., 2016; NCTPTUP, 2017). An intended pregnancy is defined by either one that is untimed or unwanted (Guttmacher, 2016). Untimed pregnancy occurs when a woman did not want to become pregnant at the time the pregnancy occurred but did want to become pregnant sometime in the future. Unwanted pregnancy occurs when a woman did not want to become pregnant at that time or anytime in the future. The unintended pregnancy rate in the United States is higher when compared to developed countries around the globe (Singh, 2010). Higher unintended pregnancy rates are typically seen among young (18-24 years), low-income, minority women (Guttmacher, 2016).

In the last 30 years, the National Survey of Family Growth data shows no overall decline in unintended birth rates (Mosher et al., 2012). Hispanic and Black women have not been as fortunate to see improvements like their non-Hispanic white counterpart. Approximately one-fourth of the unintended pregnancies were to young Latinas (20-29 years old) in the last 10 years and most recent pregnancy rate being 58 per 1000 births in

2011 (Finer et al., 2016; NATPTUP; 2012)). Latinas living in the United States have a greater chance of becoming pregnant at least once before they turn 20 years old (Martin et al., 2017; Ventura et al., 2012). Negative health and economic outcomes are often associated with unintended births, especially among disproportionately affected minority groups. Some of those outcomes include delayed prenatal care, risky health behaviors, premature birth, and negative mental health (American Academy of Pediatrics, 2012; Finer et al., 2016; (Guttmacher, 2016; Kost et al., 2015). Children that result from an unintended pregnancy also have inferior behavioral and educational success compared to their counterparts (Logan et al., 2007; NATPTUP, 2012). An unintended pregnancy not only affects those involved but also affects the public with the high medical costs. In 2010, unintended births in the United States cost the public $21 billion dollars (Guttmacher, 2016). One way to address this public health issue is to increase contraceptive use in populations disproportionately affected.

Family planning goals in Healthy People 2020 address unintended pregnancy; they include improving pregnancy planning and spacing (Healthy People, 2017). Objectives include increasing intended pregnancies, reducing repeat births (i.e., pregnancy within 18 months of previous birth), increasing contraception use at last time of intercourse, and increasing multiple contraception use (ex., condom AND pill, condom and IUD, etc.) among sexually active females (Healthy People, 2017b). The goals of Healthy People 2020 associated with decreasing unintended pregnancy rates involve increasing access to highly effective contraception and educating correct and consistent use of contraceptive

methods. To move forward, we need to look at what influences women to use contraception.

Previously, when researchers have looked at factors that influence contraceptive use, demographic variables and relationship characteristics are the focus of these studies (Frost et al., 2007; 2008; Wildsmith et al., 2012). Power dynamics, such as partner influence, personal autonomy, and gender empowerment are factors that are often overlooked, even though they have been associated with other sexual health outcomes like STI infection (Dworkin et al., 2009; Moreno, 2007). Cultural values, such as familismo, personalismo, fatalismo, and machismo, have also been previously examined (Ma et al., 2014; Ma & Malcolm, 2016; Surace, Levitt, & Horne, 2017), but few studies placed attention on the importance of gender norms and how they influence sexual health. Even fewer studies have brought power dynamics and cultural values together to examine their influence on sexual health behaviors. There are only two U.S. studies (involving Latinos) and two African studies that have identified partner influence, culture, and aspects of women's empowerment as factors that influence contraceptive use (Crissman, et al., 2012; Do & Kurimoto, 2010; Kerns et al., 2003; Moreno, 2007). To see what influences contraception use among Latinas, researchers need to explore other influential factors simultaneously.

Theory of gender and power

The Theory of Gender and Power will be the conceptual underpinning to explore the relationships between reproductive autonomy, marianismo beliefs, and certain contraception behaviors. The Theory of Gender and Power, created in 1987 by Raewyn Connell, emphasizes gender as a large-scale social structure and not solely as a personal identifier (Connell, 1987). Sexual division of labor, sexual division of power, and cathexis are the three theoretical constructs in this theory. Sexual division of labor examines economic inequities favoring males. Sexual division of power examines inequities and abuses in authority and control in relationships and institutions favoring males. Finally, cathexis examines social norms, cultural values, and gender biases. This theory focuses on societal gender and power issues and how that affects individual behaviors. The constructs in this theory work together to explain how characteristics of heterosexual relationships influence sexual health decisions and helps identify risk factors that affect women's sexual health. The theory of gender and power has previously been used to examine women's HIV exposure (Wingood et al., 2000). The theory has also been used to look at relationships between unbalanced gender, power structures, and control and condom use (Depadilla et al., 2011; Lopez et al., 2012; Wingood et al., 2000).

The analysis in this study explored how cultural values, gender norms, and reproductive autonomy play a role in sexual health decisions among women. The purpose of this study is to examine the relationships between marianismo beliefs, reproductive

autonomy, and contraception behaviors among Latinas. The goal of this study is to explore how reproductive autonomy influences contraception behaviors with marianismo as a mediator.

Methods

Participants and Procedures

This study received approval from the institutional review board (IRB) at Texas A&M University in College Station, Texas. Data was collected in November and December 2016. Participants were eligible to take part in the study if they identified as Latina and were over the age of 18 years old. All participants were recruited through flyers posted on social media outlets (Facebook, Twitter, Instagram, Snapchat, etc.) and throughout the DFW community (Restaurants, Barber Shops, Hair Salons, Tattoo Shops, Bakeries, Bars, etc.).

The questionnaire was available online and paper-pencil, and in English and in Spanish. Those participants who preferred the paper-pencil option were given a questionnaire in-person and asked to read the information sheet. After reading the information sheet, participants asked any clarifying question regarding the research study. Once completed, their questionnaire was sealed in an envelope until it data was ready to be recorded. Participants who opted for the online option were given a Qualtrics link to complete an anonymous questionnaire. The first page of the online questionnaire included details about the research study and contact information. This study qualified for use of the

waiver of documentation of consent. By starting the online questionnaire, the participants consented to taking part in the research study.

The questionnaire had 107 items and took, on average, 17 minutes to complete. Participants who completed the questionnaire were given the opportunity to enter information in a drawing that took place after all data was collected. There were 36 gift cards in the drawing: thirty $25 gift cards, five $50 gift cards, and one $100 gift card. Using gift cards was an incentive to increase the likelihood of participants to complete the survey. There was 1283 women who took part in the survey. Participants with missing data were removed resulting in a final sample of 567. The final number included women who completed the survey in its entirety.

Measures

Reproductive Autonomy. The RAS is a 14-item scale that measures a person ability to have the power to decide about and control matters associated with contraceptive use, pregnancy, and childbearing (Upadhyay, 2014). The authors drew from Connells' Theory of Gender and Power to develop the conceptual framework for this scale. This scale has 3 subscales which include: Decision-making (4 items), Freedom from coercion (5 items), and Communication (5 items). The decision-making subscale had the following answers choices: My sexual partner (1), Both me and my sexual partner (2), and Me (3). An example of an item from the first subscale includes: "Who has the most say about whether you use a method to prevent pregnancy?" The two other subscales,

Freedom from coercion and Communication, had answers choices that ranged from Strongly Disagree (1) to Strongly Agree (4). Examples of items from those subscales include: “My partner has stopped me from using a method to prevent pregnancy when I wanted to use one”, “My partner has pressured me to become pregnant”, “My partner would support me if I wanted to use a method to prevent pregnancy”, and “If I really did not want to become pregnant I could get my partner to agree with me.” Overall the full RAS established high reliability with individual subscale reliability at 0.82, 0.74, and 0.65 for Freedom from coercion, Communication, and Decision-making subscales, respectively. Alphas in this present study include: Freedom from coercion ($\alpha = 0.8385$), Communication ($\alpha = 0.7632$), and Decision-making ($\alpha = 0.5867$).

Marianismo. The MBS is a 24-item scale that measures the extent someone believes a Latina should enculturate and maintain the cultural values from the Latina female gender role construct, marianismo (Castillo et al., 2010). This scale has five subscales which include: Family Pillar (5 items), Virtuous and Chaste (5 items), Subordinate to Others (5 items), Self-Silencing to Maintain Harmony (6 items), and Spiritual Pillar (3 items). Participants had the chance to choose an answer from a four-point scale ranging from strongly disagree (1) to strongly agree (4). An example of an item includes: “A Latina…” “must be a source of strength for her family,” “should (should have) remain(ed) a virgin until marriage,” “should satisfy her partner’s sexual needs without argument,”, “Should not discuss birth control,” and “is responsible for the spiritual growth of the family.” The scores for the MBS are computed for each subscale; higher

scores on each subscale indicates a higher incorporation of marianismo beliefs in daily lives. The MBS has established adequate reliability, convergent validity, and discriminant validity among college students (Castillo et al., 2010). Alphas in this present study include: Family Pillar ($\alpha = 0.7456$), Virtuous and Chaste ($\alpha = 0.8394$), Subordinate to Others ($\alpha = 0.7237$), Self-Silencing to Maintain Harmony ($\alpha = 0.8587$), and Spiritual Pillar ($\alpha = 0.8700$).

Contraceptive Behaviors. Contraceptive behaviors were measured using three items: negotiation skills in a monogamous relationship, negotiation skills with someone you just met, and current contraception use. To measure negotiation skills in a monogamous relationship (NSR) participants were given the prompt "Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you…" and were given 13 scenarios. Each scenario included different contraceptives methods including surgical procedures (i.e. tubes tied, vasectomy), implants, shots, rings, condoms (male and female), and even withdrawal. An example included: "Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you want to start using an IUD (intra-uterine device)? [Examples: Mirena, Paraguard, Skyla, Lileta]?" The answer choices included (1) I definitely could not, (2) I probably could not, (3) I probably could, and (4) I definitely could. An average score, using the 13 items, was created for each participant ranging from 0 to 4; this average score represents the

participant's negotiation skills in a monogamous relationship. The higher the average score, the higher the participants' negotiation skills within a monogamous relationship.

To measure negotiation skills with someone you just met (NSS) participants were given a hypothetical situation: "Imagine you are going to have sex with someone you just met. You feel it is important to use a method to prevent pregnancy. Could you tell that person you…" and asked if they could negotiate six types of contraception with a person they just met. The six contraceptive methods included male condom, female condoms, foam/jelly/cream, diaphragm, family planning method, and withdrawal/pulling out. The answer choices included (1) I definitely could not, (2) I probably could not, (3) I probably could, and (4) I definitely could. An average score, using the six items, was created for each participant ranging from 0 to 4; this average score represents the participant's negotiation skills with someone they just met. The higher the average score, the higher the participant's negotiation skills with someone they just met.

To measure current contraception use (CCU), participants were asked "What methods are you (or your partner) CURRENTLY using to keep you from getting pregnant?" The answer choices included: Sterilization method (e.g., tubes tied or vasectomy), IUD (Mirena, Paraguard, Skyla, Lileta), Implant (Implanon, nexplanon), Shots (Depo-Provera), The Ring (Nuvaring), The Birth Control Patch, Birth Control Pill, Male Condoms, Female Condoms, Foam/jelly/cream, Diaphragm, Rhythm/family planning method (Not having sex at certain times), Withdrawal or Pulling out, or Nothing.

Contraception use was coded as binary, with 0 indicated nonuse and 1 indicated current use.

Demographics. Numerous items on the questionnaire collected information regarding age, location, education, relationship status, number of children, religious affiliation and church attendance, race, ethnicity, Latino subgroup(s) identification, generational status, country of origin, employment category and status, personal income and household income, health insurance status, and usual source of health services. Detailed descriptions of each item can be found in Appendix J.

Data Analysis

Descriptive statistics, such as frequencies, means, and standard deviations of variables were calculated to describe the characteristics of the study sample. SEM analysis was performed to assess the fit of the marianismo beliefs, reproductive autonomy, and contraception behaviors structural model. Model fit was assessed using $\chi 2$ model fit index with non-significance indicating model fit. Goodness-of-fit (GFI) was used as an indicator of variance explained and for model comparison. Model fit was assessed by root mean error of approximation (RMSEA<0.08), comparative fit index (CFI>0.90), Tucker-Lewis index (TLI>0.90), and standardized root mean residual (SRMR<0.05). All analyses were performed using Stata 14.2 and MPlus Version 8.

Results

Demographics

Table 1 (Appendix K) presents the sample characteristics for 567 Latinas participants in this study. The average age was 29.57 (SD $\pm$ 6.015). When asked about educational status, the three largest groups either had their bachelor's degree (34%), master's degree (20%) or had gone to college but never received a degree (18.7%). When asked to identify their relationship status, approximately one-third of the women were married and almost a quarter were currently in a monogamous relationship. Participants could choose multiple answer choices to account for different relationship types. Almost 60% of the participants reported not having children. A quarter of the participants identified as not being part of any organized religion but were spiritual, while 38.8% identified Roman Catholic, and 19.6% identified as Christian–non-denominational. One third of the women stated they went to church a few times a year (31.2%), while 23.1% of women reported they never went to church.

Over half of the participants identified as Mexican (54.5%), with Virgin Islanders and Puerto Ricans being the next big groups at 15.2% and 6.2%, respectively. Roughly 10% of the participants identified with 2 or more Latino subgroups. A little over half (52.7%) of the sample identified as second generation, meaning they were born in the USA and either parent was born in another country; approximately three-fourths of the participants were born in the United States and the next biggest group were born in Mexico (11.5%).

Almost half of the participants (47.1%) identified as being employed full-time. Half of the participants reported that insurance was provided through their current employer. When asked about a usual source for female health services, 39.3% said they went to a private OBGYN, 19% said they went to a general or family physician, and 12.9% said they did not have a usual course.

Marianismo Beliefs

The MBS measured traditional Latina gender norms through five sub-constructs: Family Pillar, Virtuous and Chaste, Subordinate to Others, Self-Silencing to Maintain Harmony, and Spiritual Pillar. The average mean for the Family pillar subscale was 3.108 (SD $\pm$ 0.5313). The average mean for the Virtuous and Chaste subscale was 2.358 (SD $\pm$ 0.6577). The average mean for the Subordinate to Others subscale was 1.501 (SD $\pm$ 0.5317). The average mean for the Silencing Self to maintain Harmony pillar subscale was 1.393 (SD $\pm$ 0.4807). The average mean for the Spiritual pillar subscale was 2.213 (SD $\pm$ 0.7527).

Reproductive Autonomy

The RAS measured autonomy through three sub-constructs: decision-making, freedom from coercion, and communication. The average mean for the Decision-making subscale was 2.57 (SD $\pm$ 0.3454). The average mean for the Freedom from Coercion subscale was 1.31 (SD $\pm$ 0.4672). The average mean for the Communication subscale was 3.52 (SD $\pm$ 0.4749).

Contraception Behaviors

Contraception behaviors was measured by questions about contraception negotiation skills in a monogamous relationship, contraception negotiation skills with someone you just met, and current contraception use. The average score for contraception negotiation skills while in a relationship was 3.702 (SD $\pm$ 0.4622). The average score for contraception negotiation skills with someone they just met was 3.402 (SD $\pm$ 0.7141). The average score for current contraception use was 0.865 (SD $\pm$ 0.3409).

Mediation model

Figure 9 (Appendix L) displays the marianismo beliefs, reproductive autonomy, and contraception behaviors structural model. Reproductive autonomy was the independent latent variable, while NSR, NSS, and CCU were dependent variables. Marianismo was included in the model to explore mediation effects. The final structural model had fair fit (RMSEA = 0.040; CFI = 0.926; TLI = 0.920; SRMR = 0.061). Table 7 (Appendix K) shows the fit statistics of the final structural model.

Out of the nine mediation models, one had all statistically significant paths. Figure 10 (Appendix L) shows a comparison of the results with communication (CM) influencing contraception negotiation skills in a monogamous relationship (NSR) (est. = 0.582; $p = 0.000$) and when MBS is included. When MBS is included in the model, the relationship between communication (CM) and contraception negotiation skills in a monogamous relationship (NSR) weakens (est. = 0.530; p = 0.000). This indicates that marianismo

beliefs (MBS) has a mediation effect on the relationship between communication (CM) and contraception negotiation skills in a monogamous relationship (NSR). The total effect, which includes the mediator, is 0.5618 and the direct effect is 0.530, which is a -8.93% change.

Another interesting mediation model to point out is the relationship between freedom from coercion (CR) and contraception negotiation skills in a monogamous relationship (NSR). In this model, not all paths are statistically significant, but the non-significant path is close to the criteria cutoff (CR→MBS; est.: -.044; p = 0.059). Figure 11 (Appendix L) shows a comparison of the original model and the mediated model. Freedom from Coercion (CM) influences contraception negotiation skills in a monogamous relationship (NSR) (est.: 0.089; p = 0.033) in the original model but when marianismo beliefs (MBS) is included the relationship between Freedom from Coercion (CR) and contraception negotiation skills in a monogamous relationship (NSR) weakens (est.: 0.082; p= =0.047). The total effect, which includes the mediator, is 0.091 and the direct effect is 0.082, which is a -7.87% change.

Discussion

The purpose of this study was to explore the relationships between reproductive autonomy, marianismo, and contraception behaviors, and explore the mediation effects of marianismo. The results indicate that marianismo beliefs mediate the relationship between reproductive autonomy constructs, communication and freedom from coercion,

and contraception negotiation skills in a monogamous relationship, weakening the effects. This means that with this sample of Latinas, an increased score of marianismo beliefs reduces the influential effects of communication and Freedom from coercion on contraception negotiation skills in a monogamous relationship. Essentially, if an individual identified more with traditional Latina gender norms, then her communication and freedom from coercion skills will have less of an effect on her contraception negotiation skills in a monogamous relationship. Previous research had associated communication with safer sex outcomes among Latino populations (Alvarez & Villarrual; 2014; Luft & Larson, 2017).

This exploratory study provides a better understanding of the relationships between marianismo beliefs, reproductive autonomy, and contraception behaviors among Latinas. The results from this study can help healthcare practitioners understand how culture influences sexual health. This can also spark the discussion among researchers regarding information that is essential to include in future interventions. Program developers can use these results to advocate for new culturally tailored interventions that put an emphasis on Latino cultural values. There is a sexual health curriculum that was customized for Latino youth called "¡Cuídate! (Take Care of Yourself)" (DHHS, n.d.). The curriculum places a positive light on Latino cultural values and reframes their meaning to teach abstinence and condom use as ways to prevent unintended pregnancies. Overall, the lessons concentrate on increasing confidence and self-efficacy by focusing

on communication and negotiation skills. The development of similar programs can push forward efforts to reduce unintended pregnancy rates among Latinos.

One strength of this study was its use of SEM to examine the relationships between marianismo beliefs, reproductive autonomy, and certain contraception behaviors. No published studies have used SEM to look at the relationship between marianismo beliefs, reproductive autonomy, and contraception negotiation behaviors among Latinas. However, this study has limitations worth discussing. This study is cross-sectional, and the findings are only a snapshot that is not guaranteed to be representative. With no follow-up data, the researchers cannot analyze any behaviors over time which means no causal effects can be determined. Data collected from this study was self-reported and is limited due to lack of proper verification. The information that was given is to be taken at face-value and it is to be understood that certain biases could influence participants answer choices. Some of these biases include, selective memory, telescoping, and exaggeration. Another limitation is the participant's self-identification as Latina. There are many factors that contribute to how a person identifies and the only criteria for this study was that the participant self-identify as a Latina. Therefore, the results stated in this study should be interpreted with caution.

In conclusion, this research is significant because it shows the relationships between marianismo beliefs, reproductive autonomy, and contraception behaviors among an exclusively Latina sample. In this study, we looked at how marianismo beliefs mediated

the relationship between reproductive autonomy aspects and certain contraception behaviors. These results supported the use of SEM to explore relationships between several constructs. Results indicated that cultural values (i.e. marianismo beliefs) do play a role in sexual health. Results from this study indicate that while communication has a positive influence on contraception negotiation skills in a monogamous relationship, that relationship can be weakened by marianismo beliefs. In the future, cultural values must be included in the development of interventions to fit the need of the populations most affected by certain health disparities, such as unintended pregnancy.

CHAPTER V

CONCLUSIONS

The purpose of this dissertation was to assess reproductive autonomy beliefs, marianismo beliefs, and contraception negotiation skills and behaviors among an exclusively Latina sample and explore the relationships between these constructs. This study examined reproductive autonomy beliefs and marianismo beliefs to see how they influenced contraception negotiation skills and contraception use among Latinas. All three constructs were previously examined independently, but no current studies explore the relationship between these three constructs. The reason for this exploratory dissertation was to see if new factors could be identified to see what influences contraception behaviors among Latinas. Latinas are disproportionately affected by unintended pregnancy and the consequences are extreme.

To complete this study, several phases occurred before final data collection and analysis. With the help from a reference librarian, I was able to explore the literature and discover potential scales to be used to measure the three constructs. I sought advice from experts in health education to choose specific scales (Chapter 1) and develop a draft questionnaire. The questionnaire included Upadhyay's (2014) reproductive autonomy scale, Castillo's (2010) marianismo beliefs scale, contraception behavior questions that were taken from previous national surveys (BRFSS, OAH TPP performance measures, etc.). Detailed information about the scales used are in previous chapters. This study

received approval from the institutional review board (IRB) at Texas A&M University in College Station, Texas and qualified for a waiver of documentation of consent. The initial questionnaire was reviewed by experts in health education, promotion, and behavior to assess relevance and clarity. Feedback was provided, and modifications were made.

All information related to the study (information sheet, questionnaire, etc.) was available in English and Spanish and was offered via paper-pencil and online. Cognitive interviews and pilot testing took place to evaluate relevance and clarity and modifications were made. Eligibility included self-identifying as Latina and being over the age of 18 years old. Recruited occurred through paper flyers distributed in Dallas communities and eFlyers that were posted on social media outlets (Facebook, Twitter, Instagram, Snapchat, etc.). Data was collected in November and December 2016. Completed paper surveys were sealed in an envelope until the data was entered. Participants who selected the online option were directed to a Qualtrics link.

To be a representative sample, 200-300 completed questionnaires were needed to analyze the data using Structural Equation Modeling. There were 1283 participants total and 567 of those completed the survey in its entirety. Participant data from 567 Latinas was used to run three different Structural Equation Models. The questionnaire had 107 items and participants took approximately 17 minutes to complete. Completing the questionnaire qualified participants for the opportunity to enter a drawing that took place

after data collection. A total of 36 gift cards were distributed. Total participation was 1,283 women. Questionnaires with missing data were removed resulting in a final sample of 567 women who had completed the survey in its entirety.

One aim of this dissertation was to examine reproductive autonomy beliefs and how they influenced contraception behaviors (Chapter 2). Overall, the model in chapter 2 had fair fit (RMSEA = 0.050; CFI = 0.942; TLI = 0.931; SRMR = 0.052). The model showed significant results with contraception negotiation skills in a monogamous relationship being influenced by reproductive autonomy beliefs pertaining to freedom from coercion (est. = 0.089; p = 0.033) and communication (est. = 0.582; $p < 0.000$). For every one-point increase in reproductive autonomy beliefs pertaining to freedom from coercion and communication, an individual's contraception negotiation skills in a relationship score went up 0.089 and 0.582 points, respectively. Contraception negotiation skills with someone new was only seen to be influenced by the reproductive autonomy sub-construct communication (est. = 0.198; p < 0.000). These results indicated that contraception negotiation skills, whether in a relationship or with someone new, are influenced by reproductive autonomy sub-constructs. The results for this aim indicate that sexual health communication is a vital issue to highlight when discussing contraception negotiation, regardless of what type of relationship. This indicates that the more Latinas believe they can communicate with their partner(s) confidently regarding sexual health, the better they can negotiate contraception. If Latinas can negotiate

contraception better, then this could initiate safer sex practices, decreasing unintended pregnancy risk (Williams et al., 2001)

Another aim of this dissertation was to examine marianismo beliefs and how they influence contraception behaviors (Chapter 3). The model seen in chapter three also had fair fit (RMSEA = 0.046; CFI = 0.938; TLI = 0.930; SRMR = 0.076). This model showed statistically significant results with marianismo beliefs influencing contraception negotiation skills in a monogamous relationship (est. = -0.349; p = 0.003). The model also showed that current contraception use was influenced by marianismo beliefs (est. = -0.516; p = 0.008). For every one-point increase in marianismo beliefs, an individual's negotiation skills in a relationship and current contraception use score was negatively affected by -0.349 and -0.516 points, respectively. Results from detailed models show contraception negotiation and contraception use influenced by marianismo sub-constructs. In a monogamous relationship, contraception negotiation skills were influences by the four sub-constructs: virtuous and chaste, subordinate to others, silencing self to maintain harmony, and spiritual pillar. With a new partner, contraception negotiation skills were influences by the sub-construct: silencing self to maintain harmony. And last, current contraception use was influences by the two sub-constructs, virtuous and chaste and subordinate to others.

These findings are significant because it validates culture as being an influential factor of contraception negotiation skills and contraception use. In this study, if a participant

identified more with traditional Latina gender norms, then it negatively impacted their ability to negotiate contraception in a relationship and the status of their current contraception use. Previous sexual health studies have similar results with Latino cultural values being associated as a risk factor (Cianelli et al., 2013; Ertl et al., 2018; Ma and Malcolm, 2016).

The last aim of this study was to examine the relationships between reproductive autonomy beliefs, marianismo beliefs, and contraception negotiation skills and contraception use (Chapter 4). In this last chapter, a mediation model was used to see if marianismo beliefs mediated the relationship between reproductive autonomy and contraception negotiation skills and contraception use. The mediation model showed fair fit (RMSEA = 0.040; CFI = 0.926; TLI = 0.920; SRMR = 0.061). Only one out of the nine mediation models had all statistically significant paths. Initially, communication (CM) influenced contraception negotiation skills in a monogamous relationship (NSR) (est. = 0.582; $p = 0.000$). When MBS is included in the model, the relationship between communication (CM) and contraception negotiation skills in a monogamous relationship (NSR) weakens (est. = 0.530; $p = 0.000$). This indicates that marianismo beliefs (MBS) has a mediation effect on the relationship between communication (CM) and contraception negotiation skills in a monogamous relationship (NSR). The total effect, which includes the mediator, is 0.5618 and the direct effect is 0.530, which is a -8.93% change.

Another interesting finding is the relationship between freedom from coercion (CR) and contraception negotiation skills in a monogamous relationship (NSR). In this model, not all paths are statistically significant, but the non-significant path is close to the criteria cutoff (CR→MBS; est.: -.044; p = 0.059). When comparing the original model and the mediated model, freedom from coercion (CR) influences contraception negotiation skills in a monogamous relationship (NSR) (est.: 0.089; p = 0.033) in the original model but when marianismo beliefs (MBS) is included the relationship between freedom from coercion (CR) and contraception negotiation skills in a monogamous relationship (NSR) weakens (est.: 0.082; p= =0.047). The total effect, which includes the mediator, is 0.091 and the direct effect is 0.082, which is a -7.87% change. This is essential information that draws attention to culture and how it impacts women's sexual health.

Contributions to the literature & implications

Each research question contributes to the body of literature pertaining to Latina sexual health by identifying influential factors that impact contraception negotiation and contraception use among Latinas. The findings, in their entirety, contribute to the new knowledge regarding the exploration of contraception behaviors and what factors influence those behaviors. After this dissertation, researchers can now understand aspects of reproductive autonomy and marianismo beliefs as influential factors towards contraception negotiation skills and contraception use. This is important for future interventions, program development, and communication efforts between healthcare providers and Latina patients regarding contraception and negotiation. Identifying these

influential factors can lead to the development of culturally tailored interventions that work well with the populations that need to be served.

The information found in this study have significant implications for health education, health promotion, and practice. The findings in this dissertation highlight vital information that can contribute to Healthy People 2020 goals to decrease unintended pregnancy and increase planned pregnancies. These contributions could be seen as a stepping stone for advocacy efforts regarding Latina sexual health. The beliefs that an individual has about their control over their sexual health and the beliefs they have towards traditional Latino gender norms is important and can cause drastic changes in one's life.

A take away messages for health educators and healthcare personnel working with Latinas is that an individual's personal reproductive autonomy beliefs can impact their sexual health more than anything else. If a woman confidently believes they are in control of their sexual health decisions, then they will negotiate contraception better. A second take away message, and the most important message to come out of this dissertation, is that cultural influence is important. Culture is often something people don not talk about because it is a controversial topic that has vast amounts of historical background and is hard to change. This dissertation overall, puts emphasis on cultural values, specifically Latina gender norms and how they impact women's sexual health. The reason so much emphasis is put on culture is because it is the one factor that

severely impacts behavior yet the only factor that is often overlooked. Incorporating Latino cultural values into sexual health research can move the entire field forward and can get us, as researchers and practitioners, closer to our goals of lower unintended pregnancy rates. These results can spark the discussion of culturally tailored interventions that are needed for populations that are most impacted by unintended pregnancy.

Recommendations for future research

This dissertation intended to explore the relationships between reproductive autonomy, marianismo, and contraception negotiation skills and contraception use. The study focused on heterosexual (man and woman) relationships and, it would benefit Latinos, as a whole, if there were studies that involved GLBTQ relationships. Differences between sexual orientations allows for a better understanding that is inclusive of all relationship types. Future studies should also investigate differences among and between Latino subgroups (ex., Mexican, Salvadorian, Peruvian, etc.) to understand how differences among Latino cultural groups affects the models. Lastly, future studies should expand the models and attempt to add demographic data to see how it impacts the relationships. With Latinos being at a higher risk for unintended pregnancy (Masinter et al., 2013), a better understanding of influential factors is needed in order address unintended pregnancy in this population.

REFERENCES

Alvarez, C. & Villarruel, A. (2014). Association of Gender Norms, Relationship Association of Gender Norms, Relationship Acculturation with Sexual Communication Among Young Adult Latinos. Research in Nursing and Health, 38, 121–132. DOI: 10.1002/nur.21645

American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. Pediatrics, 129(3), e827-e841. DOI:10.1542/peds.2011-3552

Arciniega, G.M., Anderson, T.C., Tovar-Blank, Z.G., and Tracey, T.J.G. (2008). Toward a Fuller Conception of Machismo: Development of a Traditional Machismo and Caballerismo Scale. Journal of Counseling Psychology, 55(1), 19-33. DOI: 10.1037/0022-0167.55.1.19

Bartlett, R., McCoy, T.P., Kelley, A., Beamon, E.R., Holmes, T., Shelton, T., and Wallace, D. (2018). Feasibility Testing a Family-Level Intervention to Prevent Risky Sex Behaviors among Middle School–Age Latinas. Journal of Transcultural Nursing, 29(2) 131–138. DOI: 10.1177/1043659616689289

Piña-Watson, B., Dornhecker, M., Salinas, S.R. (2015). The impact of bicultural stress on Mexican American adolescents' depressive symptoms and suicidal ideation: Gender matters. Hispanic Journal of Behavioral Sciences, 37(3), 342-364. DOI: 10.1177/0739986315586788

Castillo, L. G., Perez, F. V., Castillo, R, and Ghosheh, M. R. (2010). Construction and initial validation of the marianismo beliefs scale. Counselling Psychology Quarterly, 23, 163-175. DOI: 10.1080/09515071003776036 x

Castillo, L.G., and Cano, M.A. (2007). Mexican American psychology: Theory and clinical application. In C. Negy (Ed.), Cross-cultural psychotherapy: Toward a critical understanding of diverse client populations (2nd Ed.). Reno, NV: Bent Tree Press, Inc.

Cianelli, R., Villegas, N., Lawson, S., Ferrer, L., Kaelber, L., Peragallo, N., and Yaya, A. (2016). Unique Factors that Place Older Hispanic Women at Risk for HIV: Intimate Partner Violence, Machismo, and Marianismo. Journal of the Association of Nurses in AIDS Care, 24(4), 341-354. http://dx.doi.org/10.1016/j.jana.2013.01.009

Connell, R.W. (1987). Gender and Power. Stanford, CA: Stanford University Press.

Crissman, H.P., Adanu, R.M., & Harlow, S.D. (2012). Women's Sexual Empowerment and Contraceptive Use in Ghana. Studies in Family Planning, 43(3): 201-212.

De Santis, J.P., Provencio-Vasquez, E., Mancera, B., and Mata, H.J. (2016). Health Risk and Protective Factors among Hispanic Women Living in the U.S.–Mexico Border Region. Hispanic Health Care International, 14(1) 17-25. DOI: 10.1177/1540415316629679

Denner, J., Kirby, D., Coyle, K., and Brindis, C. (2001). The Protective Role of Social Capital and Cultural Norms in Latino Communities: A Study of Adolescent Births. Hispanic Journal of Behavioral Sciences, 23(1), 3-21.

DePadilla, L., Windle, M., Wingood, G., Cooper, H., & DiClemente, R. (2011). Condom Use among Young Women: Modeling the Theory of Gender and Power. Health psychology, 30(3): 310-319. DOI: 10.1037/a0022871

Do, M. & Kurimoto N. (2012). Women's Empowerment and Choice of Contraceptive Methods in Selected African Countries. International Perspectives on Sexual and Reproductive Health, 38(1):23-33, DOI: 10. 1363/38023 1

Dworkin, S.L., Kambou, S.D., Sutherland, C., Moalla, K. &Kapoor, A. (2009). Gendered Empowerment and HIV Prevention: Policy and Programmatic Pathways to Success in the MENA Region. J Acquir Immune Defic Syndr, 51(3): S111–S118. DOI: 10.1097/QAI. 0b013e3181aafd7

Ennis, S.R., Ríos-Vargas, M., and Albert, N.G. (2011). The Hispanic Population: 2010. 2010 Census Briefs, 1-16. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2011/dec/c2010br-04.pdf

Ertl, M.M., Dillona, F.R., Cabrera Tineoa, Y.A., Verilea, M., Jurkowskic, J.M., and De La Rosa, M. (2018). Sexual risk during initial months in US among Latina young adults. AIDS Care, 30(3), 353-360, DOI: 10.1080/09540121.2017.1368442

Finer, L.B. & Zolna, M.R. (2016). Declines in Unintended Pregnancy in the United States, 2008-2011. The New England Journal of Medicine, 374:843-52. DOI: 10.1056/NEJMsa1506575

Flores, E., Eyre, S., and Millstein, S. G. (1998). Sociocultural beliefs related to sex among Mexican American adolescents. Hispanic Journal of Behavioral Sciences, 20, 60–82.

Frost, J.J & Darroch, J.E. (2008). Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004. Perspectives on Sexual and Reproductive Health, 40(2):94–104, DOI: 10.1363/4009408.

Frost, J.J., Singh, S., & Finer, L.B. (2007). Factors Associated with Contraceptive Use and Nonuse, United States, 2004. Perspectives on Sexual and Reproductive Health, 39(2):90–99, DOI: 10.1363/3909007

Guttmacher Institute. (2016). Unintended Pregnancy in the United Stated: Fact sheet, March 2016. Retrieved from https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states

Healthy People. (2017). Family Planning: Overview. 2020 Topics and Objectives. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=13

Healthy People (2017b). Family Planning: Objectives. 2020 Topics and Objectives. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=13

Kerns, J., Westhoff, C., Morroni, C., & Murphy, P.A. (2003). Partner Influence on Early Discontinuation of the Pill in a Predominantly Hispanic Population. Perspectives on Sexual and Reproductive Health, 35(6):256-26

Kost, K. and Lindberg, L. (2015). Pregnancy intentions, maternal behaviors, and infant health: Investigating relationships with new measures and propensity score analysis. Demography, 52(1), 83-111. DOI 10.1007/s13524-014-0359-9

Krogstad, J.M. (2017). U.S. Hispanic population growth has leveled off. Retrieved from http://www.pewresearch.org/fact-tank/2017/08/03/u-s-hispanic-population-growth-has-leveled-off/

Li, Y. & Samp, J.A. (2017) Sexual Relationship Power, Safer Sexual Communication, and Condom Use: A Comparison of Heterosexual Young Men and Women. Western Journal of Communication, Vol. 00, No. 00, 1–17. DOI: 10.1080/10570314.2017.1398835

Logan, C., Holcombe, E., Manlove, J., and Ryan, S. (2007). The consequences of unintended childbearing: A white paper. Child Trends. Retrieved from http://thenationalcampaign.org/sites/default/files/resource-primarydownload/consequences.pdf

Lopez, V., Chesney-Lind, M., & Foley, J. (2012). Relationship Power, Control, and Dating Violence among Latina Girls. Violence against women, 18(6), 681-690. DOI: 10.1177/1077801212454112

Luft, H. & Larson, E. (2017). Psychosocial correlates of safe sex communication between Latina women and their stable male partners: an integrative review. AIDS Care, 29(5), 618-626. DOI: 10.1080/09540121.2016.1259457

Ma, M. & Malcom, L.R. (2016). Cultural influences on HIV testing among Latino youth. Culture, Health & Sexuality, 18(4), 470–480. http://dx.doi.org/10.1080/13691058.2015.1084650

Masinter, L.M., Feinglass, J. and Simon, M.A. (2013). Pregnancy Intention and Use of Contraception among Hispanic Women in the United States: Data from the National Survey of Family Growth, 2006–2010. Journal of Women's Health, 22(10), 862-870. DOI: 10.1089/jwh.2013.4366

Ma, M., Malcolm, L.R., Diaz-Albertini, K., Klinoff, V.A., Leeder, A., Barrientos, S., Kibler, J.L. (2014). Latino cultural values as protective factors against sexual risks among adolescents. Journal of Adolescence, 37, 1215-1225.

Malhotra A, Schuler SR and Boender C. (2002). Measuring women's empowerment as variable in international development, background paper prepared for the World Bank Workshop on Poverty and Gender: New Perspectives, Washington, DC. Retrieved from http://siteresources.worldbank.org/INTGENDER/Resources/MalhotraSchulerBoender.pdf

Martin, J.A., Hamilton, B.E., Osterman, M.J.K.; Driscoll, A.K., and Mathews, T.J. (2017) Births: Final Data for 2015. National Vital Statistics Reports, 66(1), 1-70. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf

Moreno, C. (2007). The Relationship between Culture, Gender, Structural Factors, Abuse, Trauma, and HIV/AIDS for Latinas. Qualitative Health Research, 17(3), 340-352. DOI: 10.1177/104973230629738

Mosher, W.D., Jones, J., and Abma, J.C. (2012). Intended and Unintended Births in the United States: 1982-2010. National Health Statistics Report No.55. Retrieved from http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf

National Campaign to Prevent Teen and Unplanned Pregnancy (2012). Unplanned Pregnancy among Unmarried Young Women: Briefly. Retrieved from http://thenationalcampaign.org/sites/default/files/resource-primary-download/briefly-unplanned-pregnancy-among-unmarried.pdf

National Campaign to Prevent Teen and Unplanned Pregnancy (2017). Why It Matters: Unplanned Pregnancy. Retrieved fromhttp://www.thenationalcampaign.org/why-it-matters/unplanned-pregnancy

Ojeda, L., and Piña-Watson, B. (2013). Day laborers' life satisfaction: The role of familismo, spirituality, work, health, and discrimination. Cultural Diversity and Ethnic Minority Psychology, 19(3), 270-278. DOI: 10.1037/a0032961

Panchanadeswaran, S., Johnson, S.C., Go, V.F., Srikrishnan, A.K., Sivaram, S., Solomon, S., Bentley, M.E., and Celentano, D. (2007). Using the Theory of Gender and Power to Examine Experiences of Partner Violence, Sexual Negotiation, and Risk of HIV/AIDS among Economically Disadvantaged Women in Southern India. Journal of Aggression, Maltreatment & Trauma, 15(3/4), 115-178. DOI: 10.1080/10926770802097327

Piña-Watson, B., Castillo, L. G., Ojeda, L., & Rodriguez, K. M. (2013). Parent conflict as a mediator between marianismo beliefs and depressive symptoms for Mexican American college women. Journal of American College Health, 61, 491–496. DOI:10.1080/07448481.2013.838567

Raffaelli, M. and Ontai, L.L. (2004). Gender socialization in Latino/a families: Results from two retrospective studies. Sex Roles, 50: 287–299.

Rinehart, D.J., Al-Tayyib, A.A., Sionean, C., Whitesell, N.R., Dreisbach, S., and Bull, S. (2018). Assessing the Theory of Gender and Power: HIV Risk Among Heterosexual Minority Dyads. AIDS and Behavior, 22, 1944–1954. https://doi.org/10.1007/s10461-017-1983-3

Singh S, Sedgh G and Hussain R, Unintended pregnancy: worldwide levels, trends and outcomes, Studies in Family Planning, 2010, 41(4):241–250.

Sonfield A., Hasstedt K., and Gold R.B. (2014). Moving Forward: Family Planning in the Era of Health Reform, New York: Guttmacher Institute.

Surace, F.I., Levitt, H.M., & Horne, H.G. (2017). The relation between cultural values and condom use among Latino gay men. The relation between cultural values and condom use among Latino gay men. Journal of Gay and Lesbian Social Services, 29(3), 252-272. DOI: 10.1080/10538720.2017.1320255

Triandis, H.C., Marı´n, G., Lisansky, J., & Betancourt, H. (1984). Simpatia as a cultural script of Hispanics. Journal of Personality and Social Psychology, 47: 1363–1375.

U.S. Department of Health and Human Services (DHHS). (n.d.). Teen Pregnancy Prevention Evidence Review. Program Information: ¡Cuídate! Retrieved from https://tppevidencereview.aspe.hhs.gov/document.aspx?rid=3&sid=273&mid=1

Upadhyay, U.D., Dworkin, S.L., Weitz, T.A., & Foster, D.G. (2014). Development and Validation of Reproductive Autonomy Scale. Studies in Family Planning 45(1), 19-41. DOI: 10.1111/j.1728-4465.2014.00374.x.

Ventura, S.J., Curtin, S.C., Abma, J.C., and Henshaw, S.K. (2012) Estimated Pregnancy Rates and Rates of Pregnancy Outcomes for the United States, 1990–2008. National Vital Statistics Reports, 60(7), 1-22. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf

Villarreal, Y.R., Torres, L.R., Stotts, A.L., Ren, Y., Sampson, M., Klawans, M.R., & Bordnick, P.S. (2017). Depression in the barrio: An analysis of the risk and protective nature of cultural values among Mexican American substance users. Journal of Ethnicity in Substance Abuse. DOI: 10.1080/15332640.2017.1316222

Widman, L., Golin, C.E., Noar, S.M., Massey, J., and Prinstein, M.J. (2016) PROJECTHEARTFORGIRLS.COM: Development of a Web-based HIV/STD Prevention Program for Adolescent Girls Emphasizing Sexual Communication Skills. AIDS Education and Prevention, 28(5), 365–377. DOI: 10.1521/aeap.2016.28.5.365

Wildsmith, E., Manlove, J., & Steward-Streng, N. (2015). Relationship Characteristics and Contraceptive Use among Dating and Cohabiting Young Adult Couples.

Perspectives on Sexual and Reproductive Health, 47(1), 27–36, DOI: 10.1363/47e2515

Williams, S.P., Gardos, S., Ortiz-Torres, B., Tross, S., & Ehrhardt, A.A. (2001). Urban Women's Negotiation Strategies for Safer Sex with Their Male Partners. Women & Health, 33(3-4), 149-165. DOI: 10.1300/J013v33n03_09

Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. Health Educ Behav, 27(5), 539-565.

World Health Organization. (2015). What do we mean by “sex” and “gender”? Gender, women, and health. Retrieved from https://web.archive.org/web/20150818074425/http://apps.who.int/gender/whatisgender/ean/index.html

APPENDIX A

INITIAL ENGLISH CONSENT FORM

Initial Consent Form (English).

TEXAS A&M UNIVERSITY HUMAN SUBJECTS PROTECTION PROGRAM

CONSENT FORM

"Understanding contraceptive behaviors among Latinas"

You are being invited to take part in a research study being conducted by Jovanni Reyes, a researcher at Texas A&M University. The information in this form is provided to help you decide whether or not to take part in the research. If you decide to take part in the study, you will be asked to sign/eSign this consent form. If you decide you do not want to participate, there will be no penalty to you, and you will not lose any benefit you normally would have.

WHY IS THIS STUDY BEING DONE?
The purpose of this study is to look at reproductive autonomy, marianismo beliefs, and contraception negotiation skills and behaviors among Latina adults (18 years old and over). This study aims to explore influences on women's sexual health decisions regarding pregnancy and use our findings to inform family planning and pregnancy prevention programs/trainings.

WHY AM I BEING ASKED TO BE IN THIS STUDY?
You are being asked to be in this study because you personally identified as a Latina adult (18 years old and over) or have been identified by a mutual friend as a possible participant.

HOW MANY PEOPLE WILL BE ASKED TO BE IN THIS STUDY?
There will be approximately 200-300 people invited to participate in this study.

WHAT ARE THE ALTERNATIVES TO BEING IN THIS STUDY?
The alternative is not to participate.

WHAT WILL I BE ASKED TO DO IN THIS STUDY?
If you agree to participate in this study (after you sign/eSign the consent form), you will be asked to complete a questionnaire that will take approximately 15 minutes. You can choose between completing a paper-pencil survey or a web-based survey taken online. Both surveys ask about reproductive autonomy beliefs, marianismo beliefs and your contraception negotiation skills and behaviors.

ARE THERE ANY RISKS TO ME?
The things that you will be doing have no more risk than you would come across in everyday life. Although the researchers have tried to avoid risks, you may feel that some questions that are asked make you feel stressed or upset. Please know that you do not have to answer anything you do not want to.

ARE THERE ANY BENEFITS TO ME?
There is no direct benefit to you by being in this study. What the researchers find out from this study may help to inform effective family planning and pregnancy prevention programs for women in community settings.

WILL THERE BE ANY COSTS TO ME?
Aside from your time, there are no costs for taking part in the study. If you believe you are injured because of the research, you should contact the Principal Investigator Jovanni V. Reyes, MS, CHES at 214-878-5770

WILL I BE PAID TO BE IN THIS STUDY?
By participating in this study, you will be eligible to be admitted into a drawing. After completing the research survey, the researchers will collect your personal information (name, phone number, email address) separate and independent of your responses to the survey questions. Each participant who agrees to give their information will be placed in a drawing and have the chance to win a gift card ($25/$50/$100). There will be a total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card. If you are one of the winners, you will receive the gift card after all questionnaires have been collected.

WILL INFORMATION FROM THIS STUDY BE KEPT PRIVATE?
The records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published. Research records will be stored securely in locked office space and only research personnel will have access to the records.

Information about you will be stored in a locked file cabinet or on computer files protected with a password. This consent form will be filed securely in an official area. Information about you will be kept confidential to the extent permitted or required by law.

People who have access to your information include the Principal Investigator and research study personnel. Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Subjects Protection Program may access your records to make sure the study is being run correctly and that information is collected properly.

WHO MAY I CONTACT FOR MORE INFORMATION?
You can call the Principal Investigator to tell him/her about a concern or complaint about this research study. The Principal Investigator Jovanni V. Reyes. MS, CHES can be called at 214-878-5770 or emailed at jvreyes89@hlkn.tamu.edu. You may also

contact the Principal Investigator's academic advisor, Dr. Kelly Wilson at kwilson@hlkn.tamu.edu.

For questions about your rights as a research participant; or if you have questions, complaints, or concerns about the research and cannot reach the Principal Investigator or want to talk to someone other than the Investigator, you may call the Texas A&M Human Subjects Protection Program office at (979) 458-4067 or by email at irb@tamu.edu.

WHAT IF I CHANGE MY MIND ABOUT PARTICIPATING?
This research is voluntary and you have the choice whether or not to be in this research study. You may decide not to participate or stop participating at any time. If you choose not to be in this study, there will be no effect on your employment status, medical care, evaluation, relationship with Texas A&M University, etc.

STATEMENT OF CONSENT

I agree to be in this study and know that I am not giving up any legal rights by signing this form. The procedures, risks, and benefits have been explained to me, and my questions have been answered. I know new information about this research study will be provided to me as it becomes available. I can ask more questions if I want. A copy of this entire, signed consent form will be given to me.

_____

Participant's Signature Date

_____

Printed Name Date

INVESTIGATOR'S AFFIDAVIT

Either I have or my agent has carefully explained to the participant the nature of the above project. I hereby **certify that to the best of my knowledge the person who signed this consent form was informed of the nature,** demands, benefits, and risks involved in his/her participation.

_____

Signature of Presenter Date

_____

Printed Name Date

APPENDIX B

INITIAL SPANISH CONSENT FORM

Initial Consent Form (Spanish).

TEXAS A&M UNIVERSITY HUMAN SUBJECTS PROTECTION PROGRAM

FORMA DE CONSENTIMIENTO

"Entendiendo comportamiento contraceptivos de Latinas"

Usted ha recibido una invitación para participar en el estudio educativo conducido por Jovanni Reyes, investigadora en la Universidad de Texas A& M. La información en esta forma es provista para ayudarle decidir si va tomar parte en esta encuesta. Si decide tomar parte le pedimos que firme este forma de consentimiento. Si decide no participar en la encuesta no habrá ninguna obligación de su parte.

¿PORQUE SE ESTA HACIENDO ESTE ESTUDIO?
El propósito de este estudio es de observar la autonomía reproductiva, creencias de marianismo, y habilidades de negociación contraceptiva y manierismos entre Latinas adultas (18 años y mayor). El propósito de este estudio es de explorar las influencias sobre las decisiones de salud sexual entre mujeres tratándose de embarazo y usar nuestras respuestas para informarle a programas y entrenamientos de prevención y planificación familiar.

¿PORQUE SE ME HA PEDIDO PARTICIPAR EN ESTE ESTUDIO?
Se le ha pedido participar en este estudio por que personalmente se identificó como una Latina adulta (18 años y mayor) o fue identificada como una posible participante por una amiga.

¿A CUATNAS PERSONAS SE LES PIDIO PARA QUE PARTICIPARAN EN ESTE ESTUDIO?
Habrá aproximadamente 300 personas invitadas a participar en este estudio.

¿CUALES SON LAS ALTERNATIVAS DE PARTICIPACION EN ESTE ESTUDIO?
La alternativa es de no participar.

¿QUE ME PIDIRAN HACER EN ESTE ESTUDIO?
Si usted consiente participar en este estudio (después de firmar/e-firmar la forma de consentimiento), podrá completar un cuestionario que toma aproximadamente 15 minutos. Puede escoger entre completar una encuesta con papel y lápiz o una encuesta electrónica

por el internet. Las dos encuestas preguntan sobre creencias de la autonomía reproductiva, creencias de marianismo y sus habilidades y comportamiento de negociación contraceptivas.

¿HAY ALGUNOS RIESGOS PARA MI?
Las cosas que estará haciendo no tendrán ningún riesgo mayor que las que usted enfrentara normalmente en su vida cotidiana. Aunque los que prepararon esta encuesta han tomado precauciones para tratar de evitar cualquier riesgos, es una posibilidad que algunas preguntas le hagan sentir estresada. Por favor asegúrese con no tiene que contestar ninguna pregunta que no quiere contestar.

¿HAY ALGUNOS BENEFICIOS PARA MI?
No habrá ningún beneficio directo a usted en su participación en esta encuesta. Lo que se descubra en esta encuesta quizás ayudara para informar centros de planificación de familia y centros de prevención natal para mujeres de la comunidad.

¿HABRA ALGUN COSTO DE MI PARTE?
Aparte de su tiempo, no habrá ningún costo de su parte para participar en este estudio. Si cree que usted se ha lastimado por causa de este estudio debe contactar a la Investigadora Principal, Jovanni V. Reyes, MS, CHES al 214-878-5770

¿RECIBIRE CONPENSACION POR PARTICIPAR EN ESTE ESTUDIO?
Por participar en este estudio, serás elegible para ser admitida en un sorteo. Después de completar la encuesta del studio, los investigadores tomaran su información personal (nombre, teléfono, correo electrónico) aparte de sus respuestas de la encuesta. Cada participante que a dar su información será entrado en un sorteo y tendrá la oportunidad de ganar una tarjeta de regalo ($25/$50/$100). Habrá un total de treinta tarjetas de $25, cinco tarjetas de $50 y una tarjeta de $100. Si usted es uno de los ganadores, recibirá la tarjeta regalo después de que todos los cuestionarios han sido recogidos.

¿SE QUEDARA LA INFORMACION DE ESTE ESDUIO PRIVADO?
Los resultados de este estudio se mantendrán privados. Ningún identificador que te une a este estudio se incluirán en cualquier tipo de informe que puede ser publicado. Todos los archivos y registros de esta encuesta se mantendrán en un gabinete con llave en la oficina del estudio y sólo el personal de investigación tendrá acceso a los registros. Su información se almacenará en un gabinete de archivo bloqueado o en archivos protegidos con contraseña. Este formulario de consentimiento se archivará en forma segura en una zona oficial. Su información se mantendrá confidencial en la medida permitida o requerida por la ley. Personas que tienen acceso a la información incluyen el investigador y la directiva investigación personal de estudio. Representantes de las agencias reguladoras como la oficina de protecciones investigaciones humanas (OHRP) y entidades como el *Texas A&M University Human Subjects Protection Program* pueden acceder a sus registros para asegurarse de que el estudio se ejecuta correctamente y que la información es recogida correctamente.

¿A QUIÉN PUEDO CONTACTAR PARA OBTENER MÁS INFORMACIÓN?
Se puede llamar el Investigador Principal para coméntele sobre una preocupación o queja sobre este estudio de investigación. La Investigadora Principal es Jovanni V. Reyes. MS, CHES le pueden llamar al 214-878-5770 o por correo electrónico a jvreyes89@tamu.edu. También puede contactar asesor académico de la Investigadora Principal, Dr. Kelly Wilson al correo electrónico, kwilson@tamu.edu.

Para preguntas acerca de sus derechos como participante de la investigación; o si tiene preguntas, quejas o inquietudes acerca de la investigación y no puede llegar el Investigador Principal o desea hablar con alguien que no sea el investigador, puede llamar a la oficina de *Texas A&M Human Subjects Protection Program* al (979) 458-4067 o por correo electrónico a irb@tamu.edu.

¿QUÉ PASA SI CAMBIO DE OPINIÓN SOBRE LA PARTICIPACIÓN?
Esta investigación es voluntaria y usted tiene la opción de decir sí o no a participar en este estudio de investigación. Usted puede decidir no participar o dejar de participar en cualquier momento. Si decide no participar en este estudio, no habrá ningún efecto sobre su situación en el empleo, atención médica, evaluación, relación con Texas A&M University, etc..

DECLARACION DE CONSENTIMIENTO
Estoy de acuerdo en participar en este estudio y saber que no estoy renunciando a cualquier derecho legal por firmar este formulario. Los procedimientos, riesgos y beneficios han sido explicados a mi, y mis preguntas han sido contestadas. Sé que nueva información sobre este estudio le prestará a mí cuando esté disponible. Yo puedo preguntar más si quiero. Se me dará una copia de este formulario de consentimiento firmado.

_____

Firma del participante Fecha

_____

Nombre del participante Fecha

APPENDIX C

INITIAL ENGLISH QUESTIONNAIRE

What is your current age?

Less than 18	18	19	20	21	22
23	24	25	26	27	28
29	30	31	32	33	34
35	36	37	38	39	40+

What is your current zip code?

What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received?

No schooling completed
Nursery school to 8th grade
9th, 10th or 11th grade
12th grade, no diploma
High school graduate - high school diploma or the equivalent (for example: GED)
Some college credit, but less than 1 year
1 or more years of college, no degree
Associate degree (for example: AA, AS)
Bachelor's degree (for example: BA, AB, BS)
Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
Professional degree (for example: MD, DDS, DVM, LLB, JD)
Doctorate degree (for example: PhD, EdD)
I don’t know

What is your relationship status?

Single	Open relationship (you and your partner date each other and other people)	Monogamous relationship (you and your partner only date each other)	Cohabiting (living together)
Engaged	Married	Separated/Divorced	Widow/Widower

Do you have any children? (including any biological children and/or step-children)

Yes, I have 1 child	Yes, I have 2 children	Yes, I have 3 children
Yes, I have 4 children	Yes, I have 5 or more children	No, I do not have any children

What is your religion?

No religion	Roman Catholic	Christian – no denomination	Church of England/Anglican
Presbyterian/Church of Scotland	Greek Orthodox	Methodist	Baptist
Jewish	Buddhist	Hindu	Islam/Muslim
Sikh	Other _____	I don't know	I prefer not to answer

How often do you attend church or other religious meetings?

Never	Once a year or less	A few times a year	A few times a month
Once a week	More than once/week	I don't know	I prefer not to answer

What group(s) so you identify with? [Circle all that apply]

American Indian	Alaskan Native	Asian	Pacific Islander
Black/African American	White/Caucasian	Latino/Hispanic	Other _____

What Latino subgroup (ex. Mexican, Salvadorian, etc.) do you identify with?

Antiguan or Barbudan	Chilean	Guadeloupean	Panamanian	Trinidadian or Trini
Argentinian	Colombian	Guatemalan	Paraguayan	Turks & Caicos Islander
Aruban	Costa Rican	Guyanese	Peruvian	Uruguayan
Bahamian	Cuban	Haitian	Puerto Rican	Venezuelan
Barbadian	Dominican	Honduran	Saint-Barthinois(es)	Virgin Islander
Belizean	Ecuadorian	Jamaican	Kittitian or Nevisian	Other _____
Bolivian	Salvadorian	Martinican	St. Lucian	I don't know
Brazilian	French Guianese	Mexican	Vincentian	I don't identify with any Latino subgroup
Cayman Islands	Grenadino/a	Nicaraguan	Surinamese	I prefer not to answer

What is your generation status?

1st generation (you were born in another country)	2nd generation (you were born in USA, either parent born in another country)	3rd generation (you were born in USA, both parents were born in the USA and all grandparents were born in another country)	4th generation (you and your parents were born in USA, and at least one grandparent was born in another country with remainder born in USA)	5th generation or higher (you and your parents born in the USA and all grandparents born in the USA)

What country were you born in?

United States	Cayman Islands	French Guiana	Mexico	St. Vincent and the Grenadines
Antigua & Barbuda	Chile	Grenada	Nicaragua	Suriname
Argentina	Colombia	Guadeloupe	Panama	Trinidad & Tobago
Aruba	Costa Rica	Guatemala	Paraguay	Turks & Caicos Islands
Bahamas	Cuba	Guyana	Peru	Uruguay
Barbados	Dominica	Haiti	Puerto Rico	Venezuela
Belize	Dominican Republic	Honduras	Saint Barthélemy	Virgin Islands
Bolivia	Ecuador	Jamaica	St. Kitts & Nevis	Other _____
Brazil	El Salvador	Martinique	St. Lucia	I prefer not to answer

Which of these categories best describes your primary area of employment?

Homemaker	Processing
Retired	Legal Services
Student	Manufacturing - Computer and Electronics
Unemployed	Manufacturing - Other
Agriculture, Forestry, Fishing, or Hunting	Military
Arts, Entertainment, or Recreation	Mining
Broadcasting	Publishing
Education - College, University, or Adult	Real Estate, Rental, or Leasing
Education - Primary/Secondary (K-12)	Religious
Education - Other	Retail
Construction	Scientific or Technical Services
Finance and Insurance	Software
Government and Public Administration	Telecommunications
Health Care and Social Assistance	Transportation and Warehousing
Hotel and Food Services	Utilities
Information - Services and Data	Wholesale
Information - Other	Other

What is your employment status?

Employed full time or more (40+ hours per week)	Employed part time (less than 35 hours per week)	Self-employed	In school full time
Homemaker	Unemployed	Disabled	Retired

What is your total annual PERSONAL income?	What is your total annual HOUSEHOLD income?
$0 - $9,999	$0 - $9,999
$10,000 - $19,999	$10,000 - $19,999
$20,000 - $29,999	$20,000 - $29,999
$30,000 - $39,999	$30,000 - $39,999
$40,000 - $49,999	$40,000 - $49,999
$50,000 - $59,999	$50,000 - $59,999
$60,000 - $69,999	$60,000 - $69,999
$70,000 - $79,999	$70,000 - $79,999
$80,000 - $89,999	$80,000 - $89,999
$90,000 - $99,999	$90,000 - $99,999
$100,000 +	$100,000 +

What type of health insurance do you have?

Private health insurance that you bought yourself	VA
Health maintenance organizations (HMOs)	Medicaid
Preferred provider organizations (PPOs)	Medicare
Point-of-service (POS) plans	I don’t know
TRICARE	I do not have health insurance

Where is your usual source of services for female health care, such as family planning, annual exams, breast exams, tests for sexually transmitted diseases, and other female health concerns?

A family planning clinic	A health department clinic	A community health center	A private gynecologist office
A general or family physician office	Some other kind of place	I don't know	I prefer not to answer

Instructions: The statements below represent some of the different expectations for Latinas. For each statement, please mark the answer that best describes what you **believe** rather than what you were taught or what you actually practice.

A Latina . . .

	Strongly Disagree	Disagree	Agree	Strongly Agree
1.) …must be a source of strength for her family.				
2.) …is considered the main source of strength of her family.				
3.) …mother must keep the family unified.				
4.) …should teach her children to be loyal to the family.				
5.) …should do things that make her family happy.				
6.) …should (should have) remain(ed) a virgin until marriage.				
7.) …should wait until after marriage to have children.				
8.) …should be pure.				
9.) …should adopt the values taught by her religion.				
10.) …should be faithful to her partner.				
11.) …should satisfy her partner's sexual needs without argument.				
12.) …should not speak out against men.				
13.) …should respect men's opinions even when she does not agree.				
14.) …should avoid saying no to people.				

15.) …should do anything a male in the family asks her to do.				
16.) …should not discuss birth control.				
17.) …should not express her needs to her partner.				
18.) …should feel guilty about telling people what she needs.				
19.) …should not talk about sex.				
20.) …should be forgiving in all aspects.				
21.) …should always be agreeable to men's decisions.				
22.) …should be the spiritual leader of the family.				
23.) …is responsible for taking family to religious services.				
24.) …is responsible for the spiritual growth of the family.				

The next questions are about you and your main partner or a recent sexual partner. The questions ask about who has the most say in different types of decisions. "Most say" means if there was a disagreement, the person who would have final say. If you have more than one partner, think about your main partner. If you don't have a partner, think about a previous partner. If you have not had to make any of the following decisions, please think about who would have the most say in the decision.

	My sexual partner	Both me and my sexual partner	Me
1. Who has the MOST say about whether you use a method to prevent pregnancy?			
2. Who has the MOST say about which method you would use to prevent pregnancy?			
3. Who has the MOST say about when you have a baby in your life?			
4. If you became pregnant but it was unplanned, who would have the MOST say about whether you would raise the child, seek adoptive parents, or have an abortion?			

The next questions are about you and your main or a recent sexual partner.

	Strongly Disagree	Disagree	Agree	Strongly Agree
5. My partner has stopped me from using a method to prevent pregnancy when I wanted to use one.				
6. My partner has messed with or made it difficult to use a method to prevent pregnancy when I wanted to use one.				
7. My partner has made me use a method to prevent pregnancy when I did not want to use one.				
8. If I wanted to use a method to prevent pregnancy my partner would stop me.				
9. My partner has pressured me to become pregnant.				
10. My partner would support me if I wanted to use a method to prevent pregnancy.				
11. It is easy to talk about sex with my partner.				
12. If I didn't want to have sex I could tell my partner.				
13. If I was worried about being pregnant or not being pregnant I could talk to my partner about it.				
14. If I really did not want to become pregnant I could get my partner to agree with me.				

The next few questions are about your negotiation skills. Please remember that your answers are confidential. For the next questions, please tell us how sure you are that you could do what is described. Remember that for this survey we are talking about sexual intercourse, i.e., when a male puts his penis inside a female's vagina.

Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. Could you tell your partner you…

	I definitely could not	I probably could not	I probably could	I definitely could
…want to consider a surgical procedure? (e.g., tubes tied or vasectomy)				
…want to start using an IUD (intra-uterine device)? [examples: Mirena, Paraguard, Skyla, Lileta]				
…want to start using an implant? [example: Implanon or nexplanon]				
…want to start getting birth control shots (Depo-Provera)?				
…want to start using the birth control ring (Nuvaring)?				
…want to start using the birth control patch?				

…want to start using the birth control pill?				
…want to start using male condoms?				
…want to start using female condoms?				
…want to start using foam, jelly, or cream?				
…want to start using a diaphragm?				
…want to start using a rhythm/family planning method (Not having sex at certain times)?				
…want to start using withdrawal or the pull out method?				

Imagine you are going to have sex with someone you just met. You feel it is important to use a method to prevent pregnancy. Could you tell that person you…

	I definitely could not	I probably could not	I probably could	I definitely could
…want to use male condoms?				
…want to use female condoms?				
…want to use foam, jelly, or cream?				
…want to use a diaphragm?				
…want to use rhythm/family planning method (Not having sex at certain times)?				
…want to use withdrawal or the pull out method?				

Could you use or explain to your sex partner how to use …..

	I definitely could not	I probably could not	I probably could	I definitely could
…a male condom correctly?				
…a female condom correctly?				
… foam, jelly, or cream correctly??				
…a diaphragm correctly?				
… rhythm/family planning method (Not having sex at certain times) correctly?				
… withdrawal or the pull out method correctly?				

Look at the sentences below. Which answer best matches your level of access.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I could just to go the doctor and get a method to prevent pregnancy if I wanted to.				
I could just to go the store and buy a method to prevent pregnancy if I wanted to.				
If I decide to have sex, I have access to some type of birth control, if and when I need it.				

Look at the sentences below. Have you ever thought about…

	I have never really thought about it	I have thought a little about it	I have thought about it and I know exactly whether or not I would use it	I have thought a lot about it and I know whether or not I would use it
…wanting your tubes tied?				
…wanting your partner to get a vasectomy?				
…wanting an IUD (intra-uterine device)? [examples: Mirena, Paraguard, Skyla, Lileta]				
…wanting an implant? [example: Implanon or Nexplanon]				
… wanting birth control shots (Depo-Provera)?				
… wanting the birth control ring (Nuvaring)?				
… wanting the birth control patch?				
…wanting to start using the birth control pill?				

…wanting to start using male condoms?				
…wanting to start using female condoms?				
…wanting to start using foam, jelly, or cream?				
…wanting to start using a diaphragm?				
…wanting to start using a rhythm/family planning method (Not having sex at certain times)?				
…wanting to start using withdrawal or the pull out method?				

The next few questions are about sexual behaviors, specifically sexual intercourse and use of contraception. For this study, sexual intercourse means a male putting his penis into a female's vagina. Please remember that your answers are confidential.

Have you ever had sexual intercourse?

Yes	No

The very first time that you had sexual intercourse, how old were you?

Less than 10 years' old	11-15	16-20	21-25	26-30	31+

In the past 3 months, have you had sexual intercourse, even once?

Yes	No	I don't know	I prefer not to answer

During the past 3 months, what types of sex have you engaged in? (Circle all that apply)

Vaginal sex	Oral sex	Anal sex	I don't know	I prefer not to answer

In the past 3 months, how many times have you had sexual intercourse without using any method to prevent pregnancy? (*Zero indicates that you always use a method to prevent pregnancy)

0*	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20+

What methods have you (or your partner) used or plan to use to keep you from getting pregnant (a) in the last 12 months, (b) in the last 3 months, (c) currently, (d) plan to use in the next 12 months?

	I used this method in the last 12 months…	I used this method in the last 3 months…	I am currently using this…	I plan to use in the next 12 months…
Sterilization method (e.g., tubes tied or vasectomy)				
IUD (Mirena, Paraguard, Skyla, Lileta)				
Implant (Implanon, nexplanon)				
Shots (Depo-Provera)				
The Ring (Nuvaring)				
The Birth Control Patch				
Birth Control Pill				
Male Condoms				
Female Condoms				
Foam, jelly, cream				
Diaphragm				
Rhythm/family planning method (Not having sex at certain times)				
Withdrawal or Pulling out				
Nothing				

When you choose NOT to use a method to prevent pregnancy, what is your main reason?

You don't think you are going to have sex/you don’t have a regular partner	You want a pregnancy	You or your partner don't want to use birth control	You or your partner don't like birth control/fear side effects	You can't pay for birth control	I have been doing something to prevent me from getting pregnant

APPENDIX D

INITIAL SPANISH QUESTIONNAIRE

¿Cuál es su edad actual?

Menos de 18	18	19	20	21	22
23	24	25	26	27	28
29	30	31	32	33	34
35	36	37	38	39	40+

¿Cuál es su código postal actual?

¿Cuál es el grado o nivel de escuela ha completado? Si actualmente matriculados, marcar el grado anterior o mayor grado recibido.

No termino la escuela.
Prekinder a octavo grado
Noveno, Décimo o Onceavo grado
Doceavo grado, Ningún diploma
Egresado de la escuela segundaria - Diploma de escuela segundaria o su equivalente (por ejemplo: GED)
Algunos crédito universitarios, pero menos de 1 año
1 o más años de universidad, sin título
Grado de asociados (por ejemplo: AA, AS)
Licenciatura (por ejemplo: BA, AB, BS)
Maestria (por ejemplo: MA, MS, MEng, MEd, MSW, MBA)
Licenciatura profesional (por ejemplo: MD, DDS, DVM, LLB, JD)
Doctorado (por ejemplo PhD, EdD)
No sé

¿Cuál es su estado civil?

Soltero(a)	Relación abierta (usted y su pareja están juntos y salen con otra gente)	Relación monógama (usted y su pareja sólo se ve uno al otro)	Cohabita (viviendo juntos)
Conprometido(a)	Casado(a)	Separados/divorciados	Viudo/a

¿Tiene hijos? (Inclulla los hijos biológicos y/o adoptados)

Sí, tengo 1 niño	Sí, tengo 2 niños	Sí, tengo 3 hijos
Sí, tengo 4 niños	Sí, tengo 5 hijos o más	No, no tengo ningún niño

¿Cuál es tu religión?

Ninguna religión	Católicos Romanos	Ninguna denominación Cristiana	La Iglesia Anglicana de Inglaterra
Y la Iglesia Presbiteriana de Scotland	Ortodoxa Griega	Methodist	Bautista
Judíos	Budista	Hindu	Islam/Musulmán
Sikh	Otro _____	No sé	Prefiero no responder

¿Con qué frecuencia asiste a la iglesia o a otras reuniones religiosas?

Nunca	Una vez al año o menos	Unas cuantas veces al año	Un par de veces al mes
Una vez a la semana	Más de una vez/semana.	No sé	Prefiero no responder

¿Con qué grupo(s) te identificas tú? [Circule todas las opciones que correspondan]

Los Indios Americanos	Nativo de Alaska	Asiático	Isleño del Pacífico
Negro/Afro-Americano	Blanco/Caucásico	Latino/Hispano	Otro _____

¿Con qué subgrupo Latino (ex. Salvadoreños, Mexicanos, etc.) te identificas?

Antiguan o Barbudan	Chileno	Guadalupano	Panameño	Trinitenses o Trini
Argentinos	Colombiano	Guatemalteco	Paraguayo	Los turcos & Caicos isleños
Arubense	Costarricense	Guyanese	Peruano	Uruguayo
Bahameses	Cubano	Haitianos	Puertorriqueño	Venezolano
Barbadenses	Dominicano	Hondureño	Saint-Barthinois(es)	Virgen Isleños
Beliceño	Ecuatoriano	Jamaiquino	Kittitian o Nevisian	Otro _____
Boliviano	Salvadoreño	Martinican	St. Lucian	No sé
Brasileño	Francés Guianese	Mexicano	Vicentino	Yo no me identifico con ningún subgrupo Latino
Islas Caimán	Grenadino	Nicaragüense	Surinamese	Prefiero no responder

¿Cuál es su estado de generación?

1ª generación (Usted nació en otro país).	2ª generación (Usted nació en Estados Unidos, cualquiera de los dos padres nació en otro país)	3ª generación (Usted nació en Estados Unidos, ambos padres nacieron en los Estados Unidos y todos sus abuelos nacieron en otro país)	4ª generación (Usted y sus padres nacieron en EE.UU., y al menos uno de sus abuelos nació en otro país con el resto nacidos en EE.UU.)	5ª generación o mas (Tú y tus padres nacidos en los EE.UU. y todos los abuelos nacidos en los EE.UU.)

¿En qué país nació usted?

Estados Unidos	Cayman Islands	French Guiana	Mexico	St. Vincent and the Grenadines
Antigua & Barbuda	Chile	Grenada	Nicaragua	Suriname
Argentina	Colombia	Guadeloupe	Panama	Trinidad & Tobago
Aruba	Costa Rica	Guatemala	Paraguay	Turks & Caicos Islands
Bahamas	Cuba	Guyana	Peru	Uruguay
Barbados	Dominica	Haiti	Puerto Rico	Venezuela
Belize	Dominican Republic	Honduras	Saint Barthélemy	Virgin Islands
Bolivia	Ecuador	Jamaica	St. Kitts & Nevis	Otro _____
Brazil	El Salvador	Martinique	St. Lucia	Prefiero no responder

¿Cuál de estas categorías describe mejor su área primaria de empleo?

Ama de casa	Tratamiento
Retirado	Servicios jurídicos
Estudiante	Fabricación - Informática y Electrónica
Desempleado	Fabricación - Otros
Agricultura, silvicultura, pesca, o caza	Militar
Artes , entretenimiento o recreación	Minería
Radiodifusión	Publicación
Educación - Colegio, Universidad, o adulto	Inmobiliaria, alquiler, o arrendamiento
Educación - Primaria /Secundaria (K-12)	Religioso
Educación - Otro	Tienda al por menor
Construcción	Servicios científicos y técnicos
Finanzas y Seguros	Software
Gobierno y Administración Pública	Telecomunicaciones
Salud y Asistencia Social	Transporte y almacén
Hotel y Servicios de Alimentación	Utilidades
Información - Servicios y Redes de Datos	Venta al por mayor
Información - Orto	Otro

¿Cuál es tu situacion laboral?

Está empleado a tiempo completo (40 horas o más por semana)	Empleados a tiempo parcial (menos de 35 horas por semana)	Trabajadores por cuenta propia	En la escuela de tiempo completo
Ama de casa	Desempleado	Disabilitado	Retirado

¿Cuál es el total anual de ingresos personales?	¿Cuál es el total de su ingreso familiar anual?
$0 - $9,999	$0 - $9,999
$10,000 - $19,999	$10,000 - $19,999
$20,000 - $29,999	$20,000 - $29,999
$30,000 - $39,999	$30,000 - $39,999
$40,000 - $49,999	$40,000 - $49,999
$50,000 - $59,999	$50,000 - $59,999
$60,000 - $69,999	$60,000 - $69,999
$70,000 - $79,999	$70,000 - $79,999
$80,000 - $89,999	$80,000 - $89,999
$90,000 - $99,999	$90,000 - $99,999
$100,000 +	$100,000 +

¿Qué tipo de seguro tienes?

El seguro de salud privado que compró usted mismo	VA
Las organizaciones de mantenimiento de salud (HMOs)	Medicaid
Organizaciones de Proveedores Preferidos (OPP)	Medicare
Punto de servicio (POS) los planes	No sé
TRICARE	No tengo seguro de salud

¿Dónde es su fuente habitual de servicios de cuidado de la salud femenina, tales como planificación familiar, exámenes anuales, exámenes de los senos, pruebas para detectar enfermedades de transmisión sexual y otros problemas de salud femenina?

Un consultorio de planificación	Una clínica del departamento de salud	Un centro de salud comunitario	Un ginecólogo privado oficina
Un general o consultorio	Algún otro tipo de lugar	No sé	Prefiero no responder

Instrucciones: Las declaraciones abajo representan algunas de las diversas expectativas para Latinas. Para cada declaración, por favor marque la respuesta que describe mejor lo que usted cree mas bien qué lo que le enseñaron o lo que usted practica realmente.

Una Latina . . .

	Fuertemente No De Acuerdo	No De Acuerdo	De Acuerdo	Fuertemente De Acuerdo
1.) …debería de ser una fuente de fortaleza para la familia.				
2.) …es considerada la fuente principal de fuerza para su familia.				
3.) …madre debería de mantener a su familia unida.				
4.) …debería de enseñarles a su niños ser leales a su familia.				
5.) …debería de hacer cosas que hagan feliz a su familia.				
6.) …debería (hubiera) permanecer/permanecido virgen hasta el matrimonio.				
7.) …debe de esperar hasta después del matrimonio para tener hijos.				
8.) …debería de ser pura.				
9.) …debería de adoptar los valores inculcados por su religión.				

10.) …debería serle fiel a mi pareja.				
11.) …debería satisfacer las necesidades sexuales de mi pareja sin quejarme.				
12.) …no debería alzar su voz contra los hombres.				
13.) …debería respetar las opiniones de los hombres aunque no esté de acuerdo.				
14.) …debe de evitar decirles “no” a la gente.				
15.) …debería hacer cualquier cosa que le pida un hombre de la familia.				
16.) …no debe de hablar de métodos anticonceptivos.				
17.) …no debe expresar sus necesidades a su pareja.				
18.) …debe de sentirse culpable por decirle a la gente sus necesidades.				
19.) …no debe de hablar del sexo.				
20.) ...debe perdonar en todos aspectos.				
21.) …siempre debería estar de acuerdo con las decisiones de los hombres.				
22.) …debería de ser el líder espiritual de la familia.				

23.) …es responsable de llevar a su familia a servicios religiosos.				
24.) …es responsable del crecimiento espiritual de su familia.				

Las siguientes preguntas se refieren a usted y a su pareja principal, o bien, con una pareja sexual reciente. Las preguntas tienen que ver con quién tiene más influencia en la toma de determinadas decisiones. Aquella persona que tenga la última palabra cuando hay desacuerdos es quien tiene "MÁS INFLUENCIA". Si usted tiene más de una pareja, refiérase a sólo su pareja principal. Si actualmente no tiene una pareja, refiérase a una antigua pareja. Si usted no ha tenido que tomar alguna de las siguientes decisiones, piense en quién tendría MÁS INFLUENCIA.

	Mi pareja	Mi pareja y yo por igual	Yo
¿Quién tiene MÁS INFLUENCIA sobre el uso de métodos anticonceptivos?			
¿Quién tiene MÁS INFLUENCIA sobre cuál método usar para evitar el embarazo?			
¿Quién tiene MÁS INFLUENCIA sobre cuándo tener un bebé?			
Si usted llegará a quedar embarazada sin planearlo, ¿quién tendría MÁS INFLUENCIA en la decisión, ya sea de tener y criarlo, buscan padres adoptivos o tener un aborto?			

Las siguientes preguntas también tienen que ver con usted y su pareja.

	Muy en desacuerdo	En desacuerdo	De acuerdo	Muy de acuerdo
Mi pareja me ha impedido usar algún método para evitar el embarazo cuando yo quería.				
Mi pareja ha manipulado mis métodos anticonceptivos o ha tratado de impedirme cuando los he querido utilizar.				

Mi pareja me ha obligado a utilizar un método anticonceptivo cuando yo no quería.				
Si yo quisiera utilizar un método anticonceptivo, mi pareja no me dejaría.				
Mi pareja me ha presionado para que yo quede embarazada.				
Mi pareja me apoyaría si yo quisiera usar algún método para evitar el embarazo.				
Es fácil hablar del sexo con mi pareja.				
Si yo no quisiera tener relaciones, podría decírselo a mi pareja.				
Si yo estuviera preocupada sobre si estaba embarazada o no, podría hablar con mi pareja.				
Si yo realmente no quisiera quedar embarazada, podría convencer a mi pareja.				

Las siguientes preguntas son acerca de sus habilidades de negociación. Recuerde que sus respuestas son confidenciales. Para la siguiente pregunta, por favor, díganos cómo usted está seguro que usted podría hacer lo que se describe. Recuerde que para esta encuesta estamos hablando de relaciones sexuales, es decir, cuando un hombre pone su pene dentro de la vagina de una mujer.

Imagínese que usted y su pareja han tenido relaciones sexuales, pero no han usado un método para prevenir el embarazo. Desea empezar a usar un método para prevenir el embarazo. Usted podría decirle a su pareja que usted...

	Yo definitivamente no podría	Yo probablemente no podría	Yo probablemente podría	Yo definitivamente podría
… considerando un procedimiento quirúrgico? (por ejemplo, tubos atados o vasectomía)				
… desea comenzar a usar un DIU (dispositivo intrauterino)? [Ejemplos: Mirena, Paraguard, Skyla, Lileta]				
… desea comenzar a usar un implante? [ejemplo: o Implanon nexplanon]				
… desea que empiece a recibir inyecciones anticonceptivas (Depo-Provera)?				
… desea comenzar a utilizar el anillo de control de la natalidad (Nuvaring)?				
… desea comenzar a usar el parche de control de la natalidad?				

… desea comenzar a usar la píldora para el control de la natalidad?				
… desea comenzar a usar condones masculinos?				
… desea comenzar a usar los condones femeninos?				
… desea empezar a usar espuma, gel o crema?				
… desea empezar a usar un diafragma?				
… desea empezar a usar un método de planificación de la familia/ritmo (no tener sexo en determinados momentos)?				
… desea empezar a utilizar la retirada o el método de eliminación?				

Imagínese que usted va a tener sexo con alguien que acabas de conocer. Usted siente que es importante usar un método para prevenir el embarazo. Podría decir que la persona que usted...

	Yo definitivamente no podría	Yo probablemente no podría	Yo probablemente podría	Yo definitivamente podría
…desea usar condones masculinos?				
…desea usar condones femeninos?				
…desea utilizar espuma, gel o crema?				
…desea usar un diafragma?				
…desea utilizar ritmo/método de planificación de la familia (no tener sexo en determinados momentos)?				
…desea utilizar retirada o saque el método?				

Puede utilizar o explicar a su pareja sexual cómo utilizar …..

	Yo definitivamente no podría	Yo probablemente no podría	Yo probablemente podría	Yo definitivamente podría
… un condón correctamente?				
… un condón femenino correctamente?				
… espuma, crema o jalea, correctamente?				
… un diafragma correctamente?				
… ritmo/método de planificación de la familia (no tener sexo en determinados momentos) correctamente?				
… retirada o el método de eliminación correctamente?				

Mire las siguientes frases. Respuesta que mejor se adapte a su nivel de acceso.

	Totalmente en desacuerdo	En desacuerdo	De acuerdo	Totalmente de acuerdo
Yo sólo podía ir al médico y obtener un método para prevenir el embarazo si quería.				
Yo sólo podía ir a la tienda y comprar un método para prevenir el embarazo si quería.				
Si decido tener sexo, tengo acceso a algún tipo de control de la natalidad, si y cuando lo necesite.				

Mire las siguientes frases. ¿Alguna vez has pensado…

	Nunca he pensado sobre	He pensado un poco sobre ella	Lo he pensado y sé exactamente si o no quiero utilizarlo	Lo he pensado mucho y yo sé si quiero o no utilizarlo
… cómo desea que sus trompas de Falopio atadas?				
… querer que su pareja para obtener una vasectomía?				
… que desean iniciar el uso del DIU (dispositivo intrauterino)? [Ejemplos: Mirena, Paraguard, Skyla, Lileta]				
… sobre el deseo de empezar a utilizar un implante [ejemplo: o Implanon Nexplanon]				
… sobre el deseo de comenzar a usar inyecciones anticonceptivas (Depo-Provera)?				
… querer el anillo de control de la natalidad (Nuvaring)?				

… sobre el deseo de comenzar a usar el parche anticonceptivo?				
… sobre el deseo de comenzar a usar la píldora anticonceptiva?				
… usar los condones masculinos?				
… usar los condones femeninos?				
… sobre el deseo de comenzar a usar la espuma, crema o gel?				
… sobre el deseo de comenzar a usar un diafragma?				
… que desean iniciar el uso de un método de planificación de la familia/ritmo (no tener sexo en determinados momentos)?				
… s obre el deseo de comenzar a utilizar la retirada o un método de eliminación?				

Las siguientes preguntas son acerca de los comportamientos sexuales, específicamente las relaciones sexuales y el uso de anticonceptivos. Para este estudio, la relación sexual significa un hombre pone su pene dentro de la vagina de una mujer. Recuerde que sus respuestas son confidenciales.

¿Alguna vez has tenido relaciones sexuales?

Sí	No

La primera vez que tuvieron relaciones sexuales, cuántos años tenías?

Menos de 10 años de edad	11-15	16-20	21-25	26-30	31+

En los últimos 3 meses, ¿has tenido relaciones sexuales, incluso una vez?

Sí	No	No sé	Prefiero no responder

Durante los últimos 3 meses, ¿qué tipo de relaciones sexuales has participado en? (Marque todas las que correspondan)

El sexo vaginal	El sexo oral	El sexo anal	No sé	Prefiero no responder

En los últimos 3 meses, ¿cuántas veces has tenido relaciones sexuales sin usar ningún método para prevenir el embarazo? (*cero indica que utilice siempre un método para prevenir el embarazo).

0*	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20+

¿Qué métodos tienen que usted (o su pareja) que utiliza o piensa utilizar para evitar quedar embarazadas (a) en los últimos 12 meses, b) en los últimos 3 meses, (c), (d) actualmente planea utilizar en los próximos 12 meses?

	He utilizado este método en los últimos 12 meses	He utilizado este método en los últimos 3 meses	Actualmente estoy utilizando este	Tengo la intención de usar en los próximos 12 meses
Método de esterilización (por ejemplo, tubos atados o vasectomía)				
DIU (dispositivo intrauterino - por ejemplo, Mirena, Paraguard, Skyla, Lileta)				
Implante (Implanon, nexplanon)				
Inyecciones anticonceptivas (Depo-Provera)				
El Anillo de control de la natalidad (Nuvaring)				
El control de la Natalidad parche				
Píldora anticonceptiva				
Los condones masculinos				
Los condones femeninos				

Espuma, gel, crema				
Diafragma				
Ritmo/método de planificación de la familia (no tener sexo en determinados momentos)				
Retirada o tirando hacia afuera				
Nada				

Cuando usted elige no utilizar un método para prevenir el embarazo, ¿cuál es tu razón principal?

Usted no piensa que va a tener relaciones sexuales o si no tiene una pareja habitual	Desea un embarazo	Usted o su pareja no quiere usar control de la natalidad	Usted o su pareja no le gusta el control de la natalidad/temen efectos secundarios	No se puede pagar para el control de la natalidad	He estado haciendo algo que me impide quedar embarazada

APPENDIX E

FINAL ENGLISH INFORMATION SHEET

TEXAS A&M UNIVERSITY HUMAN SUBJECTS PROTECTION PROGRAM

CONSENT FORM

"Understanding contraceptive behaviors among Latinas"

You are being invited to take part in a research study being conducted by Jovanni Reyes, a researcher at Texas A&M University. The information in this form is provided to help you decide whether or not to take part in the research. If you decide to take part in the study, you will be asked to complete a questionnaire that will take approximately 15 minutes. If you decide you do not want to participate, there will be no penalty to you, and you will not lose any benefit you normally would have.

WHY IS THIS STUDY BEING DONE?
The purpose of this study is to look at reproductive autonomy, marianismo beliefs, and contraception negotiation skills and behaviors among Latina adults (18 years old and over). This study aims to explore influences on women's sexual health decisions regarding pregnancy and use our findings to inform family planning and pregnancy prevention programs/trainings.

WHY AM I BEING ASKED TO BE IN THIS STUDY?
You are being asked to be in this study because you personally identified as a Latina adult (18 years old and over) or have been identified by a mutual friend as a possible participant.

HOW MANY PEOPLE WILL BE ASKED TO BE IN THIS STUDY?
There will be approximately 500 people invited to participate in this study.

WHAT ARE THE ALTERNATIVES TO BEING IN THIS STUDY?
The alternative is not to participate.

WHAT WILL I BE ASKED TO DO IN THIS STUDY?
If you agree to participate in this study, you will be asked to complete a questionnaire that will take approximately 15 minutes. You can choose between completing a paper-pencil survey or a web-based survey taken online. Both surveys ask about reproductive autonomy beliefs, marianismo beliefs and your contraception negotiation skills and behaviors.

ARE THERE ANY RISKS TO ME?
The things that you will be doing have no more risk than you would come across in everyday life. Although the researchers have tried to avoid risks, you may feel that some questions that are asked make you feel stressed or upset. Please know that you do not have to answer anything you do not want to.

ARE THERE ANY BENEFITS TO ME?
There is no direct benefit to you by being in this study. What the researchers find out from this study may help to inform effective family planning and pregnancy prevention programs for women in community settings.

WILL THERE BE ANY COSTS TO ME?
Aside from your time, there are no costs for taking part in the study. If you believe you are injured because of the research, you should contact the Principal Investigator Jovanni V. Reyes, MS, CHES at 214-878-5770

WILL I BE PAID TO BE IN THIS STUDY?
By participating in this study, you will be eligible to be admitted into a drawing. After completing the research survey, the researchers will collect your personal information (name, phone number, email address) separate and independent of your responses to the survey questions. Each participant who agrees to give their information will be placed in a drawing and have the chance to win a gift card ($25/$50/$100). There will be a

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card. If you are one of the winners, you will receive the gift card after all questionnaires have been collected.

WILL INFORMATION FROM THIS STUDY BE KEPT PRIVATE?
The records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published. Research records will be stored securely in locked office space and only research personnel will have access to the records.

Information about you will be stored in a locked file cabinet or on computer files protected with a password. This consent form will be filed securely in an official area. Information about you will be kept confidential to the extent permitted or required by law.

People who have access to your information include the Principal Investigator and research study personnel. Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Subjects Protection Program may access your records to make sure the study is being run correctly and that information is collected properly.

WHO MAY I CONTACT FOR MORE INFORMATION?
You can call the Principal Investigator to tell him/her about a concern or complaint about this research study. The Principal Investigator Jovanni V. Reyes. MS, CHES can be called at 214-878-5770 or emailed at jvreyes89@tamu.edu. You may also contact the Principal Investigator's academic advisor, Dr. Kelly Wilson at kwilson@tamu.edu.

For questions about your rights as a research participant; or if you have questions, complaints, or concerns about the research and cannot reach the Principal Investigator or want to talk to someone other than the Investigator, you may call the Texas A&M Human Subjects Protection Program office at (979) 458-4067 or by email at irb@tamu.edu.

WHAT IF I CHANGE MY MIND ABOUT PARTICIPATING?
This research is voluntary and you have the choice whether or not to be in this research study. You may decide not to participate or stop participating at any time. If you choose not to be in this study, there will be no effect on your employment status, medical care, evaluation, relationship with Texas A&M University, etc.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

APPENDIX F

FINAL SPANISH INFORMATION SHEET

TEXAS A&M UNIVERSITY HUMAN SUBJECTS PROTECTION PROGRAM

FORMA DE CONSENTIMIENTO
"Entendiendo el comportamiento contraceptivo de las Latinas"

Usted ha recibido una invitación para participar en el estudio de investigación conducido por Jovanni Reyes, investigadora en la Universidad de Texas A& M. La información en esta forma es proporcionada para ayudarle a decidir si quiere tomar parte en esta encuesta. Si usted consiente participar en este estudio podrá completar un cuestionario que toma aproximadamente 15 minutos. Si decide no participar en la encuesta, no habrá ninguna penalización o obligación de su parte.

¿PORQUE SE ESTA HACIENDO ESTE ESTUDIO?
El propósito de este estudio es observar la autonomía reproductiva, creencias de marianismo, y habilidades de negociación y conducta contraceptiva entre Latinas adultas de 18 años y más. El propósito de este estudio es explorar las influencias relacionadas a las decisiones de salud sexual y embarazo entre las Latinas y usar nuestras respuestas para informar programas y entrenamientos de prevención y planificación familiar.

¿PORQUE SE ME HA PEDIDO PARTICIPAR EN ESTE ESTUDIO?
Se le ha pedido participar en este estudio por que personalmente se identificó como una Latina adulta (18 años y mayor) o fue identificada como una posible participante por una amiga.

¿A CUANTAS PERSONAS SE LES PIDIO QUE PARTICIPARAN EN ESTE ESTUDIO?
Habrá aproximadamente 500 personas invitadas a participar en este estudio.

¿CUALES SON LAS ALTERNATIVAS DE PARTICIPACION EN ESTE ESTUDIO?
La alternativa es de no participar.

¿QUE ME PEDIRAN HACER EN ESTE ESTUDIO?
Si usted consiente participar en este estudio podrá completar un cuestionario que toma aproximadamente 15 minutos. Puede escoger entre completar una encuesta con papel y lápiz o una encuesta electrónica por el internet. Las dos encuestas tienen preguntas relacionadas a sus creencias de la autonomía reproductiva, marianismo y sus habilidades y comportamiento de negociación contraceptivas.

¿HAY ALGUNOS RIESGOS PARA MÍ?
Contestar la encuesta no tendrá ningún riesgo mayor que los riesgos que usted enfrenta normalmente en su vida cotidiana. Aunque los que prepararon esta encuesta han tomado precauciones para tratar de evitar cualquier riesgo, es una posibilidad que algunas preguntas la hagan sentir estresada. No tiene que contestar ninguna pregunta que no quiere contestar.

¿HAY ALGUNOS BENEFICIOS PARA MÍ?
No habrá ningún beneficio directo para usted por su participación en esta encuesta. Lo que se descubra en esta encuesta quizás ayudara para informar centros de planificación familiar y centros de prevención natal para mujeres de la comunidad.

¿HABRA ALGUN COSTO DE MI PARTE?
Aparte de su tiempo, no habrá ningún costo de su parte para participar en este estudio. Si cree que usted se ha lastimado por causa de este estudio debe contactar a la Investigadora Principal, Jovanni V. Reyes, MS, CHES al 214-878-5770.

¿RECIBIRE CONPENSACION POR PARTICIPAR EN ESTE ESTUDIO?
Todas las participantes del estudio serán elegibles para ser admitidas en un sorteo. Después de completar la encuesta, los investigadores tomaran su información personal (nombre, teléfono y correo electrónico) junto a

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

sus respuestas de la encuesta. Cada participante que proporcione su información participará en un sorteo y tendrá la oportunidad de ganar una tarjeta de regalo ($25/$50/$100). Habrá un total de treinta tarjetas de $25, cinco tarjetas de $50 y una tarjeta de $100. Si usted es uno de los ganadores, recibirá la tarjeta de regalo después de que todos los cuestionarios han sido recogidos.

¿ES PRIVADA LA INFORMACION DE ESTE ESTUDIO?
Los resultados de este estudio se mantendrán privados. Ninguna información que te identifique sera incluida en cualquier tipo de informe que pueda ser publicado. Todos los archivos y registros de esta encuesta se mantendrán en un gabinete con llave en la oficina del estudio y sólo el personal de investigación tendrá acceso a los registros. Su información se almacenará en una computadora con archivo bloqueado y/o protegidos con contraseña. Este formulario de consentimiento se archivará en forma segura en una zona oficial. Su información se mantendrá confidencial en la medida permitida o requerida por la ley. Personas que tienen acceso a la información incluyen el investigador y el personal del estudio de investigación. Representantes de las agencias reguladoras como la oficina de protecciones de investigaciones humanas (OHRP) y entidades como el *Texas A&M University Human Subjects Protection Program* pueden acceder a sus registros para asegurarse de que el estudio se ejecute correctamente y que la información es recogida correctamente.

¿A QUIÉN PUEDO CONTACTAR PARA OBTENER MÁS INFORMACIÓN?
Usted puede contactar a la investigadora Principal para comentarle si usted tiene una preocupación o queja sobre este estudio de investigación. La Investigadora Principal es Jovanni V. Reyes. MS, CHES y le puede llamar al 214-878-5770 o contactar por correo electrónico a jvreyes89@tamu.edu. También puede contactar al asesor académico de la Investigadora Principal, la Dra. Kelly Wilson al correo electrónico, kwilson@tamu.edu.

Para preguntas acerca de sus derechos como participante de la investigación; o si tiene preguntas, quejas o inquietudes acerca de la investigación y no puede contactar a la Investigadora Principal o desea hablar con alguien que no sea el investigador, puede llamar a la oficina de *Texas A&M Human Subjects Protection Program* al (979) 458-4067 o por correo electrónico a irb@tamu.edu.

¿QUÉ PASA SI CAMBIO DE OPINIÓN SOBRE MI PARTICIPACIÓN?
Esta encuesta es voluntaria y usted tiene la opción de decir sí quiere o no a participar en este estudio de investigación. Usted puede decidir no participar o dejar de participar en cualquier momento. Si decide no participar en este estudio, no habrá ninguna consecuencia sobre su situación en el empleo, atención médica, evaluación, relación con Texas A&M University, etc.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

APPENDIX G

FINAL ENGLISH QUESTIONNAIRE

Instructions: The statements below represent some of the different expectations for Latinas. For each statement, please mark the answer that best describes what you <u>BELIEVE</u> rather than what you were taught or what you actually practice.

A Latina . . .

	Strongly Disagree	Disagree	Agree	Strongly Agree
1.) …must be a source of strength for her family.				
2.) …is considered the main source of strength of her family.				
3.) …mother must keep the family unified.				
4.) …should teach her children to be loyal to the family.				
5.) …should do things that make her family happy.				
6.) …should (should have) remain(ed) a virgin until marriage.				
7.) …should wait until after marriage to have children.				
8.) …should be pure.				
9.) …should adopt the values taught by her religion.				
10.) …should be faithful to her partner.				
11.) …should satisfy her partner's sexual needs without argument.				
12.) …should not speak out against men.				
13.) …should respect men's opinions even when she does not agree.				
14.) …should avoid saying no to people.				
15.) …should do anything a male in the family asks her to do.				
16.) …should not discuss birth control.				
17.) …should not express her needs to her partner.				
18.) …should feel guilty about telling people what she needs.				
19.) …should not talk about sex.				
20.) …should be forgiving in all aspects.				
21.) …should always be agreeable to men's decisions.				
22.) …should be the spiritual leader of the family.				
23.) …is responsible for taking family to religious services.				
24.) …is responsible for the spiritual growth of the family.				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

The next questions are about you and your main partner or a recent sexual partner. The questions ask about who has the most say in different types of decisions. "Most say" means if there was a disagreement, the person who would have final say. If you have more than one partner, think about your main partner. If you don't have a partner, think about a previous partner. If you have NOT had to make any of the following decisions, please THINK about who would have the MOST SAY in the decision.

	My sexual partner	Both me and my sexual partner	Me
Who has the MOST say about whether you use a method to prevent pregnancy?			
Who has the MOST say about which method you would use to prevent pregnancy?			
Who has the MOST say about when you have a baby in your life?			
If you became pregnant but it was unplanned, who would have the MOST say about whether you would raise the child, seek adoptive parents, or have an abortion?			

The next questions are about you and your main or a recent sexual partner.

	Strongly Disagree	Disagree	Agree	Strongly Agree
My partner has stopped me from using a method to prevent pregnancy when I wanted to use one.				
My partner has messed with or made it difficult to use a method to prevent pregnancy when I wanted to use one.				
My partner has made me use a method to prevent pregnancy when I did not want to use one.				
If I wanted to use a method to prevent pregnancy my partner would stop me.				
My partner has pressured me to become pregnant.				
My partner would support me if I wanted to use a method to prevent pregnancy.				
It is easy to talk about sex with my partner.				
If I didn't want to have sex I could tell my partner.				
If I was worried about being pregnant or not being pregnant I could talk to my partner about it.				
If I really did not want to become pregnant I could get my partner to agree with me.				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

The next few questions are about your negotiation skills. Please remember that your answers are CONFIDENTIAL. For the next questions, please tell us how sure you are that you could do what is described. Remember that for this survey we are talking about sexual intercourse, i.e., when a male puts his penis inside a female's vagina.

Imagine you and your partner have been having sex but have not used a method to prevent pregnancy. You want to start using a method to prevent pregnancy. **Could you tell your partner you…**

	I definitely could not	I probably could not	I probably could	I definitely could
…are considering a surgical procedure? [examples: tubes tied or vasectomy]				
…want to start using an IUD (intra-uterine device)? [examples: Mirena, Paraguard, Skyla, Lileta]				
…want to start using an implant? [example: Implanon or nexplanon]				
…want to start getting birth control shots? [example: Depo-Provera]				
…want to start using the birth control ring? [example: Nuvaring]				
…want to start using the birth control patch?				
…want to start using the birth control pill?				
…want to start using male condoms?				
…want to start using female condoms?				
…want to start using foam, jelly, or cream? [example: spermicide]				
…want to start using a diaphragm?				
…want to start using a rhythm/family planning method (Not having sex at certain times)?				
…want to start using withdrawal or the pull out method?				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Imagine you are going to have sex with someone you just met. You feel it is important to use a method to prevent pregnancy. **Could you tell that person you…**

	I definitely could not	I probably could not	I probably could	I definitely could
…want to use male condoms?				
…want to use female condoms?				
…want to use foam, jelly, or cream?				
…want to use a diaphragm?				
…want to use rhythm/family planning method (Not having sex at certain times)?				
…want to use withdrawal or the pull out method?				

Could you use or explain to your sex partner how to CORRECTLY use …..

	I definitely could not	I probably could not	I probably could	I definitely could
…a male condom?				
…a female condom?				
… foam, jelly, or cream?				
…a diaphragm?				
… rhythm/family planning method (Not having sex at certain times)?				
… withdrawal or the pull out method?				

Look at the sentences below. Mark the answer that best matches your level of access.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I could just go to the doctor and get a method to prevent pregnancy if I wanted to.				
I could just go to the store and buy a method to prevent pregnancy if I wanted to.				
If I decide to have sex, I have access to some type of birth control or other form of contraception, if and when I need it.				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Look at the sentences below. **Have you ever thought about…**

	I have never thought about it	I have thought a LITTLE about it	I have thought about it and I THINK I know whether or not I would choose it	I have thought ALOT about it and I know EXACTLY whether or not I would choose it
…wanting your tubes tied?				
…wanting your partner to get a vasectomy?				
…using an IUD (intra-uterine device)? [examples: Mirena, Paraguard, Skyla, Lileta]				
…using an implant? [example: Implanon or Nexplanon]				
…using birth control shots? [example: Depo-Provera]				
…using the birth control ring? [example: Nuvaring]				
…using the birth control patch?				
…using the birth control pill?				
…using male condoms?				
…using female condoms?				
…using foam, jelly, or cream? [example: spermicide]				
…using a diaphragm?				
…using a rhythm/family planning method (Not having sex at certain times)?				
…using withdrawal or the pull out method?				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

The next few questions are about sexual behaviors, specifically sexual intercourse and use of contraception. For this study, sexual intercourse means a male putting his penis into a female's vagina. Please remember that your answers are CONFIDENTIAL.

Have you ever had sexual intercourse?

Yes	No (Skip the next 6 questions)

How old were you the very first time you had sexual intercourse?

Less than 10 years' old	11-15	16-20	21-25	26-30	31+

In the past 3 months, have you had sexual intercourse, even once?

Yes	No

During the past 3 months, what types of sex have you engaged in? (Circle ALL that apply)

Vaginal sex	Oral sex	Anal sex	Other: _____	I prefer not to answer

In the past 3 months, how many times have you had sexual intercourse without using any method to prevent pregnancy? (*Zero indicates that you always use a method to prevent pregnancy)

0*	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91+

When you choose NOT to use a method to prevent pregnancy, what is your main reason?

You don't think you are going to have sex/you don't have a regular partner	You want a pregnancy	You or your partner don't WANT to use a method to prevent pregnancy	You or your partner don't LIKE to use a method to prevent pregnancy
You or your partner don't like to use a method to prevent pregnancy because fear of side effects	You can't pay for any type of method to prevent pregnancy	I have been doing something to prevent me from getting pregnant	I do not know about any methods to prevent pregnancy

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

What methods have you (or your partner) used or plan to use to keep you from getting pregnant (A) in the last 12 months, (B) in the last 3 months, (C) currently, and (D) plan to use in the next 12 months?

	Sterilization method (e.g., tubes tied or vasectomy)	IUD (Mirena, Paraguard, Skyla, Lileta)	Implant (Implanon, nexplanon)	Shots (Depo-Provera)	The Ring (Nuvaring)	Birth Control Patch	Birth Control Pill	Male Condoms	Female Condoms	Foam, jelly, cream	Diaphragm	Rhythm/family planning method (Not having sex at certain times)	Withdrawal or Pulling out	Nothing
(A) I used this method in the last 12 months…														
(B) I used this method in the last 3 months…														
(C) I am currently using this…														
(D) I plan to use in the next 12 months…														

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

What is your age?

Less than 18	18	19	20	21	22
23	24	25	26	27	28
29	30	31	32	33	34
35	36	37	38	39	40+

Where do you currently live? (CITY, STATE – ex. Dallas, TX)

What is your current zip code?

What is the highest degree or level of school you have COMPLETED?

No schooling completed
Prekinder to 8th grade
9th, 10th or 11th grade
12th grade, no diploma
High school graduate - high school diploma or the equivalent (for example: GED)
Some college credit, but less than 1 year
1 or more years of college, no degree
Associate degree (for example: AA, AS)
Bachelor's degree (for example: BA, AB, BS)
Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
Professional degree (for example: MD, DDS, DVM, LLB, JD)
Doctorate degree (for example: PhD, EdD)
I don't know

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

What is your current relationship status?

Single	Open relationship (you and your partner date each other and other people)	Monogamous relationship (you and your partner only date each other)	Cohabiting (living together)
Engaged	Married	Separated/Divorced	Widow/Widower

Do you have any children? (Including any biological or non-biological children)

Yes, I have 1 child	Yes, I have 2 children	Yes, I have 3 children
Yes, I have 4 children	Yes, I have 5 or more children	No, I do not have any children

What is your religion? (Please circle ONLY ONE answer)

No organized religion but spiritual	Roman Catholic	Christian – non denominational	Church of England/Anglican
Presbyterian/Church of Scotland	Greek Orthodox	Methodist	Baptist
Jewish	Buddhist	Hindu	Islam/Muslim
Sikh	Atheist	Other _____	I prefer not to answer

How often do you attend church or other religious meetings?

Never	Once a year or less	A few times a year	A few times a month
Once a week	More than once a week	I don't know	I prefer not to answer

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

What group(s) do you identify with? (Circle ALL that apply)

American Indian	Alaskan Native	Asian	Pacific Islander
Black/African American	White/Caucasian	Latino/Hispanic	Other _____

What Latino subgroup(s) (ex. Mexican, Salvadorian, etc.) do you identify with? (Circle ALL that apply)

Antiguan or Barbudan	Chilean	Guadeloupean	Panamanian	Trinidadian or Trini
Argentinian	Colombian	Guatemalan	Paraguayan	Turks & Caicos Islander
Aruban	Costa Rican	Guyanese	Peruvian	Uruguayan
Bahamian	Cuban	Haitian	Puerto Rican	Venezuelan
Barbadian	Dominican	Honduran	Saint-Barthinois(es)	Virgin Islander
Belizean	Ecuadorian	Jamaican	Kittitian or Nevisian	Other _____
Bolivian	Salvadorian	Martinican	St. Lucian	I don't know
Brazilian	French Guianese	Mexican	Vincentian	I don't identify with any Latino subgroup
Cayman Islands	Grenadino/a	Nicaraguan	Surinamese	I prefer not to answer

What is your generation status?

1st generation (you were born in another country)	2nd generation (you were born in the USA, either parent born in another country)	3rd generation (you were born in the USA, both parents were born in the USA and all grandparents were born in another country)	4th generation (you and your parents were born in the USA, and at least one grandparent was born in another country with remainder born in the USA)	5th generation or higher (you and your parents born in the USA and all grandparents born in the USA)

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

What country were you born in?

United States	Cayman Islands	French Guiana	Mexico	St. Vincent and the Grenadines
Antigua & Barbuda	Chile	Grenada	Nicaragua	Suriname
Argentina	Colombia	Guadeloupe	Panama	Trinidad & Tobago
Aruba	Costa Rica	Guatemala	Paraguay	Turks & Caicos Islands
Bahamas	Cuba	Guyana	Peru	Uruguay
Barbados	Dominica	Haiti	Puerto Rico	Venezuela
Belize	Dominican Republic	Honduras	Saint Barthélemy	Virgin Islands
Bolivia	Ecuador	Jamaica	St. Kitts & Nevis	Other _____
Brazil	El Salvador	Martinique	St. Lucia	I prefer not to answer

Which of these categories best describes your primary area of employment? (Please circle ONLY ONE answer)

Homemaker	Processing
Retired	Legal Services
Student	Manufacturing - Computer and Electronics
Unemployed	Manufacturing - Other
Agriculture, Forestry, Fishing, or Hunting	Military
Arts, Entertainment, or Recreation	Mining
Broadcasting	Publishing
Education - College, University, or Adult	Real Estate, Rental, or Leasing
Education - Primary/Secondary (K-12)	Religious
Education - Other	Retail
Construction	Scientific or Technical Services
Finance and Insurance	Software
Government and Public Administration	Telecommunications
Health Care and Social Assistance	Transportation and Warehousing
Hotel and Food Services	Utilities
Information - Services and Data	Wholesale
Information - Other	Other _____

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

What is your employment status?

Employed full-time or more (40+ hours per week)	Employed part-time (less than 35 hours per week)	Self-employed	In school full time	In school part time
Homemaker	Unemployed	Disabled	Retired	Other _____

What is your total annual PERSONAL* income? (*How much money do *you personally* make each year?)	What is your total annual HOUSEHOLD^ income? (^How much money does *everyone* in your household make all together?)
$0 - $9,999	$0 - $9,999
$10,000 - $19,999	$10,000 - $19,999
$20,000 - $29,999	$20,000 - $29,999
$30,000 - $39,999	$30,000 - $39,999
$40,000 - $49,999	$40,000 - $49,999
$50,000 - $59,999	$50,000 - $59,999
$60,000 - $69,999	$60,000 - $69,999
$70,000 - $79,999	$70,000 - $79,999
$80,000 - $89,999	$80,000 - $89,999
$90,000 - $99,999	$90,000 - $99,999
$100,000 +	$100,000 +

What type of health insurance do you currently have? (Please circle ONLY ONE answer)

Private health insurance that you bought yourself	Medicaid
Insurance provided by employer (HMO, PPO, etc.)	Medicare
TRICARE or other insurance provided by the US military	Other: _____
I am currently on my parent's insurance	I don't know
Disability Insurance	I do not have health insurance

Where is your USUAL source of services for female health care, such as family planning, annual exams, breast exams, tests for sexually transmitted diseases, and other female health concerns?

A family planning clinic	A health department clinic	A community health center	A private gynecologist office
A general or family physician office	OTHER: _____	I do not have a usual source	I prefer not to answer

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

APPENDIX H

FINAL SPANISH QUESTIONNAIRE

Instrucciones: Las declaraciones abajo representan algunas de las diversas expectativas para Latinas. Para cada declaración, por favor marque la respuesta que describe mejor lo que usted CREE mas bien qué lo que le enseñaron o lo que usted practica realmente.

Una Latina . . .

	Fuertemente No De Acuerdo	No De Acuerdo	De Acuerdo	Fuertemente De Acuerdo
1.) …debería de ser una fuente de fortaleza para la familia.				
2.) …es considerada la fuente principal de fuerza para su familia.				
3.) …madre debería de mantener a su familia unida.				
4.) …debería de enseñarles a su niños ser leales a su familia.				
5.) …debería de hacer cosas que hagan feliz a su familia.				
6.) …debería (hubiera) permanecer/permanecido virgen hasta el matrimonio.				
7.) …debe de esperar hasta después del matrimonio para tener hijos.				
8.) …debería de ser pura.				
9.) …debería de adoptar los valores inculcados por su religión.				
10.) …debería serle fiel a mi pareja.				
11.) …debería satisfacer las necesidades sexuales de mi pareja sin quejarme.				
12.) …no debería alzar su voz contra los hombres.				
13.) …debería respetar las opiniones de los hombres aunque no esté de acuerdo.				
14.) …debe de evitar decirles "no" a la gente.				
15.) …debería hacer cualquier cosa que le pida un hombre de la familia.				
16.) …no debe de hablar de métodos anticonceptivos.				
17.) …no debe expresar sus necesidades a su pareja.				
18.) …debe de sentirse culpable por decirle a la gente sus necesidades.				
19.) …no debe de hablar del sexo.				
20.) ...debe perdonar en todos aspectos.				
21.) …siempre debería estar de acuerdo con las decisiones de los hombres.				
22.) …debería de ser el líder espiritual de la familia.				
23.) …es responsable de llevar a su familia a servicios religiosos.				
24.) …es responsable del crecimiento espiritual de su familia.				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Las siguientes preguntas se refieren a usted y a su pareja principal, o bien, con una pareja sexual reciente. Las preguntas tienen que ver con quién tiene más influencia en la toma de determinadas decisiones. Aquella persona que tenga la última palabra cuando hay desacuerdos es quien tiene "MÁS INFLUENCIA". Si usted tiene más de una pareja, refiérase a sólo su pareja principal. Si actualmente no tiene una pareja, refiérase a una antigua pareja. Si usted no ha tenido que tomar alguna de las siguientes decisiones, piense en quién tendría MÁS INFLUENCIA.

	Mi pareja	Mi pareja y yo por igual	Yo
¿Quién tiene MÁS INFLUENCIA sobre el uso de métodos anticonceptivos?			
¿Quién tiene MÁS INFLUENCIA sobre cuál método usar para evitar el embarazo?			
¿Quién tiene MÁS INFLUENCIA sobre cuándo tener un bebé?			
Si usted llegará a quedar embarazada sin planearlo, ¿quién tendría MÁS INFLUENCIA en la decisión, ya sea de tener y criarlo, buscan padres adoptivos o tener un aborto?			

Las siguientes preguntas también tienen que ver con usted y su pareja.

	Muy en desacuerdo	En desacuerdo	De acuerdo	Muy de acuerdo
Mi pareja me ha impedido usar algún método para evitar el embarazo cuando yo quería.				
Mi pareja ha manipulado mis métodos anticonceptivos o ha tratado de impedirme cuando los he querido utilizar.				
Mi pareja me ha obligado a utilizar un método anticonceptivo cuando yo no quería.				
Si yo quisiera utilizar un método anticonceptivo, mi pareja no me dejaría.				
Mi pareja me ha presionado para que yo quede embarazada.				
Mi pareja me apoyaría si yo quisiera usar algún método para evitar el embarazo.				
Es fácil hablar del sexo con mi pareja.				
Si yo no quisiera tener relaciones, podría decírselo a mi pareja.				
Si yo estuviera preocupada sobre si estaba embarazada o no, podría hablar con mi pareja.				
Si yo realmente no quisiera quedar embarazada, podría convencer a mi pareja.				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Las siguientes preguntas son acerca de sus habilidades de negociación. Recuerde que sus respuestas son CONFIDENCIALES. Para las siguientes preguntas, por favor, díganos si usted podría negociar el uso de los anticonceptivos descritos abajo. Recuerde que para los fines de esta encuesta cuando hablamos de relaciones sexuales nos referimos a cuando un hombre pone su pene dentro de la vagina de una mujer.

Imagínese que usted y su pareja han tenido relaciones sexuales, pero no han usado un método para prevenir el embarazo. Si usted desea empezar a usar un método para prevenir el embarazo. **¿Usted podría decirle a su pareja que usted...**

	Yo definitivamente no podría	Yo probablemente no podría	Yo probablemente podría	Yo definitivamente podría
… está considerando un procedimiento quirúrgico? [por ejemplo: ligadura de las trompas o vasectomía]				
… desea usar un DIU (dispositivo intrauterino)? [por ejemplo: Mirena, Paraguard, Skyla, Lileta]				
… desea usar un implante? [por ejemplo: Implanon o nexplanon]				
… desea recibir inyecciones anticonceptivas? [por ejemplo: Depo-Provera]				
… desea utilizar el anillo de control de la natalidad? [por ejemplo: Nuvaring]				
… desea usar el parche de control de la natalidad?				
… desea usar la píldora para el control de la natalidad?				
… desea usar condones masculinos?				
… desea usar los condones femeninos?				
… desea usar espuma, gel o crema? [por ejemplo: espermicida]				
… desea usar un diafragma?				
… un método natural de planificación familiar como el método del ritmo (no tener relaciones sexuales en días fértiles)?				
… desea usar el método del coito interrumpido? (extraer el pene de la vagina antes de la eyaculación)				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Imagínese que usted va a tener sexo con alguien que acaba de conocer. Usted siente que es importante usar un método para prevenir el embarazo. **¿Podría decirle a la persona que usted...**

	Yo definitivamente no podría	Yo probablemente no podría	Yo probablemente podría	Yo definitivamente podría
…desea usar condones masculinos?				
…desea usar condones femeninos?				
…desea utilizar espuma, gel o crema?				
…desea usar un diafragma?				
…desea utilizar un método natural de planificación familiar como el método del ritmo (no tener relaciones sexuales en días fértiles)?				
…desea utilizar el método del coito interrumpido? (extraer el pene de la vagina antes de la eyaculación)				

¿Puede utilizar o explicar a su pareja sexual cómo utilizar CORRECTAMENTE…..

	Yo definitivamente no podría	Yo probablemente no podría	Yo probablemente podría	Yo definitivamente podría
… un condón masculino?				
… un condón femenino?				
… espuma, crema o jalea?				
… un diafragma?				
… ritmo/método de planificación de la familia (no tener sexo en determinados momentos)?				
…el método del coito interrumpido? (extraer el pene de la vagina antes de la eyaculación)				

Lea las siguientes frases. Marque la respuesta que mejor se adapte a su nivel de acceso.

	Totalmente en desacuerdo	En desacuerdo	De acuerdo	Totalmente de acuerdo
Yo podría ir al médico y obtener un método para prevenir el embarazo si así lo quisiera.				
Yo podría ir a la tienda y comprar un método para prevenir el embarazo si así lo quisiera.				
Si decido tener sexo, tengo acceso a algún tipo de control de la natalidad, cuando lo necesito.				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Lea las siguientes frases. **¿Alguna vez has pensado…**

	Nunca he pensado sobre	He pensado un poco sobre ella	Lo he pensado y creo que sé sí o no quiero usar	Yo he pensado mucho y sé exactamente si quiero usarlo o no
… en que desea ligarse las trompas de Falopio?				
… en que quiere que su pareja obtenga la vasectomía?				
… que desea usar un DIU (dispositivo intrauterino)? [por ejemplo: Mirena, Paraguard, Skyla, Lileta]				
… en que desea utilizar un implante? [por ejemplo: Implanon o Nexplanon]				
… en que desea usar inyecciones anticonceptivas? [por ejemplo: Depo-Provera]				
… en que quiere usar el anillo de control de la natalidad? [por ejemplo: Nuvaring]				
… en que desea usar el parche anticonceptivo?				
… en que desea usar la píldora anticonceptiva?				
… en que quiere usar condones masculinos?				
… en que quiere usar condones femeninos?				
… en que quiere usar la espuma, crema o gel? [por ejemplo: espermicida]				
… en que quiere usar un diafragma?				
… en que desea usar un método natural de planificación familiar como el método del ritmo (no tener relaciones sexuales en días fértiles)?				
… en que desea usar el método del coito interrumpido (extraer el pene de la vagina antes de la eyaculación)?				

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

Las siguientes preguntas son acerca de los comportamientos sexuales, específicamente las relaciones sexuales y el uso de métodos anticonceptivos. Para los fines de este estudio, la relación sexual significa que un hombre coloca su pene dentro de la vagina de una mujer. Recuerde que sus respuestas son CONFIDENCIALES.

¿Alguna vez has tenido relaciones sexuales?

Sí	No (Saltar las siguientes 6 preguntas)

¿Qué edad tenía la primeria vez que tuvo relaciones sexuales?

Menos de 10 años de edad	11-15	16-20	21-25	26-30	31+

¿En los últimos 3 meses, ¿has tenido relaciones sexuales, por lo menos una vez?

Sí	No

¿Durante los últimos 3 meses, ¿en qué tipo de relaciones sexuales ha participado? (Marque TODAS las que correspondan)

Sexo vaginal	Sexo oral	Sexo anal	Otro: _____	Prefiero no responder

¿En los últimos 3 meses, ¿cuántas veces has tenido relaciones sexuales SIN usar algún método para prevenir el embarazo? (*cero indica que siempre utiliza un método para prevenir el embarazo).

0*	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91+

¿Cuándo usted elige no utilizar un método para prevenir el embarazo, ¿cuál es su razón principal?

Usted no piensa que va a tener relaciones sexuales o no tiene una pareja habitual	Usted desea quedar embarazada	Usted o su pareja no QUIEREN usar métodos de control de la natalidad	A usted o su pareja no le GUSTAN los métodos de control de la natalidad
A usted o su pareja no le gustan los métodos de control de la natalidad o le temen a sus efectos secundarios	Usted no puede pagar algún método de control de la natalidad	Yo siempre utilizo algún método que me impide quedar embarazada	Yo no conozco a ningún métodos de control de la natalidad

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

¿Qué métodos han utilizado usted (o su pareja) o piensan utilizar para evitar el embarazo (A) en los últimos 12 meses, (B) en los últimos 3 meses, (C) actualmente, (D) o planean utilizar en los próximos 12 meses?

	Método de esterilización quirúrgico [por ejemplo: ligadura de las trompas o vasectomía]	DIU (dispositivo intrauterino) [por ejemplo: Mirena, Paraguard, Skyla, Lileta]	Implante [por ejemplo: Implanon, nexplanon]	Inyecciones anticonceptivas [por ejemplo: Depo-Provera]	Anillo de control de la natalidad [por ejemplo: Nuvaring]	Parche anticonceptivo	Píldora anticonceptiva	Condones masculinos	Condones femeninos	Espuma, gel, crema [por ejemplo: espermicida]	Diafragma	Método natural de planificación familiar como el método del ritmo (no tener relaciones sexuales en días fértiles)	Coito interrumpido (extraer el pene de la vagina antes de la eyaculación)	Nada
(A) He utilizado este método en los últimos 12 meses														
(B) He utilizado este método en los últimos 3 meses														
(C) Actualmente estoy utilizando este método														
(D) Tengo la intención de usar este método en los próximos 12 meses														

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

¿Cuál es su edad?

Menos de 18	18	19	20	21	22
23	24	25	26	27	28
29	30	31	32	33	34
35	36	37	38	39	40+

¿Dónde vive actualmente? (Ciudad, Estado - por ejemplo: Dallas, TX)

¿Que es su código postal actual?

¿Cuál es el grado o nivel de escuela ha COMPLETADO?

No termine la escuela
Prekinder a octavo grado
Noveno, Décimo u Onceavo grado
Doceavo grado, Ningún diploma – sin diploma
Egresado de la escuela preparatoria- Diploma de escuela preparatoria o su equivalente (por ejemplo: GED)
Algunos créditos universitarios, pero menos de 1 año
Uno o más años de universidad, sin título
Grado de asociados (por ejemplo: AA, AS)
Licenciatura (por ejemplo: BA, AB, BS)
Maestria (por ejemplo: MA, MS, MEng, MEd, MSW, MBA)
Título profesional (por ejemplo: MD, DDS, DVM, LLB, JD)
Doctorado (por ejemplo PhD, EdD)
No sé

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

¿Cuál es su estado civil?

Soltero(a)	Relación abierta (usted y su pareja están juntos pero también tratan con otra gente)	Relación monógama (usted y su pareja sólo se ven uno al otro)	Cohabita (vive con su pareja)
Conprometido(a)	Casado(a)	Separados/divorciados	Viudo/a

¿Tiene hijos? (Incluya los hijos biológicos y/o adoptados)

Sí, tengo 1 hijo/hija	Sí, tengo 2 hijos/hijas	Sí, tengo 3 hijos/hijas
Sí, tengo 4 hijos/hijas	Sí, tengo 5 hijos/hijas o más	No, no tengo ningún hijo/hija

¿Cuál es su religión? (Por favor círculo sólo UNA respuesta)

Ninguna religión	Católicos Romanos	Ninguna denominación Cristiana	La Iglesia Anglicana de Inglaterra
la Iglesia Presbiteriana de Scotland	Ortodoxa Griega	Methodist	Bautista
Judíos	Budista	Hindu	Islam/Musulmán
Sikh	Ateo	Otro _____	Prefiero no responder

¿Con qué frecuencia asiste a la iglesia o a otras ceremonias religiosas?

Nunca	Una vez al año o menos	Unas cuantas veces al año	Un par de veces al mes
Una vez a la semana	Más de una vez a la semana.	No sé	Prefiero no responder

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

¿Con qué grupo(s) se identifica? (Circule TODAS las opciones que correspondan)

Indio Nativo Americano	Nativo de Alaska	Asiático	Isleño del Pacífico
Negro/Afro-Americano	Blanco/Caucásico	Latino/Hispano	Otro _____

¿Con qué subgrupo étnico Latino (ex., Mexicanos, Salvadoreños, etc.) se identifica? (Circule TODAS las opciones que correspondan)

Antiguan o Barbudan	Chileno	Guadalupano	Panameño	Trinitenses o Trini
Argentinos	Colombiano	Guatemalteco	Paraguayo	Los turcos &Amp; Caicos isleños
Arubense	Costarricense	Guyanese	Peruano	Uruguayo
Bahameses	Cubano	Haitianos	Puertorriqueño	Venezolano
Barbadenses	Dominicano	Hondureño	Saint-Barthinois(es)	Virgen Isleños
Beliceño	Ecuatoriano	Jamaiquino	Kittitian or Nevisian	Otro _____
Boliviano	Salvadoreño	Martinican	St. Lucian	No sé
Brasileño	Francés Guianese	Mexicano	Vicentino	Yo no me identifico con ningún subgrupo Latino
Islas Caimán	Grenadino	Nicaragüense	Surinamese	Prefiero no responder

¿Cuál es su estado de generación?

1ª generación (Usted nació en otro país).	2ª generación (Usted nació en los Estados Unidos, cualquiera de los dos padres nació en otro país)	3ª generación (Usted nació en los Estados Unidos, ambos padres nacieron en los Estados Unidos y todos sus abuelos nacieron en otro país)	4ª generación (Usted y sus padres nacieron enlos Estados Unidos , y al menos uno de sus abuelos nació en otro país con el resto nacidos enlos Estados Unidos)	5ª generación o mas (Tú y tus padres nacidos en los Estados Unidos . y todos los abuelos nacidos en los Estados Unidos)

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

¿En qué país nació?

Estados Unidos	Islas Caimán	Guyana Francesa	México	San Vicente y las Granadinas
Antigua & Barbuda	Chile	Grenada	Nicaragua	Surinam
Argentina	Colombia	Guadalope	Panamá	Trinidad & Tobago
Aruba	Costa Rica	Guatemala	Paraguay	Islas Turks & Caicos
Bahamas	Cuba	Guyana	Perú	Uruguay
Barbados	Dominica	Haití	Puerto Rico	Venezuela
Belice	República Dominicana	Honduras	San Bartolomé	Islas Virgen
Bolivia	Ecuador	Jamaica	St. Kitts & Nevis	Otro _____
Brasil	El Salvador	Martinica	St. Lucia	Prefiero no responder

¿Cuál de estas categorías describe mejor su área primaria de empleo? (Por favor círculo sólo UNA respuesta)

Ama de casa	Planta procesadora
Retirado	Servicios jurídicos
Estudiante	Fabricación y manufactura de equipo de - Informática y Electrónica
Desempleado	Fabricación y manufactura en general - Otros
Agricultura, silvicultura, pesca, o caza	Militar
Artes, entretenimiento o recreación	Minería
Radiodifusión	Servicios editoriales
Educación - Colegio, Universidad, o adulto	Inmobiliaria, alquiler, o arrendamiento
Educación - Primaria /Secundaria (K-12)	Religioso
Educación - Otro	Almacenes y tiendas departamentales
Construcción	Servicios científicos y técnicos
Finanzas y Seguros	Software
Gobierno y Administración Pública	Telecomunicaciones
Salud y Asistencia Social	Transporte y almacén
Hotel y Servicios de Alimentación	Utilidades
Información - Servicios y Redes de Datos	Venta al por mayor
Información - Otro	Otro

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

¿Cuál es su situación laboral?

Está empleado a tiempo completo (40 horas o más por semana)	Esta empleados a tiempo parcial (menos de 35 horas por semana)	Esta empleado por cuenta propia	Está en la escuela de tiempo completo	Está en la escuela a tiempo parcial
Es ama de casa	Está desempleado	Esta Deshabilitado	Esta retirado	Otro: _____

¿Cuál es el total anual de su ingreso personal*? (*Cuánto dinero tiene *usted personalmente* hace cada año)	¿Cuál es el total anual de su ingreso familiar^? (^Cuánto dinero tiene cada persona en su hogar hacen *todos juntos*)
$0 - $9,999	$0 - $9,999
$10,000 - $19,999	$10,000 - $19,999
$20,000 - $29,999	$20,000 - $29,999
$30,000 - $39,999	$30,000 - $39,999
$40,000 - $49,999	$40,000 - $49,999
$50,000 - $59,999	$50,000 - $59,999
$60,000 - $69,999	$60,000 - $69,999
$70,000 - $79,999	$70,000 - $79,999
$80,000 - $89,999	$80,000 - $89,999
$90,000 - $99,999	$90,000 - $99,999
$100,000 +	$100,000 +

¿Qué tipo de seguro médico tienes? (Por favor círculo sólo UNA respuesta)

El seguro de salud privado que compró usted mismo	Medicaid
El seguro de salud proporcionado por mi empleador (ex., PPO, HOM, etc.)*	Medicare
TRICARE y otro tipos de seguros proporcionados por las fuerzas armadas de los Estados Unidos	Otro: _____
Actualmente estoy en el seguro de mis padres	No sé
El seguro de discapacidad	No tengo seguro de salud

¿Dónde es su fuente habitual de servicios de cuidado de la salud femenina, tales como planificación familiar, exámenes, anuales pélvicos y de los senos, pruebas para detectar enfermedades de transmisión sexual y otros problemas de salud femenina?

Un consultorio de planificación familiar	Una clínica del departamento de salud	Un centro de salud comunitario	Un consultorio de un ginecólogo privado
Un consultorio de un médico general	Otro: _____	No tengo una fuente habitual	Prefiero no responder

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 10/26/2016
IRB EXPIRATION DATE: 07/01/2017

APPENDIX I

RECRUITMENT FLYERS (ENGLISH/SPANISH)

Final IRB Approved Flyers (English and Spanish).

Do you identify as a Latina?!

Latinas 18 years old and older are needed for an important study! The study is trying to understand women's health issues among Latinas.

If you or someone you know is interested in taking a short survey, please contact:

Jovanni Reyes, MS, CHES by calling or texting **(214) 878-5770** or emailing **jvreyes89@tamu.edu**

As a token of appreciation for completing the survey, you can get put in a drawing to win a gift card! There will be a total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card for the drawing.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 07/08/2016
IRB EXPIRATION DATE: 07/01/2017

¿Te identificas como Latina?

Se solicitan Latinas de 18 años o más para participar en un importante estudio de investigación! El propósito del estudio es comprender los problemas de salud entre mujeres Latinas.

Si usted está interesada en contestar una encuentra breve o conoce a alguien que puede estar interesada favor de comunicarse con **Jovanni Reyes, MS, CHES** por teléfono o texto al número **(214) 878-5770** o envié un correo electrónico a **Jvreyes89@tamu.edu**

En agradecimiento por completar la encuesta, su nombre será puesto en un sorteo para la posibilidad de ganar una tarjeta de regalo. Habrá un total de treinta tarjetas de $25 dólares, cinco tarjetas de $50 dólares y una tarjeta de $100 dólares que se pueden ganar en esta sorteo.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 09/13/2016
IRB EXPIRATION DATE: 07/01/2017

Do you identify as a Latina?!

Latinas 18 years old and older are needed for an important study! The study is trying to understand women's health issues among Latinas.

If you or someone you know is interested in taking a short survey, please contact:

Jovanni Reyes, MS, CHES by calling or texting **(214) 878-5770** or emailing **jvreyes89@tamu.edu**

As a token of appreciation for completing the survey, you can get put in a drawing to win a gift card! There will be a total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card for the drawing.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 07/08/2016
IRB EXPIRATION DATE: 07/01/2017

¿Te identificas como Latina?

Se solicitan Latinas de 18 años o más para participar en un importante estudio de investigación! El propósito del estudio es comprender los problemas de salud entre mujeres Latinas.

Si usted está interesada en contestar una encuentra breve o conoce a alguien que puede estar interesada favor de comunicarse con **Jovanni Reyes, MS, CHES** por teléfono o texto al número **(214) 878-5770** o envié un correo electrónico a **Jvreyes89@tamu.edu**

En agradecimiento por completar la encuesta, su nombre será puesto en un sorteo para la posibilidad de ganar una tarjeta de regalo. Habrá un total de treinta tarjetas de $25 dólares, cinco tarjetas de $50 dólares y una tarjeta de $100 dólares que se pueden ganar en esta sorteo.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 09/13/2016
IRB EXPIRATION DATE: 07/01/2017

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 07/08/2016
IRB EXPIRATION DATE: 07/01/2017

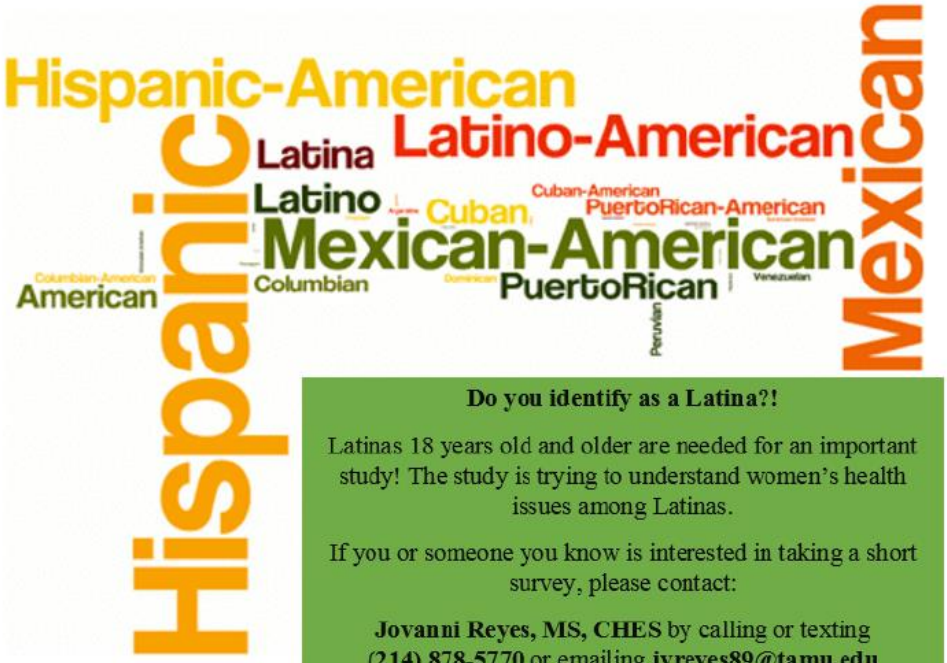
¿Te identificas como Latina?

Se solicitan Latinas de 18 años o más para participar en un importante estudio de investigación! El propósito del estudio es comprender los problemas de salud entre mujeres Latinas.

Si usted está interesada en contestar una encuentra breve o conoce a alguien que puede estar interesada favor de comunicarse con **Jovanni Reyes, MS, CHES** por teléfono o texto al número **(214) 878-5770** o envié un correo electrónico a **Jvreyes89@tamu.edu**

En agradecimiento por completar la encuesta, su nombre será puesto en un sorteo para la posibilidad de ganar una tarjeta de regalo. Habrá un total de treinta tarjetas de $25 dólares, cinco tarjetas de $50 dólares y una tarjeta de $100 dólares que se pueden ganar en esta sorteo.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 09/13/2016
IRB EXPIRATION DATE: 07/01/2017



Do you identify as a Latina?!

Latinas 18 years old and older are needed for an important study! The study is trying to understand women's health issues among Latinas.

If you or someone you know is interested in taking a short survey, please contact:

Jovanni Reyes, MS, CHES by calling or texting **(214) 878-5770** or emailing **jvreyes89@tamu.edu**

As a token of appreciation for completing the survey, you can get put in a drawing to win a gift card! There will be a total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card for the drawing.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 07/08/2016
IRB EXPIRATION DATE: 07/01/2017

¿Te identificas como Latina?

Se solicitan Latinas de 18 años o más para participar en un importante estudio de investigación! El propósito del estudio es comprender los problemas de salud entre mujeres Latinas.

Si usted está interesada en contestar una encuentra breve o conoce a alguien que puede estar interesada favor de comunicarse con **Jovanni Reyes, MS, CHES** por teléfono o texto al número **(214) 878-5770** o envié un correo electrónico a **Jvreyes89@tamu.edu**

En agradecimiento por completar la encuesta, su nombre será puesto en un sorteo para la posibilidad de ganar una tarjeta de regalo. Habrá un total de treinta tarjetas de $25 dólares, cinco tarjetas de $50 dólares y una tarjeta de $100 dólares que se pueden ganar en esta sorteo.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 09/13/2016
IRB EXPIRATION DATE: 07/01/2017

Do you identify as a Latina?!

Latinas 18 years old and older are needed for an important study! The study is trying to understand women's health issues among Latinas.

If you or someone you know is interested in taking a short survey, please contact:

Jovanni Reyes, MS, CHES by calling or texting
(214) 878-5770 or emailing **jvreyes89@tamu.edu**

As a token of appreciation for completing the survey, you can get put in a drawing to win a gift card! There will be a total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card for the drawing.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 07/08/2016
IRB EXPIRATION DATE: 07/01/2017

¿Te identificas como Latina?

Se solicitan Latinas de 18 años o más para participar en un importante estudio de investigación! El propósito del estudio es comprender los problemas de salud entre mujeres Latinas.

Si usted está interesada en contestar una encuentra breve o conoce a alguien que puede estar interesada favor de comunicarse con **Jovanni Reyes, MS, CHES** por teléfono o texto al número **(214) 878-5770** o envié un correo electrónico a **Jvreyes89@tamu.edu**

En agradecimiento por completar la encuesta, su nombre será puesto en un sorteo para la posibilidad de ganar una tarjeta de regalo. Habrá un total de treinta tarjetas de $25 dólares, cinco tarjetas de $50 dólares y una tarjeta de $100 dólares que se pueden ganar en esta sorteo.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 09/13/2016
IRB EXPIRATION DATE: 07/01/2017

Do you identify with being a Latina?!

Latinas 18 years old and older are needed for an important study! The study is trying to understand Women's health issues among Latinas. If you or someone you know is interested in taking a short survey.

Please contact Jovanni Reyes, MS, CHES
by calling or texting (214) 878 – 5770
or emailing jvreyes89@tamu.edu

As a token of appreciation for completing the survey, you can get put in a drawing to win a gift card!

There will be a total of thirty $25 gift cards, five $50 gift cards, and one $100 gift card.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 07/08/2016
IRB EXPIRATION DATE: 07/01/2017

¿Te identificas como Latina?

Se solicitan Latinas de 18 años o más para participar en un importante estudio de investigación! El propósito del estudio es comprender los problemas de salud entre mujeres Latinas.

Si usted está interesada en contestar una encuentra breve o conoce a alguien que puede estar interesada favor de comunicarse con **Jovanni Reyes, MS, CHES** por teléfono o texto al número **(214) 878-5770** o envié un correo electrónico a **Jvreyes89@tamu.edu**

En agradecimiento por completar la encuesta, su nombre será puesto en un sorteo para la posibilidad de ganar una tarjeta de regalo. Habrá un total de treinta tarjetas de $25 dólares, cinco tarjetas de $50 dólares y una tarjeta de $100 dólares que se pueden ganar en esta sorteo.

IRB NUMBER: IRB2016-0451D
IRB APPROVAL DATE: 09/13/2016
IRB EXPIRATION DATE: 07/01/2017

APPENDIX J

DEMOGRAPHIC DESCRIPTIONS

Demographics

Items on the questionnaire asked the participant to identify demographic information regarding their age, current location, education status, current relationship status, number of children, religious affiliation and church attendance, race/ethnicity, Latino subgroup(s), generational status, country of origin, employment category and status, personal income and household income, health insurance status, and usual source of health services. Listed below are the descriptions:

Age and Location. Participants self-reported their current age, current city, state, and zip code.

Education. Participants were asked about the highest degree or level of school they had completed. There were 13 response choices that ranged from "No schooling completed" to "Doctoral degree" and included the answer choice "I don't know."

Relationship status. One question was asked about the participant's relationship status and the participant chose multiple responses to the question. The response choices included: single, open relationship, monogamous relationship, cohabiting, engaged, married, separated/divorced, widow/widower.

Children. Participants were asked if they had any children (including biological or non-biological children) and the response choices ranged from "No, I do not have any children" to 'Yes, I have 5 or more children."

Religious affiliation and church attendance. Participants were asked to identify their personal religious affiliation, if they had one. Response choices included: no organized religion but spiritual, Roman Catholic, Christian – non-denomination, Church of England/Anglican, Presbyterian/Church of Scotland, Greek Orthodox, Methodist, Baptist, Jewish, Buddhist, Hindu, Islam/Muslim, Sikh, Atheist, Other (specified with text), and I prefer not to answer. Church attendance was recorded as never, once a year or less, a few times a year, a few times a month, once a week, more than once a week, I don't know, or I prefer not to answer.

Race/ethnicity and Latino subgroup(s). A question was asked regarding their race/ethnicity and participants had the following choices: American Indian,

Alaskan Native, Asian, Pacific Islander, Black/African American, White/Caucasian, Latino/Hispanic, or Other (specified with text). The participants also had the chance to mark which Latino subgroups they identified with (i.e., Argentinian, Colombian, Cuban, Salvadorian, Honduran, Mexican, Peruvian, Venezuelan, etc.).

Generational Status. Participants were asked to self-report demographic data. Generational status was assessed by asking the participants if they were first, second, third, fourth, or fifth generation Latinos. After each answer choice there was a brief description of each generation status. For instance, for the first-generation answer choice the explanation stated, "You were born in another country" and for the second-generation answer choice the explanation stated, "You were born in the USA, either parent born in another country."

*Country of origin***.** Participants were asked what country they were born in. Response choices included 42 countries/territories located in Latin American, United States, I don't know, and I prefer not to answer.

*Employment category and status***.** Participants were asked "Which one of these categories best describes your primary area of employment?" They were given 34 response choices that ranged from Homemaker to wholesale and included another option. Participants were also asked about their employment status. The response choices included: Employed Full time, Employed Part time, Self-employed, in school full time, in school part time, homemaker, unemployed, disabled, retired, and other.

*Personal and household income***.** Questions were asked regarding personal and household income. Response choices ranged from $0-$9,999 to $100,000+.

*Health insurance status***.** Participants were asked "What type of health insurance do you currently have?" and had the following response choices to choose from: Private health insurance that you bought yourself, Insurance provided by your employer (HMO, PPO, etc.), TRICARE or other insurance provided by the US military, Parent's insurance, Disability Insurance, Medicaid, Medicare, Other (Specified with text), I don't know, and I do not have health insurance.

*Usual source of health services***.** The following question was asked, "Where is your usual source of services for female healthcare, such as family planning, annual exams, breast exams, test for sexually transmitted diseases, and other female health concerns?" and were given the following choices to choose from: a family planning clinic, a health department clinic, a community health center, a private gynecologist office, a general or family physician office

APPENDIX K

TABLES

Table 1. Sample Characteristics

	M (SD)	n	%
Age	29.57 (6.02)		
Education			
9^{th}, 10^{th}, or 11^{th} grade		4	0.71
12^{th} grade, no diploma		3	0.53
HS Diploma or equivalent		44	7.76
Some college credit, but less than 1 year		31	5.47
1 or more years of college, no degree		75	13.23
Associate's Degree		39	6.88
Bachelor's Degree		193	34.04
Master's Degree (MA, MS, Med, MBA, MSW)		118	20.81
Professional Degree (MS, DDS, DVM, JD)		9	1.59
Doctorate Degree (PhD, EdD)		51	8.99
Relationship Status			
Single		89	15.70
Open Relationship		9	1.59
Monogamous Relationship		128	22.57
Monogamous and Cohabiting		42	7.41
Cohabitating		63	11.11
Engaged		17	3.00
Married		186	32.80
Separated/Divorced		7	1.23
Number of Children			
0		336	59.26
1		87	15.34
2		79	13.93
3		39	6.88
4		19	3.35
5+		7	1.23
Religion*			
Roman Catholic		220	38.80
Not organized religion but spiritual		139	24.51
Christian: non-denominational		111	19.58

Table 1. Continued

	M (SD)	n	%
Church Attendance			
Never		131	23.10
Once a year or less		89	15.70
A few times a year		177	31.22
A few times a month		71	12.52
Once a week		60	12.52
More than once a week		21	3.70
I don't know		9	1.59
I prefer not to answer		9	1.59
Latino Sub-group*#			
Mexican		309	54.50
Virgin Islanders		86	15.17
Puerto Rican		35	6.17
Generational Status			
1st		108	19.05
2nd		299	52.73
3rd		47	8.29
4th		59	10.41
5th +		54	9.52
Employment Status			
Full-time (>40 hours/week)		267	47.09
Part-time (<35 hours/week)		61	10.76
Part-time and in school full-time		57	10.05
In school full-time		49	8.64
Health Insurance*			
Insurance provided by employer		311	54.85
I do not have health insurance		82	14.46
I am currently on my parent's insurance		68	11.99
Usual source for female health services*			
A private gynecologist office		223	39.33
A general or family physician office		112	19.75
I do not have a usual source		73	12.87

Table 2. Reproductive Autonomy Measurement Model fit statistics

Statistic	Criteria	DM	CR	CM
RMSEA	<0.08	0.038	0.000	0.000
CFI	>0.90	0.997	1.000	1.000
TLI	>0.90	0.981	1.005	1.005
SRMR	<0.05	0.010	0.006	0.010

Table 3. Reproductive Autonomy and Contraception Behaviors Structural Model

Statistic	Criteria	Value
RMSEA	<0.08	0.050
CFI	>0.90	0.942
TLI	>0.90	0.931
SRMR	<0.05	0.052

Table 4. Marianismo Beliefs Measurement Model fit statistics

Statistic	Criteria	FP	VC	SO	SS	SP	MBS
RMSEA	<0.08	0.008	0.076	0.000	0.048	0.000	0.049
CFI	>0.90	1.000	0.987	1.000	0.993	1.000	0.956
TLI	>0.90	1.000	0.974	1.002	0.988	1.000	0.947
SRMR	<0.05	0.010	0.023	0.010	0.017	0.000	0.048

Table 5. Marianismo Beliefs and Contraception Behaviors Structural Model

Statistic	Criteria	Value
RMSEA	<0.08	0.046
CFI	>0.90	0.938
TLI	>0.90	0.930
SRMR	<0.05	0.076

Table 6. Detailed MBS models

Statistic	Criteria	VC→ NSR	VC→ CCU	SO→ NSR	SO→ CCU	SS→ NSR	SS→ NSS	SP→ NSS
RMSEA	<0.08	0.054	0.065	0.056	0.000	0.055	0.030	0.058
CFI	>0.90	0.976	0.983	0.973	1.000	0.972	0.994	0.978
TLI	>0.90	0.966	0.971	0.962	1.002	0.962	0.992	0.967
SRMR	<0.05	0.054	0.030	0.059	0.013	0.060	0.034	0.059

Table 7. Mediation Model

Statistic	Criteria	Value
RMSEA	<0.08	0.040
CFI	>0.90	0.926
TLI	>0.90	0.920
SRMR	<0.05	0.061

APPENDIX L

FIGURES

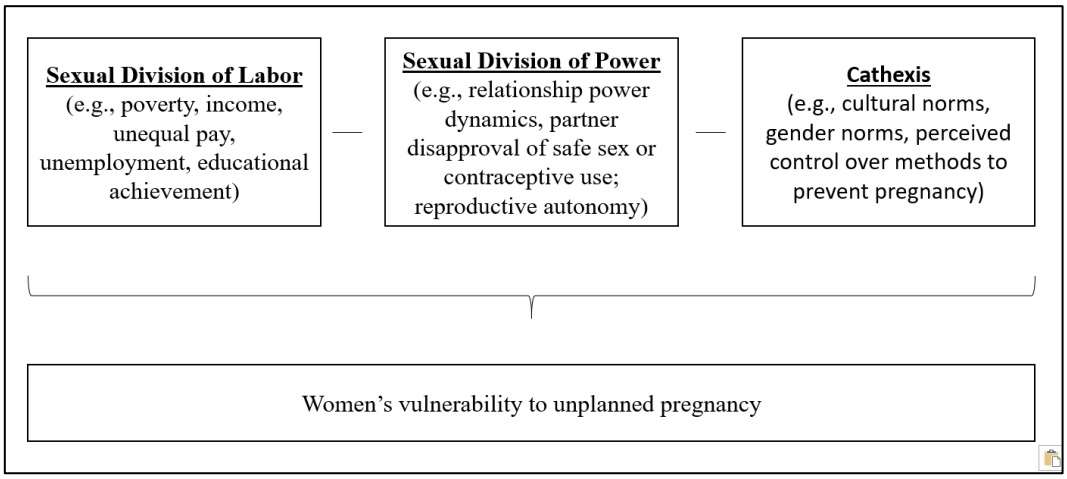


Figure 1. Theory of Gender and Power

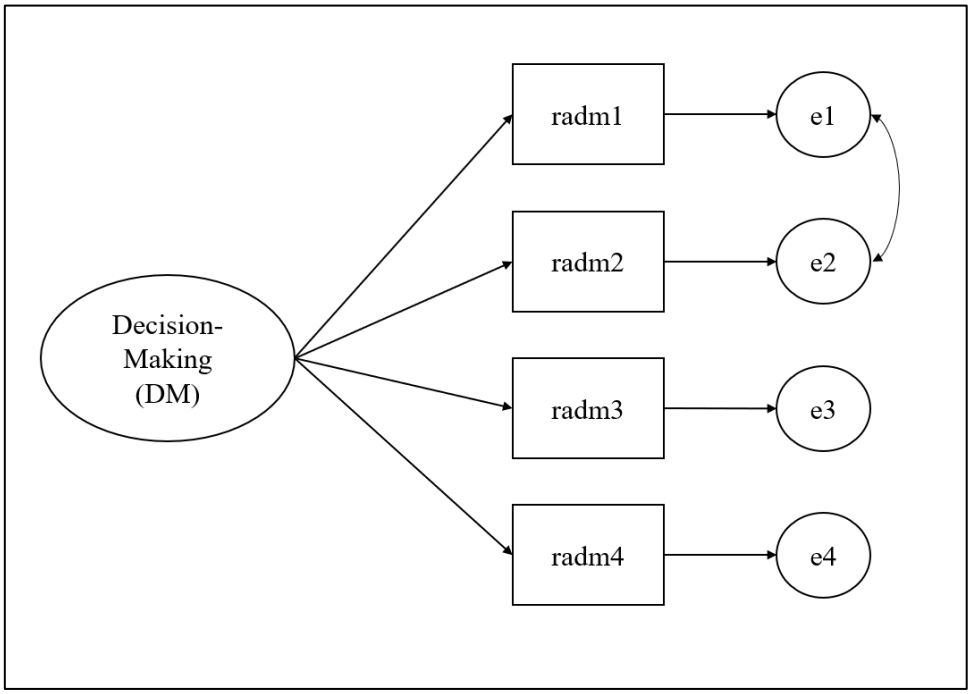


Figure 2. Reproductive Autonomy Measurement Model – Decision-Making

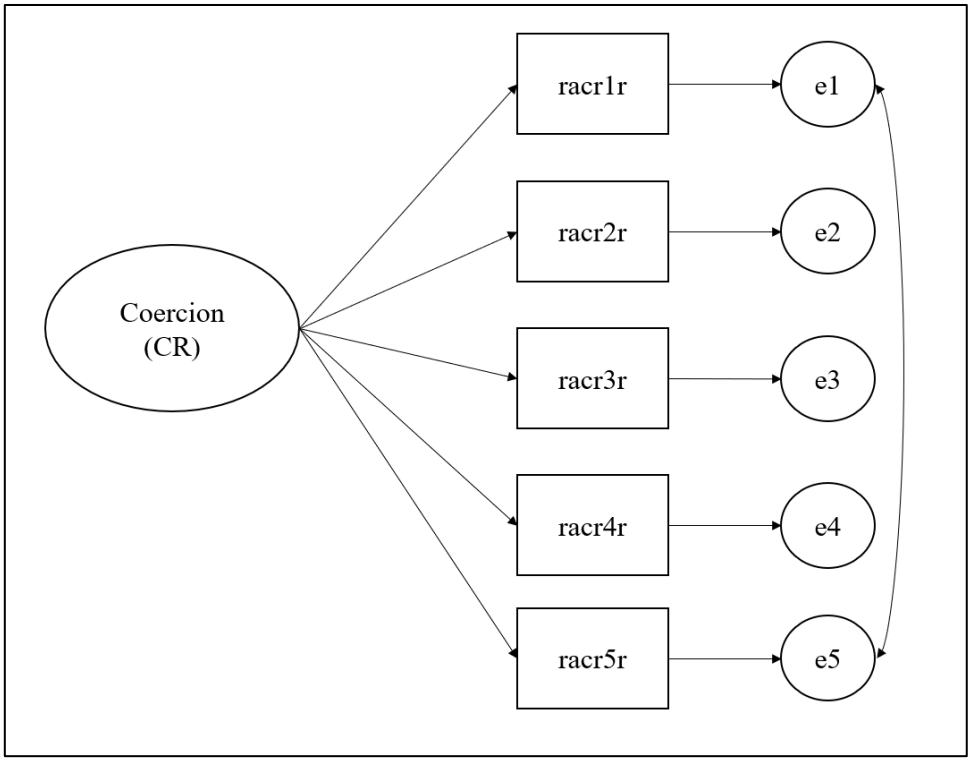


Figure 3. Reproductive Autonomy Measurement Model – Freedom from Coercion

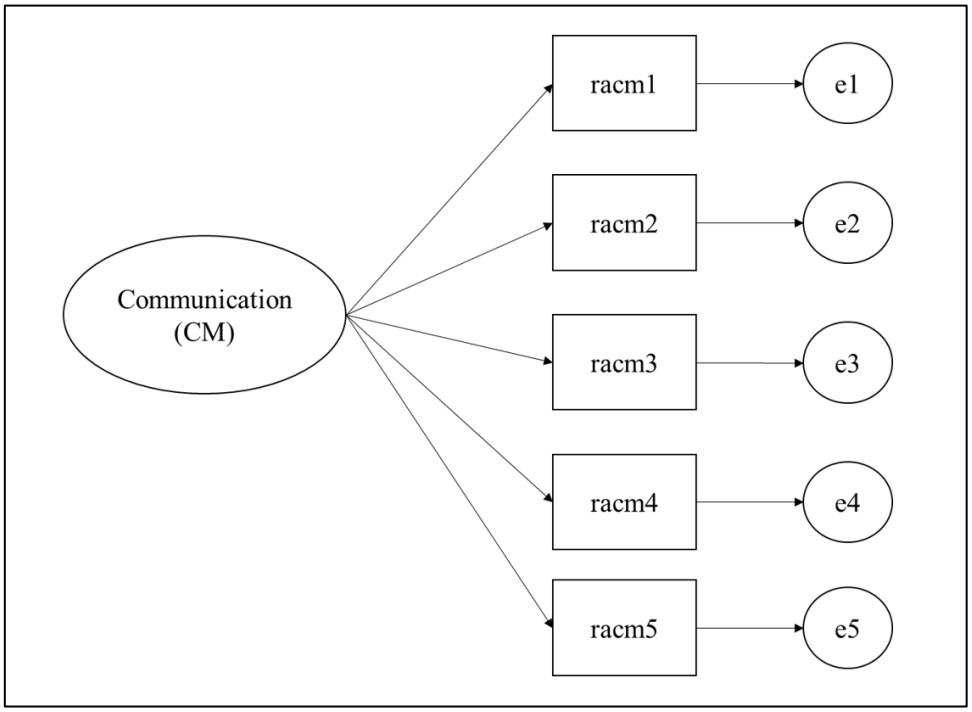


Figure 4. Reproductive Autonomy Measurement Model – Communication

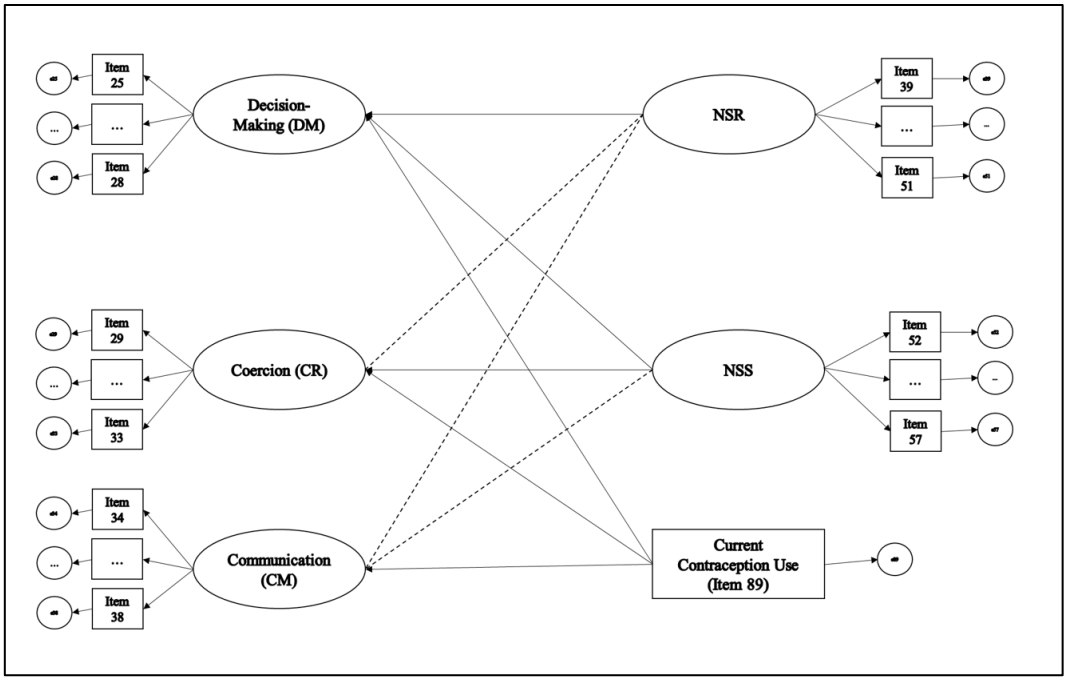


Figure 5. Reproductive Autonomy and Contraception Behaviors Structural Model
Note: Statistically significant relationships indicated by dotted line

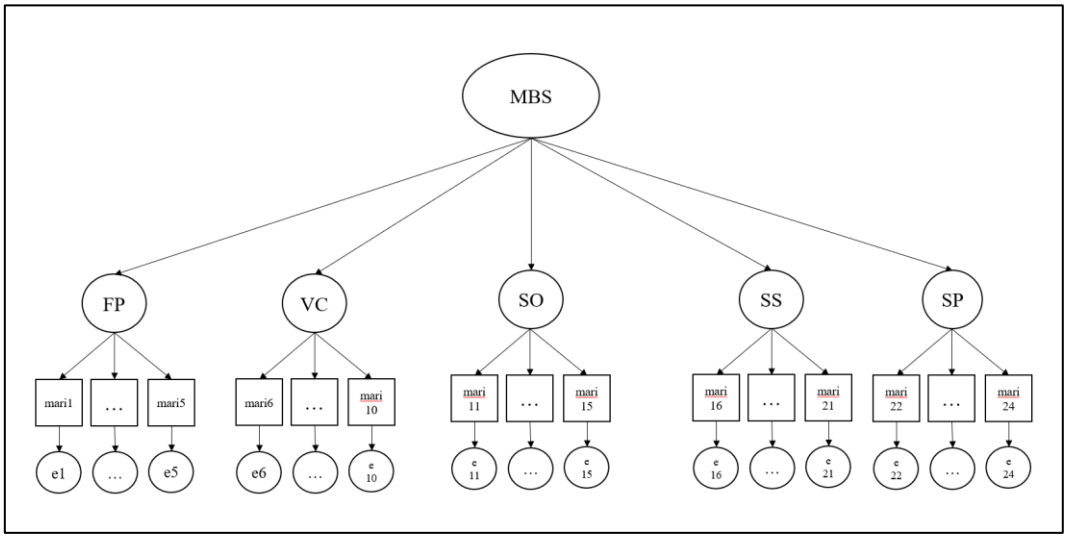


Figure 6. Marianismo Beliefs Measurement Model

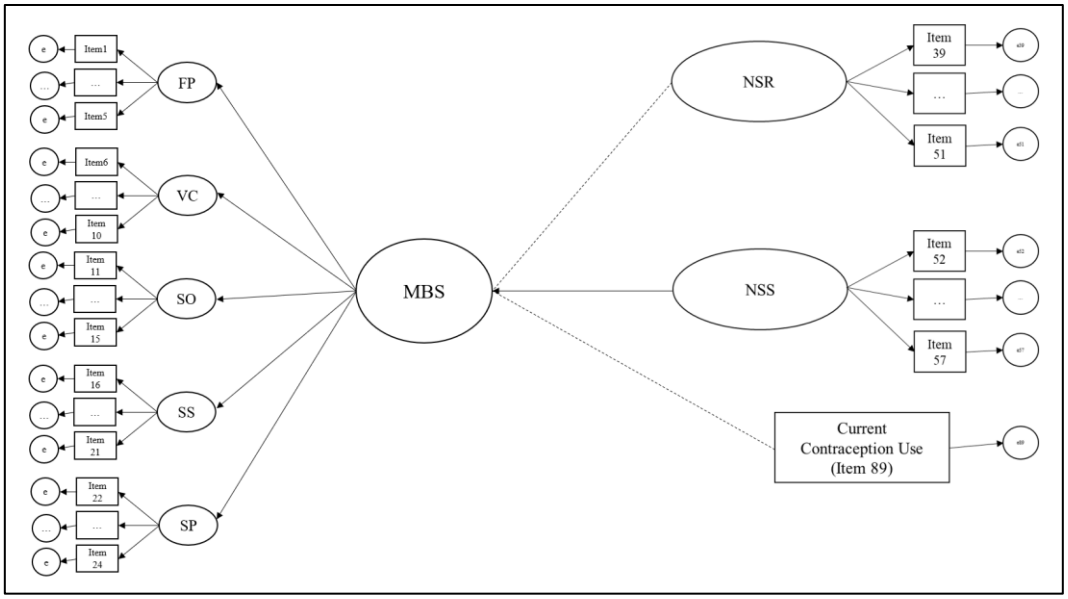


Figure 7. Marianismo Beliefs and Contraception Behaviors Structural Model
Note: Statistically significant relationships indicated by dotted line

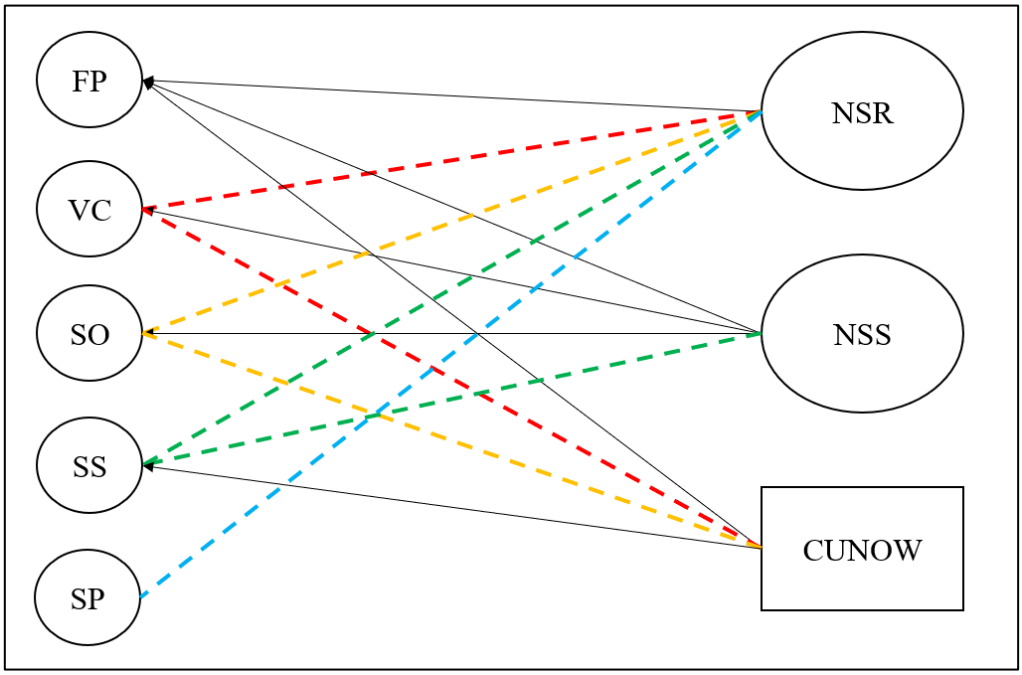


Figure 8. Detailed MBS model
Note: Statistically significant relationships indicated by dotted line

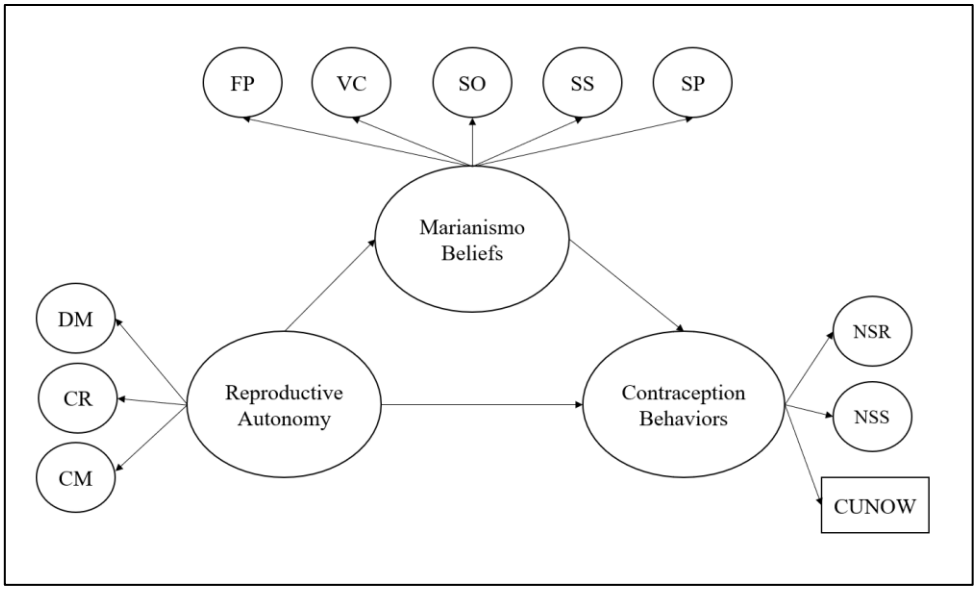


Figure 9. Simplified Mediation Model

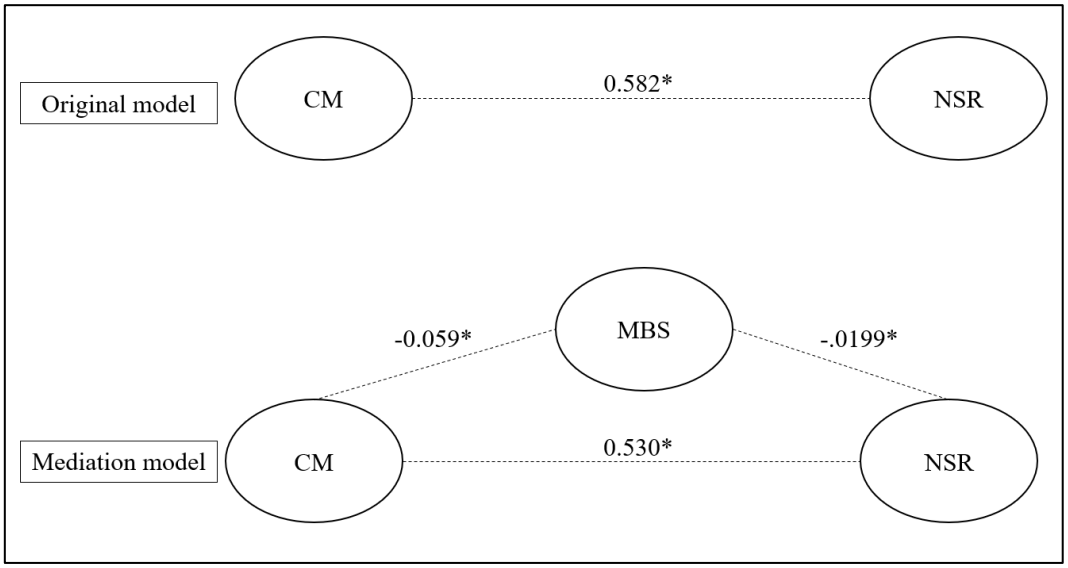


Figure 10. Partial Mediation: CM→NSR

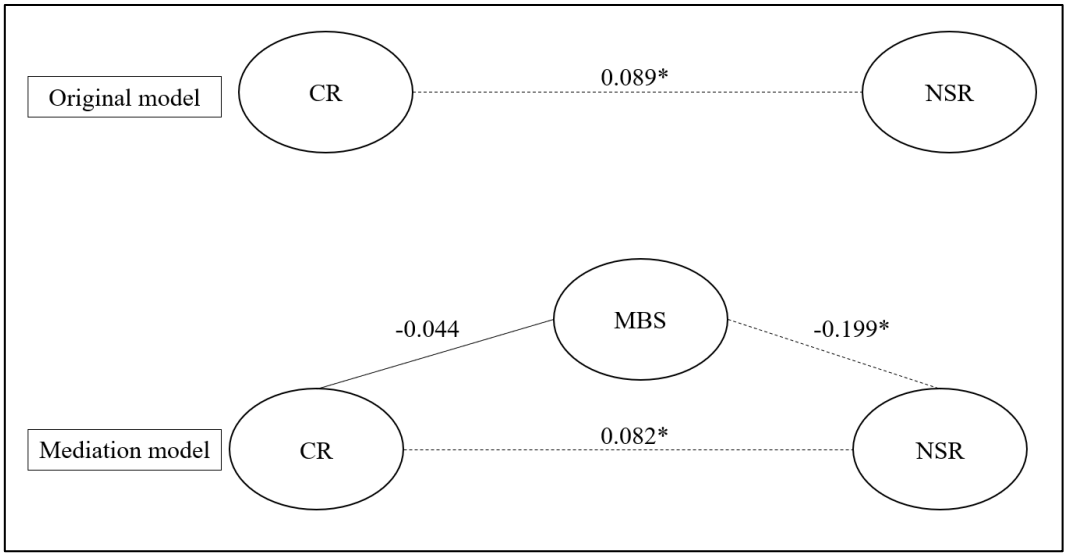


Figure 11. Partial Mediation: CR→NSR