Safe Sex Communication between Women and their Stable Partners in the Dominican Republic

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ABSTRACT

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Aside from sub-Saharan Africa, the Caribbean is the only region where the number of women and girls living with human immunodeficiency virus (HIV) is greater than that of men and boys. In the Dominican Republic (DR), the number of all diagnosed HIV cases that were women increased from 27% in 2003 to 51% in 2013, which indicates a shift in the burden of HIV from men to women. Women in stable relationships in the DR have risk for HIV and other sexually transmitted infections (STIs) related to high rates of multiple concurrent partners and low condom use among stable partners. Past HIV prevention efforts in the DR have largely focused on encouraging consistent condom use. However, this may not be a feasible solution for women in relationships. In this dissertation, I sought to examine safe sex communication (SSC) as a possible alternative to consistent condom use for HIV/STI prevention among women in stable heterosexual relationships in DR. I began by conducting an integrative literature review and identified multiple relationship, individual, and partner factors related to SSC among Latina women in stable relationships. Then I conducted a mixed methods study guided by the Theory of Gender and Power with women in stable heterosexual relationships who seek care at Clínica de Familia La Romana in the DR. First, I conducted a qualitative descriptive study to describe SSC. Emergent content analysis of eleven interview transcripts following Colaizzi's method revealed two main themes: (1) Context of sexual risk (i.e., the meaning of safe sex for stable partners, behaviours related to sexual risk, beliefs and attitudes related to sexual risk, *confianza* (trust) between stable partners, economic power within relationships, and learning to manage safe sex within a stable relationship) and (2) SSC (i.e., reasons to talk about safe

sex, methods, content, and outcomes, influential factors, and ideas for improvement). Second, I conducted a cross sectional survey with 100 women to identify psychosocial correlates of SSC. The mean age of women was 35.72 years, average relationship length was 8.5 years, and 46.91% were living with HIV. Logistic regression analysis revealed that lower SSC self-efficacy (OR = 0.20, 95% confidence interval = 0.08 – 0.50) and greater difference in age between partners (OR = 0.91, 95% confidence interval = 0.85 – 0.98) were both significantly related to less SSC. Information from this dissertation can be used to help identify women in the DR who are at risk for poor SSC with their stable partners and guide researchers, health care providers, and other individuals involved in efforts to reduce HIV/STI risk among this population to develop more effective interventions for this population. Future research should determine which safe sex behaviours SSC is related to among Latina women with stable partners, as well as which aspects of SSC can be generalized to women of all Latino subcultures and nationalities. Additionally, more information is needed about the male partner's role in SSC within their stable relationship and what factors influence partner SSC among Latino men in stable relationships.

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Dedication

The dissertation is dedicated to all Latina women, especially those who experience sexual risk as a result of complex power dynamics within their relationships and those who agreed to participate in these studies. I hope this work helps elucidate how sexual risk can enter into stable relationships and what the experience of safe sex communication can be like for some Latina women, so that more effective solutions can be developed for reducing sexual risk among this population.

Chapter One: Introduction

Chapter one summarizes information on the background and organization of my dissertation. First, the current state and historic trends of human immunodeficiency virus (HIV) in the Dominican Republic (DR) is examined, specifically among women with stable male partners. Second, safe sexual communication (SSC) and its relevance to the prevention of HIV and other sexually transmitted infections (STIs) among women with stable male partners in the DR is addressed. Third, the significance of this topic is discussed and gaps in existing literature will be identified. Fourth, the theory guiding this dissertation is explained. Fifth, three separate chapters that address four research aims are introduced along with target journals for their submission to satisfy requirements of Graduate School of Arts and Sciences at Columbia University. This chapter concludes with the overall aim of this proposed dissertation and a brief discussion of what this research will add to global health literature.

HIV and STIs in the DR

The Caribbean is the region with the highest prevalence of HIV in the Western Hemisphere (De Boni, Veloso, & Grinsztejn, 2014). Approximately 75% of individuals living with HIV in this region reside on the island of Hispaniola, comprised of the DR and Haiti (Rojas et al., 2011). In the DR, accurate health and epidemiological surveillance systems are lacking, so incidence rates of HIV infection are not available and prevalence rates likely underestimate the true number of people living with HIV (Halperin, de Moya, Perez-Then, Pappas, & Garcia Calleja, 2009; Rojas et al., 2011). The HIV epidemic in the DR began in 1983 (Rojas et al., 2011) and continued to expand (The Caribbean Epidemiology Centre [CAREC] & Pan American Health Organization [PAHO], 2007) until 2002 when rates finally began to fall (Centro de Estudios Sociales y Demográficos [CESDEM] & Macro International, 1991, 1996, 2002, 2007).

Most recently, it has been estimated that around 1% individuals between 15 and 49 years old in the DR are living with HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2015).

Within the DR, HIV is more prevalent in particular regions and subgroups of the population. Regions with greater tourism and sex trade have been hit especially hard by the epidemic, with total prevalence reaching as high as 1.8% in the most affected region (Barrington et al., 2009; CESDEM & ICF International, 2014; Halperin et al., 2009). The prevalence of HIV among female sex workers has most recently been estimated at 4.8% (The United States Agency for International Development [USAID], 2011). Men who have sex with men (MSM) are also considered a key population in controlling the HIV epidemic in the DR. At the same time, they are considered a "hidden population" and are difficult to identify due to the strong stigma associated with homosexuality within the Dominican healthcare system and society at large (de Moya & Garcia, 1996; Halperin, 1999a, 1999b; USAID, 2008). As a result, many homosexually transmitted HIV cases among MSM are likely to be documented as being acquired through heterosexual transmission (de Moya & Garcia, 1996; Frias & Lara, 1987; Tabet et al., 1996), leading to underreporting of prevalence rates among this group (Rojas et al., 2011). However, USAID has estimated that around 6.1% of MSM in the DR are living with HIV (2011).

Located within rural DR are sugar plantains (bateys), which employ large numbers of Haitian immigrants. HIV prevalence among these communities is estimated to be between 3.2-12% (ENDESA, 2007; USAID, 2008, 2011), with the highest rates being among men and women over the age of 40 and those with preschool or no education (Dominican Republic Demographic and Health Survey [ENDESA], 2007; USAID, 2008, 2011). HIV prevalence in the bateys is influenced by poor living conditions, poor access to HIV prevention and treatment

services, the undocumented status of Haitians in the DR, and poor political representation (Rojas et al., 2011; USAID, 2008).

Women in the DR are especially vulnerable to HIV (Padilla et al., 2008; Rojas et al., 2011). This is becoming more evident as we see a shift in the burden of HIV from men to women. In 2003, 27% of all recorded HIV cases in the DR were among women (UNAIDS, 2004) as compared to 51% in 2013 (UNAIDS, 2013). In the DR, women with no education are almost 14 times more likely to be living with HIV compared to women with secondary or higher education and 1.5 times more likely to be living with HIV compared to men with no education (CESDEM & ICF International, 2014). Furthermore, women are almost eight times more likely to have HIV if they have had ten or more lifetime partners compared to one lifetime partner and 1.5 times more likely to have HIV compared to men who have had ten or more lifetime partners (CESDEM & ICF International, 2014).

Factors that Increase Risk of HIV Infection in the DR

Previously, the HIV epidemic in the DR was thought to be driven primarily by heterosexual intercourse (Dirección General de Control de Infecciones de Transmisión Sexual y SIDA [DIGECITSS], 2006; Rojas et al., 2011; UNAIDS, 2002, 2006b). However, in recent years the infection ratio between men and women has neared 1:1 (ENDESA, 2007), which leads scholars to believe the epidemic is now being driven by a combination of heterosexual and homosexual contact (Halperin et al., 2009). For this reason, it is important to consider risks associated with MSM sexual behaviour in HIV prevention. This group experiences an exceptionally high risk of being infected with HIV due to higher transmission rates during anal sex (Halperin, Shiboski, Palefsky, & Padian, 2002), having multiple and concurrent sex partners, and having less access to prevention services (CAREC & PAHO, 2007). Although sex work is

not legal in the DR, it is often overlooked by law enforcement. (Kerrigan, Moreno, Rosario, & Sweat, 2001) and it is a very lucrative profession in the DR. For lack of other work options that pay as well, some MSM may participate in sex work to increase their income and better support their families (CAREC & PAHO, 2007; Halperin et al., 2009; Padilla, 2008). However, because clients of MSM are often wealthy and willing to pay up to three times more for sex without condoms (Padilla et al., 2008), this population may be more susceptible to coercion, difficulty negotiating use of condoms, and ultimately lower rates of condom use compared to female sex workers (de Moya & Garcia, 1999).

In the DR, there are also sociocultural, socioeconomic, and structural factors that lead to increased risk of HIV infection. Sociocultural risks include early sexual debut, the common practice of anal sex among homosexual and heterosexual partners, inconsistent condom use (Rojas et al., 2011), and the high prevalence of individuals who have multiple concurrent sexual partners (CESDEM & ICF International, 2014). Furthermore, in the DR there are also high rates of adolescent pregnancy, low risk perception of HIV (Rojas et al., 2011), cultural barriers to HIV prevention (ENDESA, 2007), sexism against women (Padilla et al., 2008; Rojas et al., 2011), high levels of alcohol use and abuse (Caceres, 2003), and strong stigma surrounding homosexuality and HIV that lead individuals to try to hide their diagnosis (Rojas et al., 2011). Socioeconomic and structural risk factors include increased migration from rural to urban areas within the DR, the growing tourism industry that contributes to increased sex tourism, as well as influx of migrants from Haiti and Dominican-Americans from the US and Puerto Rico (Rojas et al., 2011). Furthermore, there is a general lack of access to healthcare and HIV prevention services (Padilla et al., 2008; Rojas et al., 2011), as well as high illiteracy levels, low education levels, and lack of education about sexuality and HIV (ENDESA, 2007; Stonbraker et al., 2016).

HIV and STIs Among Women with Stable Partners in the DR

A population largely absent from the literature and past HIV prevention efforts in the DR is women who are in stable relationships with a male partner. However, there are many ways that being in stable heterosexual relationship predisposes women to risk of HIV infection. Up to 38.7% of Dominican men, including those in a stable relationship, report multiple concurrent sexual partners in the previous twelve months, compared to 7.8% of Dominican women (CESDEM & ICF International, 2014). In the DR, condom use among stable partners is considerably different compared to those not in a stable relationship. For example, female sex workers report consistent condom use 60% of the time (Kerrigan et al., 2006) and non-married, non-cohabitating men and women report condom use 68% and 40% of the time respectively. However, as low as 0.4% - 4% (CESDEM & International, 2014; Halperin et al., 2009) of married or cohabitating partners report using condoms, which has remained stable over the past decade (CESDEM & ICF International, 2014; CESDEM & Macro International, 1991, 1996, 2002, 2007). Similarly, condom use has been found to be low among sex workers with their regular partners (Halperin et al., 2009; Perez-Jimenez, Seal, & Serrano-Garcia, 2009b). These differences in condom use based on relationship status reflect the commonly held belief by Dominicans that condoms should be used with casual sexual partners and sex workers, but not in stable relationships where trust has been built (Kerrigan et al., 2003; Kerrigan et al., 2006; Perez-Jimenez, Seal & Serrano-Garcia, 2009).

Another factor that increases risk of HIV infection for women in stable heterosexual relationships is the MSM activity in the DR. In the DR, due to stigma, men who partake in MSM activity but are outwardly heterosexual or married are extremely discrete when seeking out other male partners (de Moya & Garcia, 1996). Studies have found that over half of MSM identify as

heterosexual and also have sex with women (Halperin et al., 2009; Tabet et al., 1996). Therefore, this "bridge" population cannot be ignored when considering risk of HIV infection among women with stable partners.

The Response to HIV in the DR

There has been a multilevel response to the HIV epidemic in the DR that has resulted in some success at slowing the spread of the disease. In general, these efforts have been limited by technicalities within the Dominican government, management and enforcement issues, and a national health system that is "overcrowded, inefficient, and fraudulent" and continues to discriminate against people living with HIV (International Treatment Preparedness Coalition: Treatment & Advocacy Project [IPTC], 2008; Rojas et al., 2011). On the national level, the Presidential Commission Against AIDS (COPRESIDA) has attempted to improve HIV care within the national health care system (ITPC, 2008). There have also been national efforts to increase condom use among sex workers by implementing policies for brothels and making condoms more readily available (Kerrigan et al., 2001). The National AIDS Program (NAP) has developed additional health policies and HIV surveillance methods, and the Dominican government has enacted laws to protect people living with HIV against discrimination (Rojas et al., 2011). However, the largest impact on the HIV epidemic in the DR has been at the international level, by organizations including the United States Agency for International Development (USAID) DR, President's Emergency Plan for AIDS Relief (PEPFAR), World Bank, and Global Fund to fight AIDS. These organizations have focused primarily on preventing vertical transmission of HIV from mother to baby and increasing condom use among sex workers (Marquez & Montalvo, 2013). As a result of this combined response, the DR has seen a progressive decrease in the number of men with multiple partners (Halperin et al., 2009),

increased condom use among sex workers (Halperin et al., 2009; Kerrigan et al., 2003; Kerrigan et al., 2006), and reduced HIV prevalence in the country's population as a whole (Halperin et al., 2009).

Safe Sex Communication

For the purpose of this dissertation, safe sex communication (SSC) refers to verbal or non-verbal relaying of information to one's partner regarding methods of HIV/STI prevention. There is no one definition of SSC in the literature, but it has been referred to as encompassing activities such as negotiating condom use, sharing one's sexual history or asking about a partner's sexual history, discussing HIV/STI testing and results, and notifying a partner of a new HIV/STI diagnosis or other concurrent sexual partners. Communication as a process has been modeled by multiple scholars (Foulger, 2004). Most of these models include some version of the following components: (1) an information source, or person who creates the message, (2) a message, (3) a transmitter, or method of conveying the message, such as verbally via the mouth or non-verbally via body language, and (4) a receiver, or method of receiving the message such as using one's eyes or ears. Many models also include the communication environment, interpretation of the message, and feedback (Foulger, 2004).

Scholars have found that SSC is associated with HIV prevention behavior among women. Studies involving Dominican women living in US found support for the association between discussing HIV and higher levels of condom use (Moore, Harrison, Kay, Deren, & Doll, 1995; Sherry, Shedlin, & Beardsley, 1996). These findings are consistent with those from two large-scale meta-analyses with mixed samples that examined the association between SSC and condom use (Noar, Carlyle, & Cole, 2007; Sheeran, Abraham, & Orbell, 1999). Similarly, systematic

reviews that have examined interventions to increase condom use among mixed samples have found that an emphasis on sexual communication and negotiation skill building is strongly linked to the success of the intervention (Johnson et al., 2002; Robin et al., 2004). Individual studies conducted with stable Hispanic partners have also found that communication about HIV risk reduction between partners is associated with reduced HIV transmission (Saul et al., 2000) and lasting improvements in condom use (El-Bassel et al., 2003).

Another important consideration about the potential of SSC as a method of HIV prevention in the DR is that Dominican men may be more likely to decrease their number of sexual partners than use a condom (Green & Conde, 2000).

Furthermore, safe sex communication is a more gender appropriate safe sex behavior for women compared to encouraging consistent condom use. For example, since women are not the actual users of male condoms, their safe sex behavior related to male condoms is negotiating the use of condoms with their partner. Women may also negotiate and communicate with their partners about other safe sex topics related to HIV and STI testing or test results, as well as sex and condom use with men or women outside of their relationship.

Communication and negotiation related to safe sex topics could result in safer sex by helping women to more accurately measure their risk of being infected with HIV/STIs and negotiate other safer sex behaviors with their stable partner. Therefore, safe sex communication was selected for this study to be investigated as an additional deterrent to HIV and STIs, as well as a moderator of condom use for women in stable relationships who live in the DR.

Significance of SSC of between women and their primary male partners in the DR

The growing disparate burden of HIV among Dominican women indicates a lack of attention to the health needs of this vulnerable population. HIV infection can lead to isolation

(Gien, 1993; Kaplan, Marks, & Mertens, 1997) and physical discomfort (Hewitt et al., 1997), and it contributes to over 40 million dollars spent annually to treat HIV and AIDS in the DR (El Consejo Nacional para el VIH y el SIDA [CONAVIHSIDA], 2014). Furthermore, a lack of communication about sexual health and risk has been suggested to propogate hegemonic norms of masculinity among Latinos (Cook, 2005; Fleming, Andes, & DiClemente, 2013). Therefore, not addressing inadequate SSC between partners the DR may perpetuate the sexual oppression of women that prevents them from effectively protecting themselves from HIV.

Women are currently recognized globally as a key population for HIV prevention efforts. The USAID DR, PEPFAR, Ministry of Health (MoH), and Centers for Disease Control and Prevention (CDC) currently have objectives to reduce HIV incidence in the DR by focusing on the unique needs of women. In specific, they advocate for interventions that help women become more empowered to effectively protect themselves from HIV by reducing gender-based violence, addressing the unique needs of women, and delivering HIV prevention messages that address cultural barriers and emphasize positive gender norms and behaviors (Centers for Disease Control and Prevention [CDC], 2012; Office of the United States Global AIDS Coordinator, 2014). Locally, Clínica de Familia La Romana (Clínica de Familia), a comprehensive care clinic that specializes in HIV care, located in a region of the DR with high HIV prevalence (ENDESA, 2007), is developing HIV prevention services that are more sensitive and responsive to the sex- and gender-related needs of their female clinic users.

With modern HIV prevention methods such as pre-exposure prophylaxis (PrEP) not yet widely available in the DR (R. Lantigua, personal communication, June 3, 2015), behavioral interventions are still a relevant and cost-effective method for reducing HIV risk among Dominicans (Huedo-Medina et al., 2010). Understanding SSC between women in the DR and

their stable male partners could provide valuable information about how to more effectively help these women to protect themselves from HIV/STIs within their relationship.

Gaps in the Literature

Overall, HIV prevention research in the DR has not been adequately prioritized by public health entities or academic and biomedical sectors (Rojas et al., 2011). Much of the HIV prevention research among women in the DR has focused on increasing condom use among sex workers (Kerrigan et al., 2006; Sweat et al., 2006; Welsh, Puello, Meade, Kome, & Nutley, 2001). However, this research may not pertain to the needs of women in stable relationships or be relevant to the context and dynamics HIV prevention within a close relationship. Furthermore, most of the research in the DR that has focused on SSC as a method of HIV prevention has focused on SSC that occurs among and between men, particularly clients of sex workers (Barrington & Kerrigan, 2014; Fleming, Barrington, Perez, Donastorg, & Kerrigan, 2014). Little is known about SSC that occurs between Dominican women and their stable male partners. Chapters three through five of this dissertation address this gap through a mixed methods study. Additionally, there has been no review of research with Latina women on the topic of SSC. Chapter 2, an integrative review, addresses this gap in the literature.

Theoretical Framework

Wingood and DiClemente's adaptation of the Theory of Gender and Power (2000, 2002), which is specific to both women and their risk of HIV and STIs, guided this dissertation. According to this theory (Figure 1.1), culturally bound gender roles that favor men and lead to decreased power over sexual risk for women lead to women's increased vulnerability to HIV. In this dissertation, I examined poor SSC as a specific form of vulnerability to HIV and STIs.

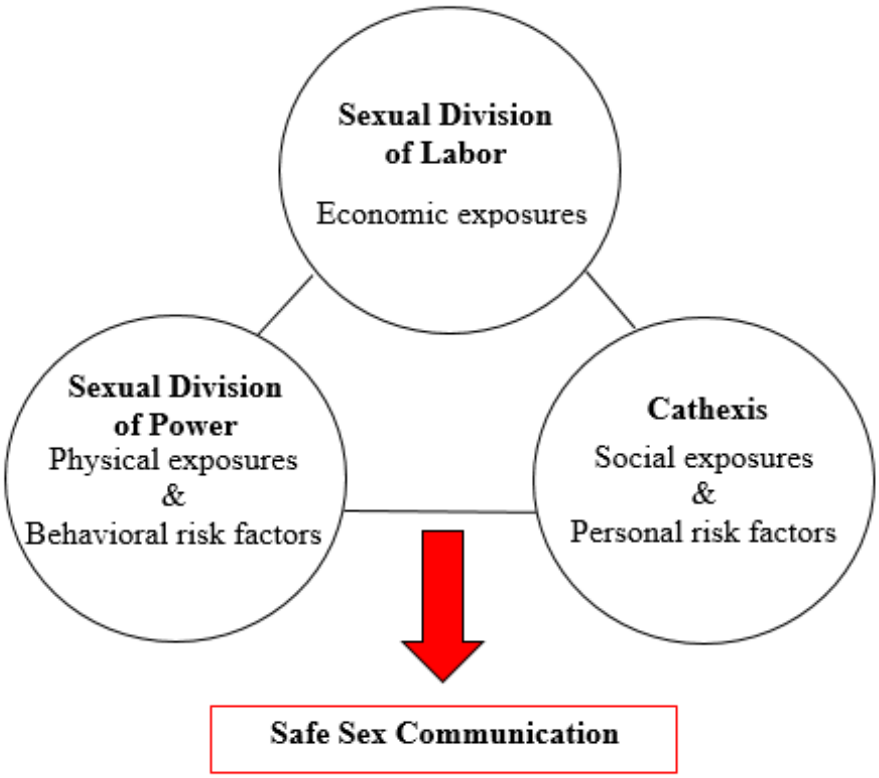
Accordingly, the inequalities in power between male and female partners that affect SSC are perpetuated by three structures: sexual division of labor, sexual division of power, and cathexis (affective attachments and social norms). Sexual division of labor refers to factors that lead to economic inequality. Sexual division of power refers to factors that result in men having more control in relationships, leading to physical exposures to risk of HIV/STIs and behavioral risks. Cathexis refers to the social norms related to gender roles and creating social exposures to risk of HIV/STIs and personal risk factors.

In support of this theory, research in HIV prevention with Latina women suggests that cultural norms impact values and practices related to condom use (Deardorff et al., 2013; Deardorff, Tschann, Flores, & Ozer, 2010; Marin, 2003; Marin, Gomez, Tschann, & Gregorich, 1997; Phinney & Flores, 2002). Of particular influence are the Latino cultural constructs *machismo* (masculinity defined as being virile, sexually dominant, and risk-taking) (Parker, 1996) and *marianismo* (femininity defined as being sexually naïve, selfless and subordinate to men) (Jezzini, 2013). These cultural expectations for gendered behavior have been found to place Latina women in a position of less control over negotiating condom use with their partners and ability to reduce their risk of STIs (Amaro & Gornemann, 1992; Marin, 2003; Marin et al., 1997).

This theory is helpful for investigating SSC that occurs between women in the DR and their stable male partners, because it outlines some of the key factors that influence women's vulnerability to HIV, specifically SSC with their partner. It also considers the context of women's experience in society and their relationships. This theory will serve as a guiding framework for developing the interview guide for Chapter three and survey development of

Chapter four. It will also be used to inform the analyses and interpretation of results in Chapters three and four.

Figure 1.1 Wingood and DiClemente's Adapted Theory of Gender and Power

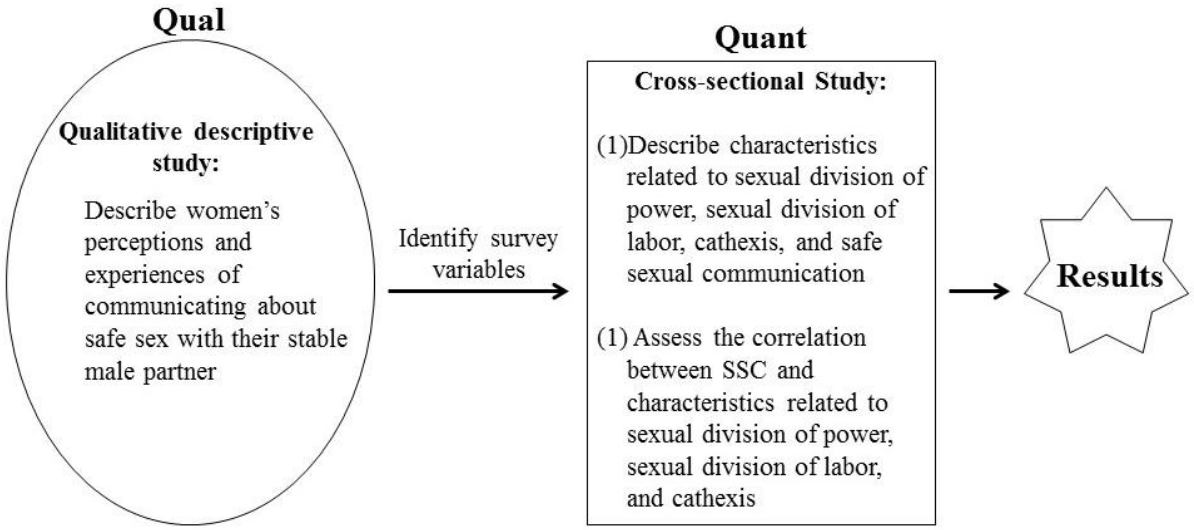


Mixed Methods Study Design

A mixed methods study design is used to address aims presented for chapters three and four (Figure 1.2), Specifically, an exploratory sequential mixed methods approach in which a qualitative descriptive study was followed by a cross-sectional survey study and findings from each hold equal weight of importance. Both will be conducted with women in the DR who have stable partners. The qualitative study was implemented to explore and gain an in-depth understanding of the SSC. Findings from the analysis were then used to inform variable selection

for the cross-sectional survey with the purpose of empirically describing SSC and quantify correlations between SSC and other factors. Because very little is known about SSC among women in the DR with stable partners, a mixed methods approach that involves a qualitative and quantitative perspective can provide a deep and comprehensive understanding of the phenomenon in this population.

Figure 1. 2 Diagram of mixed methods study design



Study Setting and Sample

Data were collected from women who sought care at Clínica de Familia in the DR, a comprehensive care clinic that specializes in HIV care. In 2015 the clinic provided the following number of physician visits for 8,524 clinic users: 17, 068 HIV care, 2,489 pediatrics, 3,516 social work, 537 counseling/psychology, 2,087 general medicine, 308 cardiology, 164 diabetes, and 1,675 gynecology and obstetrics, and 3,686 family planning services (Annual Report 2015 - Clinica de Familia, 2015). I have been collaborating with Clínica de Familia since January 2015.

Data collection for the third manuscript of the dissertation was collected in August 2015. Data collection for the fourth manuscript was collected between October through December 2016.

Eligibility criteria for the study were that women were: adults (18 years or older), Dominican, clients of Clínica de Familia, provided consent to participate and reported being in a stable heterosexual relationship. A stable relationship for this study was defined as women's relationship with the individual women considered to be their main partner. We were aware of the possibility that women may have had more than one current sexual partner at the time of the survey, so we used the terms *pareja fija* and *pareja de confianza* to clarify that we wanted to speak with them about their current stable partner and relationship. Furthermore, for this study, we recruited both women living with HIV and those who were not living with HIV. This decision was made to enable determining whether there were differences between safe sex communication between the two groups, as, to our knowledge, this has not been examined in previous literature.

IRB Approval

Prior to beginning data collection in the DR for both phases of the mixed-methods study, approval was obtained from Columbia University Medical Center (CUMC) Institutional Review Board (IRB) (Protocol IRB-AAAP2405) and the research ethics review board in the DR, Consejo Nacional Bioetica en Salud (CONABIOS) (Protocol# 015-2015).

Aims and Organization of Dissertation

Table 1.1 summarizes the title and aims of each chapter of this dissertation. Four aims are described in the following three chapters. Chapter 2 presents findings from an integrative review in which published empirical and theoretical research that examines psychosocial

correlates of SSC among adult Latina women from the US, Latina America, and the Caribbean with their stable male partners was synthesized. Chapters three and four present findings from the individual studies that comprise the mixed-methods study conducted at Clínica de Familia with women who have stable male partners. Chapter three summarizes findings from a qualitative descriptive study that aimed to explore and describe women's perceptions and experiences of SSC with their stable male partners. Chapter four presents findings from a cross-sectional study that aimed to: (1) describe characteristics related to sexual division of power, sexual division of labor, cathexis (structure of affective attachments and social norms), and SSC among Dominican women in a stable heterosexual relationship, and (2) assess the correlations between SSC and characteristics related to sexual division of power, sexual division of labor, and cathexis.

Table 1.1 Chapters of dissertation with aims addressed

Chapter	Title	Aim(s)
2	Psychosocial correlates of safe sex communication between Latina women and their stable partners: An integrative review	1. Synthesize published empirical and theoretical research that examines psychosocial correlates of safe sexual communication between adult Latina women and their stable male partners in the USA, Latina America, and the Caribbean.
3	Understanding safe sex communication between women and their stable partners in the Dominican Republic: A qualitative descriptive study	2. Describe women's perceptions and experiences of communicating about safe sex with their stable male partner.
4	Psychosocial correlates of safe sex communication for women with stable partners living in the Dominican Republic	3. Describe characteristics related to sexual division of power, sexual division of labor, cathexis (structure of affective attachments and social norms), and safe sex communication and 4. Assess the correlation between safe sex communication and characteristics related to sexual division of power, sexual division of labor, and cathexis
Note: Chapters three and four pertain to the adult women with stable partners who seek services at Clínica de Familia La Romana in the Dominican Republic		

All the studies in this dissertation are designed to create a comprehensive understanding of SSC among women in the DR with stable partners. Each of the following chapters will be addressed by a separate manuscript. Target journals for each manuscript are presented in Table 1.2.

Table 1. 2 Target journals for each chapter of the dissertation

Chapter	Title	Potential Target Journals
2	Psychosocial correlates of safe sex communication between Latina women and their stable partners: An integrative review	Published November 25, 2016 in AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV (Luft & Larson, 2017)
3	Understanding safe sex communication between women and their stable partners in the Dominican Republic: A qualitative descriptive study	1. Culture, Health and Sexuality
		2. Journal of Health Communication
		3. International Journal of STDs and AIDS
4	Psychosocial correlates of safe sex communication for women with stable partners living in the Dominican Republic	1. AIDS and Behavior
		2. Health Education and Behavior
		3. International Journal of STDs & AIDS

Conclusion

The overall purpose of this dissertation proposal is to understand SSC that occurs between women in the DR and their stable partners. Manuscripts of each chapter will be submitted for publication and the results shared with Clínica de Familia. This dissertation research will contribute to global literature by adding a comprehensive understanding of SSC among Latina women with stable partners that may be generalized to regions in the Caribbean, Latin America, and the US. It will enable researchers and clinicians to more accurately assess SSC among Latina women with stable partners and could help inform the development of comprehensive and more relevant HIV prevention interventions for Latina women.

Chapter two: Psychosocial correlates of safe sex communication between Latina women and their stable male partners: An integrative review

Chapter two of the proposed dissertation addresses aim one, to synthesize published empirical and theoretical research that examines psychosocial correlates of safe sexual communication (SSC) between adult Latina women and their stable male partners from the USA, Latina America, and the Caribbean. To satisfy this aim, an integrative review of the literature was conducted between May and July 2016. The final manuscript was published in the Journal *AIDS Care* (Luft & Larson, 2017). See Appendix A.1 for the published version of the manuscript.

Abstract

Latina women in stable relationships have risks for human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). Improving SSC could enable women to accurately assess and mitigate their risk of infection within their relationship. Literature to identify psychosocial correlates that facilitate or inhibit SSC between Latina women and their partners has not yet been synthesized. The purpose of this study was to conduct an integrative review (IR) and synthesis of empirical and theoretical research that examines psychosocial correlates of SSC between adult Latina women and their stable male partners from the United States, Latina America, and the Caribbean. A systematic search of LILACS, EBSCO, and PsychInfo databases was conducted to identify qualitative and quantitative studies that investigated psychosocial correlates of SSC among adult Latina women with a stable male partner. Pertinent data were abstracted and quality of individual studies was appraised. A qualitative synthesis was conducted following Miles and Huberman's method (1994). Five qualitative and three quantitative studies meet eligibility criteria. Factors related to SSC related

to three main themes: 1) relationship factors such as length, quality, and power/control, 2) individual factors including attitudes, beliefs, background, behaviors, and intrapersonal characteristics, and 3) partner factors related to partner beliefs and behaviors. The interplay of relationship, individual, and partner factors should be considered in the assessment of SSC for Latina women with their stable partners. To inform future interventions and clinical guidelines, additional research is needed to identify which factors are most related to SSC for this population, and how comparable experiences are for Latina women of different subcultures and living in different countries.

Background

Latina women in the United States (US), Latin America, and the Caribbean experience a disproportionate burden HIV and other STIs. In the US, Latina women are approximately 1.5 times more likely to be infected than heterosexual Latino men (Centers for Disease Control and Prevention [CDC], 2015). In the Dominican Republic (DR), the burden of HIV is shifting from men to women, as the proportion of HIV cases that are women increased from 27% in 2003 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2004) to 51% in 2013 (UNAIDS, 2013). In many Latin American countries, such as Mexico and Columbia, the HIV epidemic has also been found to be affecting a greater number of women than previously (UNAIDS, 2006a).

Latina women in stable heterosexual relationships have risk factors for HIV infection (UNAIDS, 2006a), but have received little attention in HIV prevention research. The primary route of transmission of HIV among Latina women, regardless of geographic location, is through heterosexual sexual activity (The Henry J. Kaiser Family Foundation [KFF], 2014; Halperin, de Moya, Perez-Then, Pappas & Garcia Calleja, 2009). Furthermore, in Latino communities it is common for men, including those in stable relationships, to have multiple sex partners

(CESDEM & ICF International, 2014; VanOss Marin, Tschann, Gomez, & Gregorich, 1998). This practice is often accepted by their female partners (Macauda, Erickson, Singer, & Santelices, 2011). Additionally, men who have sex with men (MSM) have high rates of HIV infection, which has also been documented among Latino MSM (Halperin et al., 2009; Rojas, Malow, Ruffin, Roth & Rosenberg, 2011; Siegel, Schrimshaw, Lekas, & Parsons, 2008). This is relevant to HIV risk among Latina women, because many Latino MSM also have sex with women, creating a "bridge population" that increases risk of HIV infection for Latina women in heterosexual relationships (Rojas et al., 2011; Siegel et al., 2008; UNAIDS, 2006a).

Despite decades of HIV prevention efforts, the proportion of Latinos in stable relationships who report using condoms is as low as 0.4% - 4% in some areas (CESDEM & International, ICF 2014; Halperin et al., 2009).This may be in part due to the meanings assigned to condom use among stable Latino partners related to trust and intimacy (D. Kerrigan et al., 2003; Kerrigan et al., 2006; D. Perez-Jimenez, D.W. Seal, & I. Serrano-Garcia, 2009), along with religious beliefs of Catholic Latinos that prohibit contraceptive use. Hence, condom use may be an unrealistic option for HIV risk reduction among Latina women in stable relationships.

Safe sex communication (SSC) may be a more feasible and effective method of preventing HIV/STIs than consistent condom use for Latina women in stable heterosexual relationships. SSC includes verbal or non-verbal relaying of information to one's partner regarding methods of HIV/STI prevention such as condom negotiation, discussion of sexual history or HIV/STI testing, and notification of new STI/HIV diagnosis or other concurrent sexual partners. Previous studies have demonstrated the potential of SSC to increase HIV testing among husbands (Manopaiboon et al., 2007), as well as reduce HIV transmission (Saul et al.,

2000) and increase condom use (El-Bassel et al., 2003; Noar, Carlyle, & Cole, 2007) among stable partners.

To improve SSC among Latina women in heterosexual relationships, an adequate understanding is needed of the barriers and facilitators of SSC and what types of SSC are most commonly utilized and avoided in the context of a stable relationship. Hence, an integrative review (IR) of existing empirical and theoretical research and synthesis of study findings would enable researchers to develop more relevant and comprehensive tools to investigate this topic, as well as provide guidance on appropriate content for interventions and the development of clinical practice guidelines for HIV/STI prevention for Latina women who are in stable relationships. Therefore, the purpose of this study is to review and synthesize empirical and theoretical research that examines psychosocial correlates of SSC between adult Latina women and their stable male partners from the US, Latin America, and the Caribbean.

Methods

Due to lack of recommended guidelines for integrative reviews, this study followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, & Group, 2009), where possible, to increase the rigor of procedures and reporting. An audit trail of decisions was kept throughout the entire review process regarding decisions, analytic ideas, thoughts, and issues.

Inclusion and exclusion criteria. Qualitative and quantitative primary studies of any design except interventional research were eligible if they met the following criteria: 1) sample consisted of adult (18 or older) Latina women in a stable heterosexual relationship or included a mix of ethnicities or sexes with data on adult Latina women that could be abstracted, 2) qualitative studies with the purpose of examining Latina women's experiences of talking with

their partner about different methods HIV/ STI prevention OR quantitative studies with the purpose of examining psychosocial correlates of partner communication or negotiation related to HIV and/or STI prevention (SSC as primary or secondary outcome), 3) set in the US, Latin America, or the Caribbean, 4) reported in English or Spanish, and 5) published as a peer reviewed journal article with full text available in the databases searched.

Studies with the following characteristics were excluded: 1) sample consisted of transgender individuals or women who were involved with illicit drug us, mentally ill, or disabled, 2) examined only behavioral correlates, parent-child or provider-patient communication about safe sex, provider-partner or health department notification of HIV or STIs, communication only about pregnancy prevention or contraception, negotiation only of asexual act, or communication only about sexual pleasure, 3) set in Spain or Brazil, or 4) published as a book chapter, review article, opinion, or dissertation. No limits were placed on date of publication.

Database and search strategy. A two-stage search strategy was used (Counsell, 1997; Dickersin, Scherer, & Lefebvre, 1994). First, a preliminary limited search of Ovid MEDLINE was conducted to identify optimal search terms. Articles that fit the purpose of this integrative review were collected. Terminology used in these articles to describe the sample, as well as the phenomenon or outcome variable were recorded in an Excel document. An information specialist was then consulted to determine the most effective methods of combining these terms and appropriate databases to search.

Second, a comprehensive systematic search was conducted using three databases: Latin American and Caribbean Health Science Literature (LILACS), PsychInfo, and EBSCO. LILACS was selected because includes research with Hispanic and Latino populations. PsychInfo was

selected due to the psychosocial focus of the topic. EBSCO was selected because it includes a large number and variety of databases from both psychosocial and health sciences disciplines. Within EBSCO the following databases were selected for this study: Chicano Database, Gender Studies Database, SocIndex, Social Work Abstracts, Family and Society Studies Worldwide, and Social Sciences Full Text.

Comparable terms and strategies were used for each database (Appendix A.2). Because, the structure and functioning of each database were unique, search strategies were modified accordingly. For example, Hispanic qualifiers were excluded in the search of LILACS, because this database only includes studies conducted with Hispanic and Latino populations.

Study selection. An online program designed to facilitate the screening process for review studies (Covidence, www.covidence.org), was used by both authors to screen all articles yielded by the comprehensive search. First, all titles and abstracts were independently screened for inclusion criteria by each author. Both authors discussed discrepancies and reached consensus. Next, both authors independently conducted a full text evaluation of potentially eligible articles independently. This was followed by another discussion of discrepancies to reach consensus about the final list of articles which met inclusion criteria.

Data abstraction. Two separate data collection forms were developed prior to data abstraction based on the purpose of the integrative review to facilitate systematic examination and organization of information from included studies (Higgins & Green, 2005). Abstraction forms were developed for both qualitative and quantitative study designs, pilot tested, and modified to improve the adequacy of abstracted data (completed forms available upon request).

The first author abstracted the following data on an Excel spread sheet for all studies: 1) sample characteristics, 2) sampling method, 3) inclusion and exclusion criteria, 4) setting, 5)

recruitment and enrolment, 6) purpose, 7) study design, 8) phenomenon of focus, 9) guiding theory or framework, 10) data collection method, 11) data analysis method, 12) major findings and reporting method, and 13) correlates of SSC. For quantitative studies, data were also abstracted pertaining to: 1) sample size calculation, 2) response rate, 3) method of measuring SSC outcome, and 4) independent variables examined. The second author verified data abstracted for each study by reviewing data in the spread sheet.

Quality assessment. Qualitative studies were appraised using the Critical Appraisal Skills Programme tool (CASP) (Chenail, 2011), which includes 10 questions assessing study 1) aims, 2) methodology, 3) design, 4) recruitment, 5) data collection, 6) relationship between researcher and participants, 7) ethics, 8) data analysis, 9) write up of findings, 10) value of research. Response options for the specific questions were modified to include: "Yes" (2 points), "Partially" (1 point), "Can't tell" (0 points), or "No" (0 points). The assessment was scored as a percentage determined by adding the points obtained (numerator) and dividing by the total possible points (20 points). For the purpose of this IR, focus groups were not considered a qualitative study design, but rather a method of data collection.

Quantitative studies were appraised using a modified version of the "Quality assessment tool for observational cohort and cross-sectional studies" (National Institute of Health [NIH], 2014). Questions not applicable for cross-sectional studies were removed, as all included studies were cross-sectional. Ultimately, eight assessment criteria were used: 1) the research question, 2) study population, 3) recruitment, 4) sample size justification, 5) variance in exposure variables, 6) psychometrics of exposure variables, 7) psychometrics of outcome variable, and 8) statistical adjustment for confounding variables. Response options were modified to include: "Yes" (2 points), "Partially" (1 point), "Cannot determine" (0 points), "Not reported" (0 points), and "No"

(0 points). The assessment was scored as a percentage determined by adding the points obtained (numerator) and dividing by the total possible points (16 points).

There is risk that including poor quality studies may distort data synthesis and cause difficulties in interpretation (Dixon-Woods, Booth, & Sutton, 2007). However, an a priori decision was made not to exclude any such studies, because to our knowledge this is the first review on the topic and the primary goal was to identify, describe, and appraise eligible articles.

Data synthesis/analysis. There is no single recommended or agreed upon method for analyzing or synthesizing data for an IR. However, it has been suggested that analysis methods used for mixed-methods and qualitative data that use constant comparison also function well for IRs (Whittemore & Knafl, 2005). Hence, Miles and Huberman's method of qualitative data analysis guided the analysis and synthesis of data (Miles & Huberman, 1994). This method involves five main steps: 1) data reduction, 2) data display, 3) data comparison, 4) conclusion drawing, and 5) verification.

During the data reduction phase, significant correlations with SSC from quantitative studies and influential factors of SSC expressed by participants mentioned in qualitative studies were extracted from each individual study and coded. All findings, including conflicting findings, were included in the synthesis. During the data display phase, coded data from the individual studies were combined, organized, and displayed.

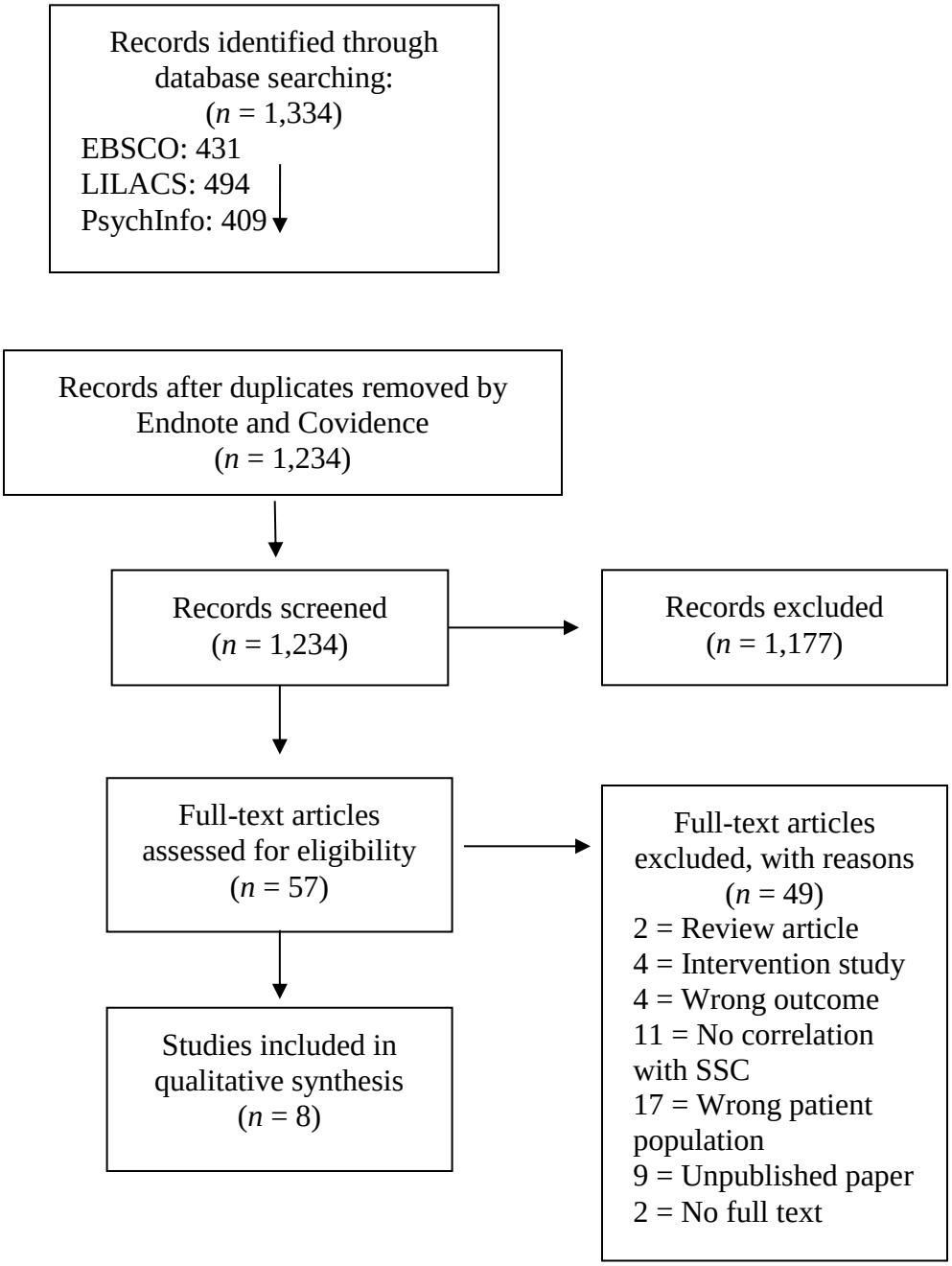
For the data comparison phase, we examined the summary of findings for patterns, themes, and relationships. Notes of conflicting findings were kept. During the conclusion-drawing phase, a final list of categories and overall general themes was determined. We also identified commonalities and differences across studies. During the final verification phase, overall thematic categories were verified with results from the individual included studies to

ensure that the results and interpretation of the body of evidence were grounded in data from the original primary articles.

Results

Study selection. Figure 2.1 provides detail regarding the literature search and selection process. The initial search of all databases yielded 1,334 studies. After removing duplicates, 1,234 titles and abstracts were screened for eligibility criteria and 1,177 of these articles were ineligible and excluded. We reviewed the full text of 57 articles. The primary reasons for exclusion at this stage were: wrong participant population (n = 17), no correlations with SSC explored (n = 1), and unpublished paper (n = 9). Ultimately, five quantitative (Alvarez & Villarruel, 2015; Ashburn, Kerrigan, & Sweat, 2008; Castañeda, 2000; J. Moore, Harrison, Kay, Deren, & Doll, 1995; Saul et al., 2000) and three qualitative studies (Alvarez & Villarruel, 2013; Davila, 2002; McQuiston & Gordon, 2000) met eligibility criteria and were included in the integrative review and qualitative synthesis.

Figure 2. 1 Selection process for inclusion in the integrative review



Description of studies. Table 2.1 describes characteristics of the included studies. A range of purposes related to investigating SSC were reported across studies. Of the included qualitative studies, one used a qualitative descriptive design (Alvarez & Villarruel, 2013), one naturalistic inquiry (Davila, 2002), and one an unspecified qualitative design (McQuiston & Gordon, 2000). All quantitative studies utilized a cross-sectional design (Alvarez & Villarruel, 2015; Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995a; Saul et al., 2000). Four studies included mixed samples of both men and women (Alvarez & Villarruel, 2013; Alvarez & Villarruel, 2015; Castañeda, 2000; McQuiston & Gordon, 2000) and four included women only (Ashburn et al., 2008; Davila, 2002; Moore et al., 1995a; Saul et al., 2000). Of the studies that reported participant age, the mean age was mid-twenties for three studies (Alvarez & Villarruel, 2013; Alvarez & Villarruel, 2015; McQuiston & Gordon, 2000) and low to mid-thirties for four studies (Ashburn et al., 2008; Castañeda, 2000; Davila, 2002; Moore et al., 1995a). Of the six studies that reported participant ethnicity, two included Puerto Ricans (Moore et al., 1995; Saul et al., 2000), four included Mexicans or Mexican Americans (Castañeda, 2000; Davila, 2002; McQuiston & Gordon, 2000; Moore et al., 1995), two included Dominicans (Ashburn et al., 2008; Moore et al., 1995), and one unspecified other Latina (Castañeda, 2000). All studies (Alvarez & Villarruel, 2013; Alvarez & Villarruel, 2015; Castañeda, 2000; Davila, 2002; McQuiston & Gordon, 2000; Moore et al., 1995; Saul et al., 2000) but one were conducted in the continental US; the other was conducted in the DR (Ashburn et al., 2008).

Types of SSC investigated included sexual communication in general (Alvarez & Villarruel, 2013), sexual health communication (Alvarez & Villarruel, 2015), HIV-related communication or negotiation (Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000), and condom negotiation (Davila, 2002; McQuiston & Gordon, 2000). In

quantitative studies, a variety of independent variables were investigated. The most common were acculturation (Alvarez & Villarruel, 2015; Castañeda, 2000; Moore et al., 1995), age (Ashburn et al., 2008; Moore et al., 1995; Saul et al., 2000), education (Ashburn et al., 2008; Saul et al., 2000), perceived partner approval about sexual communication (Alvarez & Villarruel, 2015; Moore et al., 1995), length of time in relationship (Alvarez & Villarruel, 2015; Saul et al., 2000), relationships status (Alvarez & Villarruel, 2015; Castañeda, 2000), and commitment to the relationship (Castañeda, 2000; Saul et al., 2000). Qualitative data were analyzed using grounded theory methods (Alvarez & Villarruel, 2013) or an unspecified method of content analysis (Davila, 2002; McQuiston & Gordon, 2000). For quantitative studies, correlations were examined using regression methods (Alvarez & Villarruel, 2015; Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995) or by structural equation modeling (Saul et al., 2000). Results of the individual studies are reported in Table 1.

Study quality. Quality scores for qualitative studies ranged between 60% (McQuiston & Gordon, 2000) and 75% (Davila, 2002). All qualitative studies lacked adequate reporting of the relationship between the researcher and the participants, as well as rigorous data analysis methods (Alvarez & Villarruel, 2013; Davila, 2002; McQuiston & Gordon, 2000). Quality of the studies was also negatively affected by inadequate reporting of ethical considerations (Davila, 2002; McQuiston & Gordon, 2000). Finally, for studies that did not state a particular study design (Alvarez & Villarruel, 2013; McQuiston & Gordon, 2000), we were unable to determine whether the research design was appropriate to address the aims of the study.

Quality ratings for quantitative studies ranged between 68.8% (Castañeda, 2000) and 87.5% (Alvarez & Villarruel, 2015). A limitation for all studies was inadequate description and reporting of psychometrics, particularly the validity, of the exposure and outcome measures

(Alvarez & Villarruel, 2015; Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000). For most studies (Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000), lack of justification of sample size also negatively affected the quality score.

Table 2.1 Characteristics of included studies

First Author (Year)	Study Design & Purpose	Sample	Variables/Phenomena	Analysis Method & Results	Quality Score (%)
Alvarez (2013)	• Qualitative descriptive • To describe sexual communication among young adult Latinos	• 20 Latino men and women; *n* = 10 women; mean age of women 24.2 years • *Education:* 4 high school graduate or less & 5 some college • *Ethnicity:* NR • *Location:* Midwest (USA)	*Phenomenon:* Sexual communication	• Grounded Theory (Corbin & Strauss, 2008) • 5 themes: 1) Barriers to verbal communication, 2) facilitators of communication, 3) Sex and Condom use, 4) Contexts for verbal communication, 5) Non-verbal sexual communication	70
Alvarez (2015)	• Cross-sectional • To examine the role of traditional gender norms, relationship factors, intrapersonal factors, and acculturation as statistical predictors of three different types of sexual communication in Latino women and men.	• 220 Latino men and women; *n* = 111 women; mean age of women 24.28 years • *Education:* NR • *Ethnicity:* NR • *Location:* Midwest (USA)	• *Dependent SSC variable:* Sexual health communication • *Independent variables:* Traditional gender norms, sexual relationship power, length of time in relationship, difference in time in US, age difference of partners, relationships status, attitudes towards sexual communication, sexual	• Multiple regression • *Positive association:* Relationship length (β = .21, *p* < .05), Relationship power (□ = .27, *p* < .001), Attitudes towards sexual health communication (β = .32, *p* < .001), Subjective norms towards sexual communication (β = .28, *p* < .001),	87.5

			attitudes, social norms about preventative behaviors, perceived partner approval about sexual communication, subjective norms, acculturation	Acculturation ($\beta =$ .5.67, $p < .001$) • *Negative association:* Difference in time in US ($\beta = -.18$, $p < .05$), Attitudes towards pleasure discussions ($\beta = -.29$, $p < .05$), partner approval toward sexual communication ($\beta = -.29$, $p < .05$)	
Ashburn (2008)	• Cross-sectional • To examine the relationship between women's empowerment and negotiation of partner's behavior change to avoid HIV infection among partnered sexually active women in rural DR.	• 273 Latina women; mean age 36.49 years • *Education:* 69% some primary school • *Ethnicity:* Dominican • *Location:* Southwestern DR	• *Dependent SSC variable:* HIV-related negotiation • *Independent variables:* Micro-credit loan participation, level of participation in women's groups, control of own money, perception of partner's monogamy, age, education, residence, religion, number of children living at home	• Multivariate logistic regression • *Positive association:* Unfaithful partner (*AOR* = 6.39, $p < .001$), Control own money (*AOR* = 2.43, $p < .001$), residence in Peravia (*AOR* = 3.53, $p < .001$) • *Negative association*: Evangelical religion (*AOR* = 0.12, $p < .001$), no religious affiliation(*AOR* = 0.29, $p < .05$)	75
Castañeda (2000)	• Cross-sectional • To determine the association of relationship variables to	• 115 Latino men and women; *n* = 76 women; mean age 30.8 years	• *Dependent SSC variable:* HIV-related communication	• Hierarchical multiple regression • *Positive association:* Intimacy ($\beta = .35$, $p < .02$)	68.8

	participants' HIV risk perception, use of condoms, and HIV-related communication with a relationship partner.	• *Education:* 26% less than high school, 94.73% high school graduate • *Ethnicity:* 98.7% Mexican American, 1.3% other Latina • *Location:* Southwestern US	• *Other dependent variables*: Condom use, HIV risk perception • *Independent variables:* Demographics, relationship status, commitment, intimacy, overall sexual satisfaction in relationship, sexual regulation, level of acculturation		
Davila (2002)	• Naturalistic inquiry • Explore the influence of abuse on the condom negotiation attitudes, behaviors, and practices of Mexican American women involved in abusive relationships.	• 20 Latina women; mean age 30.7 years • *Education:* 5-12 years (mean = 10.4 years) • *Ethnicity:* Mexican American • *Location:* South-central Texas	*Phenomenon:* Condom negotiation	• Content analysis • 3 Main categories: 1) "He beat me", 2) "He made me feel bad", 3) "He forced me"	75
McQuiston (2000)	• Qualitative • Gain insight into (a) whether newly immigrated Mexican men and women in the Southeast discussed HIV/STD	• 31 Latino men and women, *n* = 16 women; age 20-29 years • *Education:* mean = 8.73 years	*Phenomenon:* Condom negotiation	• Content analysis • 4 Themes: 1) Women: Communication comes first - it's safe sex, 2) Men: Trust comes first - it's safe sex, 3) Women: Machismo and Trust, 4) Men, Machismo, and Trust	60

	prevention with each other, and (b) how condom use was discussed	• *Ethnicity:* Mexican American • *Location:* Southeastern US			
Moore (1995)	• Cross-sectional • To determine the factors influencing Hispanic women's HIV-related communication and condom use with their primary male partner.	• 189 Latina women; mean age 30 years • *Education:* 68% at least high school • *Ethnicity: n* = 44 Dominican, *n* = 54 Puerto Rican, *n* = 91 Mexican • *Location:* New York City, NY and El Paso Texas	• *Dependent SSC variable:* Level of HIV-related communication • *Other dependent variables:* Condom use • *Independent variables:* acculturation, perceived risk for HIV, conflict, sex communication, openness of communication, expected partner reactions to request for condom use, age, Hispanic subgroup, whether woman had multiple sex partners	• Ordinary least squares regression • *Positive association:* perceived risk of HIV infection ($\beta = .30$, $p = .0001$), openness of communication with partner ($\beta = .17$, $p = .05$) • *Negative association:* Mexican ethnicity ($\beta = -.36$, $p = .0003$), woman has other sex partners ($\beta = -.28$, $p = .0003$)	75

Saul (2000)	• Cross-sectional • To empirically test the association between power and women's HIV-related communication and condom use with male partners	• 187 Latina women; age NR • *Education:* NR • *Ethnicity:* Puerto Rican • *Location:* New York City, NY	• *Dependent SSC variable:* HIV related communication • *Independent variables:* Sexual power (education, employment, decision-making, perceived alternatives to relationship, commitment to the relationship, investment in the relationship, absence of abuse in relationship), age, relationship length	• Structural equation modeling • *Negative association:* Currently employed (t (1,166) = -3.32, $p <$ .05), high commitment to the relationship (t (1,166) = -3.67, $p < .01$)	75

Notes: NR = not reported; HIV = human immunodeficiency virus; DR = Dominican Republic

Findings of data synthesis. Table 2.2 summarizes the thematic findings and corresponding categories of variables related to SSC across all included studies. Ultimately, three main themes emerged that summarize factors related to SSC between Latina women and their stable male partners: 1) relationship factors, 2) individual factors, and 3) partner factors.

Relationship factors. Subthemes that comprised relationship factors include: 1) relationship length, 2) relationship quality, 3) use of initial sexual activity to set a foundation for SSC, 4) difference in time living in the US between partners, and 5) power or control in the relationship. Helpful factors included 1) *longer time in relationship* (Alvarez & Villarruel, 2013; Alvarez & Villarruel, 2015; McQuiston & Gordon, 2000), 2) *using the initial sexual activity* to set a foundation for talking about safe sex (Alvarez & Villarruel, 2013), 3) and better relationship quality (Castañeda, 2000; McQuiston & Gordon, 2000; Moore et al., 1995). Better *relationship quality* encompassed characteristics such as greater intimacy (Castañeda, 2000), mutual trust (McQuiston & Gordon, 2000), mutual understanding (McQuiston & Gordon, 2000), and good partner communication in general (McQuiston & Gordon, 2000; Moore et al., 1995). One factor that inhibited SSC is a greater *difference in time living in the US* between partners (Alvarez & Villarruel, 2015). Finally, factors related to *power and control* in one's relationship can positively or negatively affect SSC. For example, greater relationship power in general (Alvarez & Villarruel, 2015) and greater control over one's own money (Ashburn et al., 2008) facilitated SSC. However, currently being employed (Saul et al., 2000), being highly committed to maintaining the relationship (Saul et al., 2000), feeling powerless (Davila, 2002), and fear of or actual physical, psychological, and sexual abuse from partner as a response to bringing up these topics (Davila, 2002) led to less or poorer SSC.

Individual factors. Subthemes under individual factors included: 1) attitudes/beliefs, 2) background characteristics, 3) behaviors, 4) intrapersonal characteristics, and 5) skills. *Attitudes and beliefs* that helped with communication included: having a more positive attitude and subjective norms towards sexual health communication (Alvarez & Villarruel, 2015), perceiving a greater risk of HIV infection (Moore et al., 1995), not subscribing to traditional gender roles (McQuiston & Gordon, 2000), and greater perceived openness of partner to discussing these topics (Alvarez & Villarruel, 2013). Attitudes and beliefs that inhibited SSC included: having a negative attitude towards pleasure discussions (Alvarez & Villarruel, 2015), feeling embarrassed (Alvarez & Villarruel, 2013), not wanting to know partner's response (Alvarez & Villarruel, 2013), subscribing to evangelical religious beliefs or having no religious affiliation (Ashburn et al., 2008), having low perceived personal risk for AIDS (Davila, 2002; McQuiston & Gordon, 2000), subscribing to traditional gender roles (McQuiston & Gordon, 2000), having greater trust in her partner (McQuiston & Gordon, 2000), and having low perceived partner approval toward sexual communication (Alvarez & Villarruel, 2015).

Background characteristics that were reported to help with SSC were residence in urban areas (Peravia versus Asua, DR) (Ashburn et al., 2008), and greater acculturation (Alvarez & Villarruel, 2015). In contrast, Mexican ethnicity compared to Puerto Rican (Moore et al., 1995) and having children (Davila, 2002) inhibited communication about safe sex. A *behavior* that facilitated SSC was women's use of communication technology (Alvarez & Villarruel, 2013). However, women having additional sexual partners (Moore et al., 1995) was a behavior that inhibited SSC. *Intrapersonal characteristics* that could hinder SSC included poor sense of identity and low self esteem (Davila, 2002). Furthermore, if the woman lacked *skills* or had difficulty problem solving, this was also a barrier.

Partner factors. Sub themes that emerged under partner factors were partner's attitudes and behaviors. With respect to *attitudes,* if the woman's partner subscribed to ideas and attitudes associated with "machismo" (Alvarez & Villarruel, 2013; McQuiston & Gordon, 2000) this inhibited SSC. Partner *behaviors* that were found to inhibit SSC included partner refusal to talk about these topics (McQuiston & Gordon, 2000) and substance use (Davila, 2002). In contrast, if her partner was unfaithful (Ashburn et al., 2008) or if her partner had a positive response to initiating discussion of these topics, such as listening and not getting mad (McQuiston & Gordon, 2000), this facilitated SSC.

Table 2. 2 Thematic map of factors that facilitate or hinder safe sex communication for Latina women in stable relationships

Relationship Factors	Individual Factors	Partner Factors
Relationship Length + Longer relationship (Alvarez & Villarruel, 2013, 2015; McQuiston & Gordon, 2000) **Relationship Quality** + Good general communication (McQuiston & Gordon, 2000; Moore et al., 1995) + Greater intimacy (Castañeda, 2000) + Mutual trust (McQuiston & Gordon, 2000) + Mutual understanding (McQuiston & Gordon, 2000) **Use of Initial Sex Activity** + Use of initial sexual activity to create foundation for SSC (Alvarez & Villarruel, 2013) **Difference in Time in the US** – Greater difference in time living in the US between partners (Alvarez & Villarruel, 2015) **Power/Control**	**Attitudes/Beliefs** + Greater perceived risk of HIV infection (Davila, 2002; McQuiston & Gordon, 2000; Moore et al., 1995) + More positive attitudes or subjective norms towards SSC (Alvarez & Villarruel, 2015) + Greater perceived openness of partner to SSC (Alvarez & Villarruel, 2013) – Poor attitude towards pleasure discussions (Alvarez & Villarruel, 2015) – Feeling embarrassed (Alvarez & Villarruel, 2013) – Not wanting to know (Alvarez & Villarruel, 2013) – Greater endorsement of traditional gender roles (McQuiston & Gordon, 2000) – High levels of trust of her partner (McQuiston & Gordon, 2000) – Low perceived partner approval toward sexual communication (Alvarez & Villarruel, 2015) **Background characteristics** + Residence in Peravia (compared to Azua), DR (Ashburn et al., 2008)	**Attitudes/Beliefs** – Partner has greater endorsement of traditional gender roles ("Machismo") (Alvarez & Villarruel, 2013; McQuiston & Gordon, 2000) **Behaviors** + Partner has other concurrent sex partners (Ashburn et al., 2008) + Positive partner response to SSC (McQuiston & Gordon, 2000) – Partner refuses to talk about SSC (McQuiston & Gordon, 2000) – Partner substance use (Davila, 2002)

+ Greater relationship power (Alvarez & Villarruel, 2015) + Greater control of own money (Ashburn et al., 2008) – Currently employed (Saul et al., 2000) – High commitment to maintaining the relationship (et al., 2000) – Feeling powerless (Davila, 2002) – Fear of or actual physical, psychological, and sexual abuse from partner (Davila, 2002)	+ Greater acculturation (Alvarez & Villarruel, 2015) – Mexican ethnicity compared to Puerto Rican (Moore et al., 1995) – Children (Davila, 2002) – Evangelical religion or no religious affiliation (Ashburn et al., 2008) **Behaviors** + Use of communication technology (Alvarez & Villarruel, 2013) – Woman has other concurrent sex partners (Moore et al., 1995) **Intrapersonal Characteristics** – Poor sense of identity (Davila, 2002) – Low self-esteem (Davila, 2002) **Skills** – Difficulty problem solving (Davila, 2002)

Notes: + indicates factors that facilitate SSC, - indicates factors that hinder SSC; DR = Dominican Republic; HIV = human immunodeficiency virus

Discussion

Five quantitative and three qualitative research studies that examined psychosocial correlates of SSC between adult Latina women and their stable male partners in the US, Latina America, and the Caribbean were reviewed, appraised, and synthesized in this study. Various factors found to be related to SSC were categorized as relationship, individual, or partner and confirmed that while certain factors facilitate SSC between Latina women and their stable male partners, they still face many challenges.

Multiple relationship factors were found to be related to SSC. As in this review (Alvarez & Villarruel, 2015; Davila, 2002), past research with a sample of Latina women of mixed relationships status also found relationship power in general to be related to SSC (Davila, 1999). Similarly, among Kenyan women who are cohabitating with their male partners, participation in decision-making has been found to be positively associated with spousal communication about HIV prevention (Chiao, Mishra, & Ksobiech, 2011). Interpersonal violence (IPV) is often considered a proxy for sexual relationship power. Like the Latina women in studies included in this review (Davila, 2002), past research with African American women who have stable partners has also found IPV to be related to various forms of SSC (Morales-Alemán et al., 2014). Education level is also a component of sexual relationship power. Although not reported to be related to SSC by any study in this review, research with cohabitating Kenyan couples, as well as research with Latina women in the US of mixed relationship status have found that higher levels of education for the female partner is positively associated with partner SSC (Alexander, 2014; Chiao et al., 2011). Despite evidence that relationship power is related to SSC, it remains unclear which specific aspects of sexual relationship power are most related to SSC. Future research

should consider taking a more comprehensive and detailed approach to investigating constructs within sexual relationship power as they relate to SSC.

Using the initial sexual activity to create a foundation for SSC was another relationship factor found to facilitate SSC for Latinas in stable relationships (Alvarez & Villarruel, 2013). A study conducted with men and women in primary relationships of various different ethnicities also found that requesting condoms early in the relationship and continuing to do so often facilitated SSC between partners (Pulerwitz & Dworkin, 2006). Gaining a better understanding of timing of SSC between stable partners may provide valuable for improving the effectiveness of this HIV prevention behavior.

Individual factors such as, specific Latino subculture (Moore et al., 1995), and acculturation level (Alvarez & Villarruel, 2015), appear to not only be related to SSC but also to condom use among stable partners, as well (Deren, Shedlin, & Beardsley, 1996; Moreno & El-Bassel, 2007). Further research on SSC is needed with Latinas of different subcultures and who are living in countries outside of the US to facilitate identification of similarities and differences between Latina sub culture and influence of acculturation to American culture.

In this review, we found that cultural norms and gender roles appear to have an effect on SSC for Latina women in stable relationships where neither partner has HIV (Alvarez & Villarruel, 2015; McQuiston & Gordon, 2000), and past research has found this to be true among Latinos in serodiscoradant relationships as well (Orengo-Aguayo & Pérez-Jiménez, 2009). This may be a factor that affects couples regardless of ethnicity, as previous research has also found a significant effect on SSC among an ethnically diverse sample of men and women in the US in stable relationships (Pulerwitz & Dworkin, 2006). However, the influence of cultural norms and gender roles may not be unique to the close relationship context, as it was also found to influence

SSC in research conducted with Latina samples of mixed relationship status within (Alexander, 2013) and outside of the US (Noland, 2006). HIV prevention efforts for Latinas should tailor interventions to the cultural context and address culturally bound messages related to HIV prevention behaviors.

Perceived negative partner reaction to SSC seems to be an important factor for many women in stable relationships, not only Latinas. Among Puerto Rican women in serodiscordant relationships, fear of being judged, misunderstood or partner not taking the topic seriously inhibited SSC (Orengo-Aguayo & Pérez-Jiménez, 2009). Similarly, among a sample of predominantly white and African-American college students (Dilorio, Dudley, Lehr, & Soet, 2000), as well as a sample of African-American adolescents (Sionéan et al., 2002), perception of more positive partner attitude towards SSC was associated with greater SSC and more consistent refusal of unwanted sex.

Finally, fidelity of both the female and male partner also appears to influence SSC not just in the relationships of Latina women. Among an ethnically diverse sample of young couples in the US, it was found that if the woman has sexual partners outside of their relationship this is negatively related to SSC (Albritton et al., 2014). With regards to male partners, as opposed to facilitating SSC as found among Latino couples (Ashburn et al., 2008), among cohabitating couples in Kenya, if the male had other sexual partners, the couple was less likely to have discussed HIV prevention (Chiao et al., 2011).

Limitations. There are limitations to this review. We did not search for or examine unpublished or grey literature. It is possible that eligible studies were missed, despite our best efforts to develop a comprehensive search strategy. Additionally, due to the small number of studies and characteristics of the sample, it is not appropriate to generalize findings to Latina

women living outside of the US or to women of all Latino subcultures. Furthermore, results of the data synthesis are descriptive, so conclusions could not be made about pooled statistical correlations using a meta-analysis. Similarly, because all studies were qualitative or cross-sectional in design, causation cannot be assumed.

Conclusion

Multiple relationship, individual, and partner factors were reported to be related to SSC that Latina women have with their stable male partners. More qualitative research is needed on types of SSC aside from condom negotiation. Future quantitative studies on the topic should include more variables specifically related to the close relationship context. In addition, more research is needed with Latinas of different subcultures and with those who live outside of the US. With this information, a more accurate and complete understanding of the needs of Latina women in stable heterosexual relationships with regards to SSC can be achieved, and recommendations for clinical practice and interventional research can be made.

Chapter three: Understanding safe sex communication between women and their stable partners in the Dominican Republic: A qualitative descriptive study

Chapter three addresses aim two of the proposed dissertation, to describe women's perceptions and experiences of communicating about safe sex with their stable male partner. Data collection occurred between August and September 2015.

Abstract

Although Latina women with stable partners may be at risk for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) due to the power dynamics in their relationships, minimal research has been conducted in this area with Dominican women, specifically. The aims of this qualitative descriptive study, grounded in the Theory of Gender and Power, were to, among women in the Dominican Republic (DR), describe perceptions and experiences of communicating about safe sex with a stable male partner. Open-ended interviews were conducted with adult Dominican women in stable heterosexual relationships who sought care at a clinic in La Romana, DR. Colaizzi's method of emergent content analysis was used to identify themes of the transcript data. From the accounts of eleven women, two main themes emerged: (1) "Context of sexual risk", which included the meaning of safe sex for stable partners, behaviours related to sexual risk, beliefs and attitudes related to sexual risk, *confianza* (trust) between stable partners, economic power within relationships, and learning to manage safe sex within a stable relationship. (2) "Safe sex communication (SSC) between stable partners" which encompassed reasons to talk about safe sex, methods, content and outcomes, influential factors, and ideas for improvement. SSC is multifaceted and reflects the cultural contexts

in which it occurs. Characteristics of and influences on SSC were identified in this study. Future research should determine which factors have a significant association with SSC and how to best work with these factors among women in the DR to improve SSC as an HIV/STIs risk reduction method.

Background

Apart from sub-Saharan African, the Caribbean is the only region where the number of women and girls living with HIV is greater than that of men and boys (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014). In the DR, the number of all diagnosed HIV cases that were women increased from 27% in 2003 (UNAIDS, 2004) to 51% in 2013 (UNAIDS, 2013), indicating a shift in the burden of HIV from men to women. Sexual risk for women in the DR is affected by the high prevalence of having additional concurrent sexual partners outside of one's main relationship (Barrington & Kerrigan, 2014; Panos Caribbean, 2012; Davila, 2002; Guliamo-Ramos, Padilla, Cedar, Lee, & Robles, 2013; Population Services International [PSI], 2006; Padilla et al., 2008), as well as low rates of condom use between stable partners (3%) (CESDEM & International, 2013). Furthermore, although efforts to increase condom use have been more effective among casual partners and sex workers, they are still not used consistently (Barrington & Kerrigan, 2014; Barrington et al., 2009; Fleming, Barrington, Perez, Donastorg, & Kerrigan, 2014; Sears, Cabrera, Ortiz, Anderson, & Stein, 2011). Combined, these factors lead to higher risk of HIV and other STIs for many women in stable heterosexual relationships.

Despite the increasing risk of HIV/STIs for women in stable relationships living in the DR, they have been largely absent from the literature and past HIV prevention efforts (Guliamo-Ramos et al., 2013; Kerrigan et al., 2003; Kerrigan et al., 2006; Sweat et al., 2006). Furthermore, encouraging condoms may not be a feasible option for women in stable relationships due to

meanings of trust and intimacy related to their use (Kerrigan et al., 2003; Kerrigan et al., 2006; Perez-Jimenez, Seal, & Serrano-Garcia, 2009), as well as culturally-bound social norms that define the roles of men and women in relationships and unevenly distribute sexual power (Amaro, 1995; Amaro & Gornemann, 1992; Perez-Jimenez et al., 2009; Pulerwitz, Gortmaker, & De Jong, 2000; Sears et al., 2011). Therefore, there is an urgent need for investigation of alternatives to condom use for reducing sexual risk among this population.

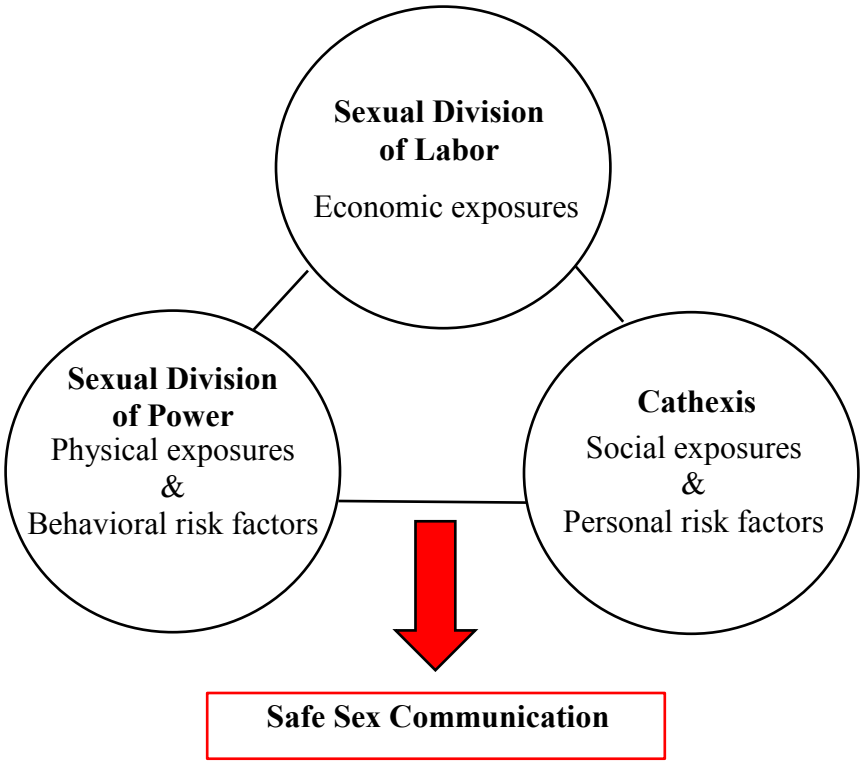
SSC may be an effective method of HIV/STI prevention among Caribbean and Latina women in stable relationships, including those in the DR. Past research has found SSC to be more comprehensive and specific among married couples compared to unmarried couples, which may include topics such as condom use, multiple partners or extramarital affairs, and health care seeking such as seeking STI treatment (Sivaram et al., 2005). These forms of SSC can lead to increased condom use (Moore et al., 1995; Noar, Carlyle, & Cole, 2007; Sheeran, Abraham, & Orbell, 1999; Sherry, Shedlin, & Beardsley, 1996), reduced HIV transmission (Saul et al., 2000), and increased HIV testing (Manopaiboon et al., 2007). However, most research on the topic is outdated and little is known about the experiences of Caribbean-Latina women. Therefore, the purpose of this qualitative descriptive study is to describe perceptions and experiences of communicating about safe sex with a stable male partner among women living in the DR.

Conceptual Framework

Wingood and DiClemente's adaptation of the s Theory of Gender and Power (2000, 2002) guided the development of the interview guide and assisted with interpretation of study results. The theory posits that there are three structures that, together, explain and constrain gender roles in heterosexual relationships and ultimately influence women's vulnerability to HIV/STIs. These structures are sexual division of labor, sexual division of power, and cathexis

(social norms and affective attachments). Figure 3.1 displays an adapted version of a diagram of the Theory of Gender and Power, where the structures within the theory influence specifically women's SSC, as opposed to women's general vulnerability to HIV/STI. Within this adapted diagram, the structure 'sexual division of labor' includes economic factors that affect SSC such as inequalities in educational attainment or wages, segregation of unpaid work (housework and childcare) to women, and spending power. The structure 'sexual division of power' includes physical exposures and behavioral risk factors that may influence SSC. For example, a woman is exposed to physical factors if she experiences interpersonal violence, has a high risk sexual partner, or has a partner who does not approve of SSC. She has behavioral risk if she has poor SSC skills, low SSC self-efficacy, limited perceived control over SSC, or high risk sexual behavior. The structure cathexis (affective attachments and social norms) encompasses social and personal factors that can affect SSC. Social factors may include being part of a community that holds conservative SSC or sexual behavioral norms, having an older partner, or being affiliated with a religion that is against SSC. Personal factors may include negative attitudes or beliefs about SSC, poor self-esteem, or acceptance of men's risky sexual behavior.

Figure 3.1 Wingood and DiClemente's Adapted Theory of Gender and Power



Methods

Study design, subjects, setting, and recruitment. This qualitative descriptive study was designed with phenomenological overtones. Data were collected from August to September of 2015 at Clínica de Familia in La Romana (Clínica de Familia), DR, a comprehensive care clinic that specializes in HIV care. The clinic provided 46,383 services to 8,524 clients in 2015 (Annual Report 2015 - Clinica de Familia, 2015). The study was approved by the Executive Director of Clínica de Familia, as well as the Columbia University Medical College Institutional Review Board and the DR National Bioethical Committee (Consejo Nacional de Bioética en Salud).

Convenience sampling was used to identify women who meet the following eligibility criteria: (a) users of Clínica de Familia (b) 18 years of age or older, (c) born in the DR and/or self-identify as Dominican, (d) have a current stable male partner, and (e) provide informed consent. The researcher collaborated with clinic staff to recruit women for the study. Nurses and doctors were informed of eligibility criteria for the study. When potentially eligible women came in for their scheduled visit, clinic staff used a short recruitment script to invite them to the study (Appendix A.3 and A.4). If women were interested, they then met with the researcher who provided a more detailed written and verbal explanation of the study purpose and requirements of participation. Verbal informed consent to participate and audio-record the interviews was solicited from women interested in being part of the study. Women were also provided with a study information sheet (Appendix A.5 and A.6). Women did not receive compensation for their participation but light refreshments were offered during the interviews. Recruitment continued until data saturation was achieved and new information on the main themes was no longer emerging.

Data collection.

Study instruments. A semi-structured interview guide with open-ended questions was used to facilitate one-on-one interviews in Spanish (Appendix A.7 and A.8). Topics were informed by Wingood and DiClemente's adaptation of the Theory of Gender and Power (2000, 2002). To avoid leading participants, constructs within the theory were not directly asked about (i.e. economic exposures, physical exposures, behavioral risk factors, social exposures, personal risk factors). Instead, participants were asked more general questions such as, "what can make it easier or more difficult to talk about safe sex topics with your main partner" and "how do you think expectations for women regarding safe sex and SSC affect how you talk with your partner about safe sex?".

Development of the interview guide was also informed by examples of interview guides and questions from past studies that have examined SSC (Alvarez & Villarruel, 2013; Crosby et al., 2002; Davila & Brackley, 1999; Huong, 2010; Hutchinson, 1998; Martinez-Donate, Hovell, Blumberg, & Zellner, 2004; Moore et al., 1995; Noland, 2006; Rispel, 2012; Prestage et al., 2006; Thurman, Holden, Shain, Perdue, & Piper, 2008; Whitaker, Miller, May, & Levin, 1999) andrecommendations from the literature on appropriate question topics, effective wording, and structure (Weiss, 1994). In pilot testing, five Dominican women with experience conducting research with Dominicans in New York City, a women's health nurse practitioner and Dominican physician working in New York City, as well as a physician and social worker at Clínica de Familia provided feedback regarding content and flow of the interview guide. The guide was also iteratively edited throughout the data collection period to improve flow, wording of questions, and content. For example, we found that the terms *pareja fija* or *pareja de*

confianza were better understood by participants than *pareja estable* for the translation of "stable partner".

The guide opened with general questions about safe sex and sexual risk, such as "what does 'safe sex' mean to you?". To elicit information about content of safe sex conversations, participants were asked to provide a concrete description of a recent discussion about safe sex topics. They were asked questions such as, "Can you tell me how the most recent conversation you had with your partner about safe sex went, starting from the beginning?" Probes were used to extend participant responses and to fill in details. Inner experiences were solicited through questions such as, "Could you tell me what thoughts or feelings you had during the conversation?". Participants were also asked about outcomes of talking about these topics. Then, information about non-verbal communication and other sexual risk reduction methods were elicited through questions, such as "If you decide to not talk with your partner about a safe sex topic, what other things do you do to protect yourself from STIs within your relationship?". Women were also asked about how they perceive that gender roles affect communication within their relationship. For example, "Being a woman, what do you think are the expectations for you when talking with your partner about safe sex?". The interviews ended with questions about how the participant learned to talk about safe sex topics within a stable relationship and if there was anything else she would like to share. A brief a seventeen-item questionnaire was also administered to collect demographic and sexual health information from participants (Appendix A.9 and A.10).

Translation of instruments. The interview guide and questionnaire were first translated from English to Spanish by the researcher and then reviewed and modified by the same five bilingual and bicultural Dominican women that consulted on interview guide flow and content.

The committee translation method was then used, in which a group of experts in both languages and the target population meet to discuss and decide upon the final translation (Brislin, 1970). Cultural de-centering was used, so that focus was placed on developing translations that were equivalent in content, semantics, and concepts across language and culture, as opposed to direct translation (Sechrest & Fay, 1972). Monolingual staff at the research site also confirmed translations for the interview guide.

Data collection procedures. Sixty to ninety minutes were allotted for each interview, which were audio recorded and conducted by the first author in Spanish in a private office at Clínica de Familia before or after the participant's scheduled appointment. The researcher started the encounter by asking demographic questions from the questionnaire. Then, the interview began. The researcher followed the interview guide, but allowed the participant set the pace for the interview and choose the specific information they wanted to share. The researcher redirected the participant and used probes to elicit further detail as needed. The encounter ended by completing the sexual health portion of the questionnaire. After each interview, the researcher took field notes on potential themes and observations of participant behavior. Interviews were continued until no new information regarding overarching themes was emerging, indicating that data saturation was reached. All data were de-identified. Two bilingual Dominican women living in New York City transcribed the audio files verbatim, and the researcher reviewed transcripts for accuracy

Data analysis. After the first interview, data analysis was on going and iterative to identify preliminary themes and identify when saturation was reached. Analysis of the Spanish transcripts was conducted by a research team comprised of the researcher, two bilingual

Dominican female physicians in New York City, and a nursing doctoral student who speaks fluent Spanish and has extensive research experience in the DR.

In accordance with Colaizzi's method of emergent content analysis (1978), throughout the analysis process, each member bracketed thoughts, feelings, and ideas. First, transcripts were read to gain a general idea of the body of data. Then, significant statements related to the purpose of the study were extracted and recorded in a new document. Next, significant statements from four transcripts were coded and the codes were organized into larger categories. This resulted in a preliminary code book that was agreed upon by team members. Significant statements from all transcripts were then entered into the qualitative data analysis software NVIVO (Version 10, QSR International Pty Ltd, 2014), and nodes (codes) and parent nodes (categories) were created from the code book. Within NVIVO, all significant statements were then organized into nodes and parent nodes. This was first done independently by two team members. Then, the two members met to discuss coding discrepancies. Consensus on coding was achieved by discussing reasons for independent coding choices and deciding on the most accurate and authentic reflection the women's accounts. A third party, familiar with the data, was consulted if consensus was not able to be achieved between the two analysts. Throughout the coding process, nodes and parent nodes were added, modified, and deleted to achieve more accurate analysis results. Once the final list of nodes and parent nodes was agreed upon by the team, the researcher determined the overarching themes of the data by grouping parent nodes together. The research team then discussed the results and final modifications to the analysis were made. Two members from the research team also met to discuss which quotes would be included in the manuscript as representative exemplars.

Triangulation methods. Once the analysis was complete, findings were verified by a group of five women at the Clinic, who shared similar characteristics to those who participated in the study. Discussion addressed the accuracy and completeness of the findings. Where needed, codes and categories were rearranged and missing examples of codes were added. Table 3.1 summarizes other steps taken to maximize methodologic rigor throughout the study.

Table 3.1 Methodologic rigor

Principles of rigor	Techniques	Examples from this study
Credibility	• Prolonged engagement	• Researcher planned study logistics with key informants at the study site. Extensive time spent in field throughout all phases of the study to learn and understand various aspects of the culture and social setting.
	• Triangulation	• Analyst triangulation, via four-person research team diverse in culture and discipline, used to ensure thorough elucidation of data.
	• Peer debriefing	• Peer debriefing occurred during team meetings surrounding data analysis
	• Referential adequacy	• Two researchers compared their independent coding findings for each step of the analysis and reached consensus on patterns emerging from the data.
Dependability	• Inquiry audit	• Decision trail recorded; analysis process described.
		• External audit of study processes and outcomes conducted by nurse researcher not involved in the project
Confirmability	• Audit trail	• Steps for managing, analyzing and reporting data were outlined in the study
	• Triangulation	• Source triangulation examined the consistency of different data sources by comparing women with different view points
		• Analyst triangulation of findings via four-person research team diverse in culture and discipline
	• Reflexivity	• Authors reported research perspectives, positions and assumptions in the manuscript. Reflexive journaling and team dialogue conducted throughout project
Transferability	• Thick description	• Researchers provided a detailed account of the settings, participants, and behaviors to illuminate the patterns of behaviors in context

Results

Eleven women completed interviews. One decided to stop the interview after five minutes. The average duration of interview was 38 minutes, ranging from 19 to 63 minutes. Table 3.2 summarizes participant characteristics. Two main themes emerged from the transcript data: context of sexual risk and SSC between partners. Table 3.3 summarizes the categories that comprise each theme and provides sample quotes from the transcripts.

Table 3. 2 Participant Characteristics

Characteristics	n or □ (range) ± SD
Demographic	
Age (years) *N* = 11	
Mean (range)	26.83 (19 – 42)
SD	± 6.2
Length of relationship with partner (years) *N* = 11	
Mean (range)	3.63 (.43 – 10)
SD	± 2.75
Religion *N* = 11	
Evangelical	4
Catholic	3
None	3
Adventist	1
Highest level of education achieved *N* = 11	
Primary (some or completed)	5
Secondary (some or completed)	3
Any post-secondary	3
Primary source of income *N* = 11	
Sell food or small items from home	3
Bodega	3
Domestic work	2
Massage	1
No paid work	2
Secondary source of income *N* = 10	
Family member	8
Child care	1
Sex work	1
Individual monthly income* *N* = 8	
Mean (range)	~ 166.30 (15.2 - 324.8)
SD	± 146.84
Primary financial provider in household *N* = 10	
Herself	3
Her partner	7
Sexual health	
HIV status *N* = 11	
Positive	4
Use condoms with stable partner during vaginal or anal sex	
Yes *N* = 11	4
Every time in the past 3 months *N* = 4	2

Notes: STI = sexually transmitted infection; HIV = human immunodeficiency virus;
* Estimated US dollar equivalence to Dominican pesos

Theme 1: context of sexual risk. The theme 'context of sexual risk' includes the categories: (1) the meaning of safe sex for stable partners, (2) behaviors related to sexual risk, (3) *confianza* (trust) between partners, (4) beliefs and attitudes related to sexual risk, (5) economic power within relationships, and (6) learning to manage safe sex within a stable relationship.

The meaning of safe sex for partners. Women described safe sex between stable partners as many things, such as getting to know your partner at the beginning of the relationship and not making assumptions about one's level of sexual risk based on their physical appearance, getting checked for STIs before having sex for the first time and periodically throughout the relationship, and using condoms with stable and casual sex partners. Women also said safe sex was not getting or giving an STI, being with only one partner, not getting pregnant, and both partners mutually taking care of one another.

Behaviors related to sexual risk. Women assumed that most men in relationships also have sex or relationships with other women in *la calle* (the street). Participants explained that having concurrent sexual relationships is also becoming more common among women, especially when younger women are in relationships with much older men. *La calle* was a word women used to refer to the environment and activities outside of the home, as well as having sex outside of their main relationship. They felt that the social atmosphere of *la calle* contributes to having additional concurrent sexual partners outside of one's main relationship, because of increased temptations that might arise when outside of the home, especially when consuming alcohol. Women also thought that *machismo* (male chauvinism) leads to having multiple concurrent sexual partners, because of the pride, entitlement, and power men often feel when they have more than one partner. Participants also expressed uncertainty about whether men use

condoms with their partners in *la calle*, and explained that within relationships condom use typically only happens for a short period at the beginning.

Women explained that relationships are often affected by lies and deceit among both partners, and that there is typically poor or no communication about sexual risk. These behaviors between partners make it more challenging to measure sexual risk. Instead, to determine if a man is unfaithful, women often resort to getting checked for HIV/STIs, paying more attention to their partner's behavior, or trying to catch him cheating. Women shared that if they learn their partner is unfaithful, she may start cheating on him as well or she may do nothing at all. Leaving the relationship was expressed as being very rare.

Abuse between partners was also reported to complicate the context of sexual risk. Women explained that physical violence is common among both the male and female partners and may often take the place of effective communication. They also reported men using forms of psychological and financial abuse to control their partner's behavior.

Confianza. *Confianza* directly translates to trust. However, women's accounts alluded that the meaning and existence of *confianza* between partners extends beyond presence or absence of trust. Between stable partners *confianza* often means not using condoms and assuming that the partner is either faithful or using safe sexual practices with other partners. It is also sometimes understood as an expectation of blind trust and total forgiveness. Therefore, lies and deceit within a relationship may not necessarily lead to less *confianza* between partners. However, many women reported that it is common for partners to not have *confianza* in one another. Still, condoms are often not used, and women anticipated that bringing up their use would be interpreted by their partner as a lack of *confianza* in his sexual behavior, an admission of her having additional sexual partners outside of their relationship, or admission of having an

STI. Women recognized how the complexities of *confianza* in relationships can increase sexual risk for the stable partners.

Beliefs and attitudes related to sexual risk. Participants expressed beliefs and attitudes that can lead to heightened sexual risk within relationships. For example, there are misconceptions among men and women that STIs can come from wearing tight underwear or pants, using well water to bathe, or the lubricant of condoms. Similarly, some believe condoms are only for people who have HIV and that birth control pills can prevent STIs. Also, women reported that many men and women do not like using condoms, especially with their stable partner, because they inhibit the physical and emotional experience of sex. Furthermore, some women believe it is not worth it to leave a relationship where there is risk if, for example, they believe their children would suffer, they would not find a new or better partner, or their partner would physically harm her or take revenge.

Economic power in relationships. Participants explained that some women are not able to get jobs, often due to having little formal education or a positive HIV diagnosis, which causes them to be financially dependent on their partner or participate in transactional sex with men outside of the relationship to obtain the things they need. This dependence was reported to potentially make it more challenging for them to leave a sexually risky relationship. Alternatively, participants perceived that women who do work are more able leave relationships or effectively encourage their partner to change risky sexual behaviors.

Learning to manage safe sex within a relationship. Participants reported that access to information about safe sex and sexual health in general is limited, and that few parents talk with their children about these topics. Additionally, the church in the DR has prohibited a national sex education program in schools. Participants reported that most women and girls get this

information from friends or at medical centers when they are pregnant. Information about SSC within a stable relationship was reported to be even sparser. Participants said that what is learned is typically acquired as a young girl through observing parent interactions, or in time through their own relationship experiences.

Theme 2: SSC between stable partners. The theme SSC between stable partners contains the categories: (1) reasons to talk about safe sex with your stable partner, (2) methods, content, and outcomes, (3) influential factors, and (4) ideas for improving SSC between partners. It is important to mention that of the women who volunteered their HIV status, those living with HIV and those not living with HIV expressed similar experiences of safe sex communication. The one notable difference was that women living with HIV often expressed more concern about protecting their partners from being infected compared to women who reported not living with HIV.

Reasons to talk about safe sex with your stable partner. Women stated that they talk with their partner about safe sex to prevent infections and also in reaction to events. For example, women may talk with their partner if he is acting in a sexually risky manner with her, such as removing a condom during sex. Women also reported starting conversations if they were to find evidence that indicates he may be having sex in *la calle,* such as a condom in his pocket or if he is texting on his phone often. Similarly, women report starting safe sex conversations after finding out he is being unfaithful by catching him or being told by someone else.

Methods, content, and outcomes. Participants reported that it is almost always the woman in the relationship who begins conversations about safe sex. They explained that conversations most often take place before or after making love, but women also mentioned the importance of determining when their partner was open to talking. Multiple methods were

reported to be helpful for starting and maintaining conversations such as showing affection, starting with a story of something that happened to her or another couple, asking her partner how he would feel if he was in her situation, and moving from small to large topics during the course of the conversation.

Women disagreed upon which topics were discussed or avoided, as in the case of discussing condom use within the relationship, having other sexual partners outside of the relationship, a positive HIV diagnosis, and symptoms of a possible infection. Many women said that they used the phrase, *cuídate* (take care of yourself) to indirectly advise their partners to practice safe sex with women in *la calle.* Others reported warning their partners to not judge the sexual risk of women in *la calle* by their physical appearance. Positive outcomes reported by participants from talking about safe sex topics were that the man changed his behavior and the relationship improved. Examples of negative outcomes reported were ultimately submitting to what her partner wants, her partner not changing his behavior, and her partner reacting negatively (i.e. becoming offended, angry or aggressive, denying her request to talk, or giving the silent treatment).

Influential factors. Relationship, participant, and partner factors were suggested by women to influence SSC within a stable relationship. Examples of relationship factors included religious affiliation, age difference between partners, trust, respect and love. Examples of participant factors included whether or not she was living with HIV or would accept that her partner had another partner, as well as her level of independence in the relationship and trust that her partner will not react to her communication violently or share their conversation with others. Examples of partner factors were whether he has a calm or violent personality, as well as his

level of education and endorsement of *machismo* ideologies (i.e. whether he accepts talking about condoms or thinks women have a say).

Ideas for improving SSC between partners. Women expressed that information regarding safe sex and SSC should be provided to men, the couple together, and women at home in addition to sex workers. Women reported that information would be most effective coming from teachers at schools, parents, doctors, or public chats and workshops. Examples of information they thought couples needed to improve SSC were: how to build *confianza* within the relationship, general values, and effective SSC method.

Table 3. 3 Themes with corresponding categories and example excerpts

Category	Example excerpts from transcripts
	Theme: Context of sexual risk
Meaning of safe sex for stable partners	"In this country, sometimes someone is with their partner and that partner has someone else and they don't use protection. So, safe sex is using a condom" (P22).
	"… try not to have another partner without having a medical check-up done. Why? Because I could have HIV, but it could be that the other partner that I am going to try to have a relationship with could have human papilloma virus. So, if he does not take care of himself, he could infect me more" (P10)
	"Mutually take care of one another, because an illness could be deadly" (P24)
Behaviors related to sexual risk	"…in the Dominican Republic, it's very rare that a man is with just one women [pause]. But, very rare" (P13).
	"… many [women] want to be with their partner even when they have another woman. But, they also look for a boyfriend, because then everything is the same and equal" (P22).
	"… [girls] focus on being with people much older than themselves. Much much much older. A fifty-year-old man for a twenty-year-old girl. So, because of that the twenty-year-old girl gets together with a younger guy, and is unfaithful to the older man" (P11)
	"You know how men are. Normally they never put on a condom" (P11)
	"For me, when they go out and come back drunk, they are having sexual relations. Because, they drink and grab a girl that they like and go to bed together" (P10)
	"… sometimes, when neither of the partners have communication, the couple takes the risk, because you know that the flesh is a temptation that many men cannot pass up" (P10)

	"… if I am being unfaithful to him and he asks me… I am not going to say, 'yes, I am [having sex with someone else]'… that is what always happens with couples… because maybe he is afraid that [if he says], 'ah, I have another woman', that I am going to leave him" (P26)
	"… all the types of *negocios* require and send you to the clinic [to be tested for STIs]. And for that reason, women that work in the *negocios* do not have HIV and venereal diseases. The ones who have it… are the woman at home" (P11)
	"He needs to know that he needs to take care of himself. Because of that… I take [my partner] to the doctor. Every time I have my appointment, he has to come. I show him my results, he also shows me his results… and when I go in with my doctor, he goes in with my doctor to talk, [and] I going in with his doctor to talk" (P25)
	"You want to reconcile and end well, and that is where the error comes, because they abuse you. Sometimes they do a kind of kidnapping, and with luck they let you live. Sometimes they have sex with you without you wanting" (P11)
Beliefs and attitudes related to sexual risk	"Sill [men] say, 'I don't use condoms. Why? So, I can't feel satisfied when I am with my woman?'" (P10)
	"Many do not use [condoms], because many say that… they don't have feeling with the condom, that it is not the same…" (P10)
	"I wouldn't want that, because of my insecurity, he gets tired and we end the relationship… then the children are going to suffer, they are going to end up more affected… and that would cause me pain" (P22)
***Confianza* between partners**	"Well, *confianza* for me is when one loves, they forgive everything, and they are blinded…" (P20)
	"… an example, it's her husband and she has *confianza*, and she has sex with him, and he is infected. Now he is going to infect you, too. It could be and STI, it could be HIV" (P12)
	"Imagine, the majority [of women] do not trust their partner" (P12)

Learning to manage safe sex within a stable relationship	"…one goes learning it by having… difficulties, problems in the relationship. It could be that the partner has let them down, and one goes picking up, for example… what is better for them… for one to have more communication with their partner, how to get along better… to have a better relationship" (P19)
	"No. How to fix or start communication with your partner, in terms of those topics, no [they do not teach that in schools]" (19)
	"… it wasn't so much that they sat us down and oriented us [on how to talk about safe sex topics], but instead that we saw in [our mother] that example and we followed that example" (P22)
	"… When we are pregnant, they give us chats about this and that [at medical centers]. They told me that women cannot have relations in *la calle*, and men either. Because… if you want to have *confianza* in your partner, you cannot be going around… That is why it is called looking for infections" (P12)
Economic power within relationships	"…because of not having a good economic situation you have to depend on the man… what can a woman do, who has three children, or who knows, four, who doesn't work, who has never become a professional, that everything that she eats, the man has to bring to the house? So, it's much more difficult to leave him, because there she thinks about her children and such" (P22).
	"Because of there is a lot of unemployment in this country, the men who have [economic] possibilities… make indecent proposals to women… even professors, they propose, 'Look, I'm going to do you a favor', and you need to know how to deal with that if you don't have a partner… who helps you in those economic ways" (P11).
	"More [economic] power... isn't going to control that the man looks at or is with another woman, but now she can decide if she wants to stay with him or not" (P22)
Theme: Safe sex communication (SSC) between partners	
Reasons to talk about safe sex	"I [usually start the conversation], because you know that usually the woman wants to protect herself from infections and things like that" (P24)
	"Sometimes the conversation is provoked like that, when we women see how the husband is acting with one. Because, sometimes, when the man has a woman outside of the house, he treats the woman at home poorly" (P23)

	"Sometimes there are women who are living with your husband, and because of that woman you realize [what's going on], because she comes to you looking for problems. [Pause]. They want to cut you, they want to grab you, do you understand? And there we go into discussions…." (P25)
Methods, content, and outcomes	"[we talk about these topics] when we are (pause), well in few words, we finish making love, we are good, we are happy, we are relaxed (nervous laugh)" (P13)
	"… I tell him, if I would do that, go out to *la calle* looking for another partner, how would he feel? And he explains how he would feel, and I tell him, 'Well that's the same way I would feel if you were to do it'…" (P20)
	"… you pass your hand over his head… Then, if the person is angry, they start cooling down, because one says to them, 'my love, I love you, I want you, I adore you, but relax. Breath deep. Please, we are going to talk civilized like two people. We are two adults, we can resolve things without fighting and without arguing" (P23)
	"One says, 'My love, look, if you are going to go out to *la calle* or whoever, you can put on a condom. I don't want that you come and get me sick'. The majority of women do that" (P12)
	"I asked him, 'Are you with someone else?', and he told me he was" (P21)
	"We don't talk about [whether he has other women] anymore. I just tell him that he should take care of himself and that there are condoms and things like that. Because, if I start talking to him... what he will do is become upset" (P25)
	"When a wife or normal couple wants to say something to the other about protection or something, the first thing they say to you is, 'I'm not with anyone else. I'm with you. If you give me something, you are the one who is going to give it to me'. They always try to put the blame on the other person, even though they know they are [having sex with] half the world out there" (P13)
	"He sometimes, once, hit me. He hit me. I had my teeth, and he, hitting me, knocked out this tooth, because of a woman" (P25)
	"… there are many men who now have changed their routine, because now there are women who don't put up with anything… from any man" (P22)

Influential factors

"… it depends on the character of the man. Often it is hard, because if one doesn't have sufficient *confianza*, there are topics they can't talk about, because they are scared that the man will be aggressive towards them or respond in an offensive way…" (P20)

"…mainly respect, on top of everything… We are going to try to understand one another, to respect one another. Because if you respect me, I respect you, and you don't do to me what you don't like, and I don't do to you what I don't like, and that's how you get along well together…" (P20)

"… in my case, well, I feel I have the right [to talk about these topics], because in reality he works, but I am at home doing everything with the children, and just for that reason, I feel I have the right to ask. Because I am taking care of my family and him too..." (P22)

"There are partners who don't know how to talk. Instead of talking, they fight, argue. One throw something over there, the other is throwing another thing over there" (P23)

"'If you don't want to be with me, then, even better, leave'. That is a *machista* man and a brutality… he doesn't see the problem and you continue explaining it to him. Reason doesn't enter. For that reason, I say it's *machismo*" (P13)

"… I don't like to speak badly to people. There are others who don't mind saying anything. So, that depends on… the attitude of shyness that someone has" (P22)

"There are still women who accept that the man has another partner. Even knowing, it they prefer to keep quiet" (P22)

	"Most men have that way of saying to women… 'Go home and do your job. You are too annoying'. Those are the things that women find difficult. How the man treats her. Sometimes the woman says, 'No, well, my husband is going to talk poorly to me, he's going to say mean things, it's better I don't say anything'" (P23)
	"Sometimes I think, 'Dang! From attacking him so much, it's going to become true [that he is with another woman]'" (P22)
Ideas for improving SSC between partners	"I think that if they start giving chats outside of the institution [Clínica de Familia], and don't focus as much on the women in the *negocios*, but on the women who are at home, as they are the ones that mostly [have risk of STIs]…" (P11)
	"If both [partners] are there [at the talk], you are going to see how they look at each other… you're going to see when they are beginning to move their head, and that yes you are right. I'm sure that everything is going to get fixed, because… she is going to start to say to them, 'No, what happens is that he is this and that', and he is going to start, 'She does this and that', and I think that it will go from there, because everything starts with a third person" (P11)
	"I would suggest to her that, that it is best to tell him the truth [that she has another partner]. Tell him the truth. Sit and talk with the partner, and tell him what is happening. That there you will see more *confianza,* there you will see more communication, and you will see more union" (P10)

Notes: STIs = sexually transmitted infections; HIV = human immunodeficiency virus; *la calle* = the street/outside of the relationship; *negocio* = bar where sex workers serve alcohol; *confianza* = trust; *machista*/*machismo*= male chauvinism

Discussion

This study presents the findings of an analysis of eleven interviews conducted with women in the DR about their experiences discussing safe sex topics with their stable partner. Two themes, context of sexual risk and SSC between partners, summarize the data and closely align with constructs within Wingood and DiClemente's adapted Theory of Gender and Power (2000, 2002). Findings contribute to an updated understanding of this HIV/STI risk behavior among one group of Latina women and compliment past HIV prevention research conducted with men in the DR.

Results in the context of the theory of gender and power.

Sexual division of labor: economic factors. In addition to our study, others conducted in the Caribbean have found that poverty and financial dependence on one's partner create barriers to leaving relationships and cause women to be more inclined to participate in transactional sex outside their relationship, as a way of earning money (Panos Caribbean, 2012). Similarly, as found in our study, if Latina women are more committed to maintaining the relationship, they may be less likely to discuss safe sex topics with their partner (Saul et al., 2000).

Sexual division of power: physical exposures and behavioral factors. Women explained that it is common for men in the DR to have concurrent sex partner(s) in *la calle*. Other studies have also found having additional concurrent sexual partners outside of one's main relationship to be common among Dominican men in relationships (Barrington & Kerrigan, 2014; Panos Caribbean, 2012; Guliamo-Ramos et al., 2013). Similarly, women in our study expressed concern about men assessing the sexual risk of women in *la calle* based on their looks or reputation, a behavior corroborated by past studies conducted with men in the DR (Alvarez & Villarruel, 2013; Barrington & Kerrigan, 2014; Fleming et al., 2014).

As in this study, other reports have found that if Latino men do not want to use condoms, women often comply (Davila, 2002). Other studies conducted in the DR also found that condom use with sex workers is lower among Dominican men who consume greater amounts of alcohol (Barrington, 2008), and that drinking alcohol and having sex often occur together (Guliamo-Ramos et al., 2013). Furthermore, these studies corroborate that men often stop using condoms with concurrent sex partners, including sex workers and tourists, if they have sex with their concurrent partner regularly (Barrington, 2008; Barrington & Kerrigan, 2014; Guliamo-Ramos et al., 2013).

Past studies provide additional evidence that lies and deceit contribute to sexual risk in the DR. Specifically, results show that men do not disclose having additional sex partners outside of the relationship to their stable partner (Guliamo-Ramos et al., 2013) and often lie to others in their social networks about using condoms and other aspects of their sex life (Barrington & Kerrigan, 2014). Similarly, *confianza* has been found to influence safe sex and SSC in past studies with Latina women. For example, having *confianza* that their partner would maintain confidential the information exchanged lead to Latina women being more open to talking about safe sex (Alvarez & Villarruel, 2013). However, as in our study, greater *confianza*, when understood as security with one's partner, could result in less discussion of safe sex topics (McQuiston & Gordon, 2000).

Further, trust and understanding (McQuiston & Gordon, 2000), as well as greater intimacy and love (Castaneda, 2000) have been reported to facilitate communication. In contrast, fear of or past experience of physical, psychological and sexual abuse (Davila, 2002; McQuiston & Gordon, 2000) impede communication. As in this study, women's perceptions of their male partner's attitude or reaction towards SSC (Alvarez & Villarruel, 2013; Alvarez & Villarruel,

2015; Davila, 2002; Fleming et al., 2014) and endorsement of *machista* behaviors and attitudes (Alvarez & Villarruel, 2013) had an impact on SSC.

A report on infidelity and concurrent sexual partners in the Caribbean corroborates the finding from this study that more women are being unfaithful to their husbands in the DR, and posits that this may be happening more as gender roles transform and women begin to feel they have the same right to cheat as their partner (Panos Caribbean, 2012). Living with HIV is another behavioral risk factor that has been found to affect SSC for other Latina women (Padilla et al., 2008).

Cathexis: social exposures and personal factors. Similar to women's reports in our study, other studies with Dominican men have found it to be socially normal for them to be proud of having multiple concurrent partners (Panos Caribbean, 2012; Guliamo-Ramos et al., 2013). The norm of resignation or acceptance of this behavior by women was also noted by Latina women in an earlier study (McQuiston & Gordon, 2000). Also, like in our study, being an Evangelic Christian has been linked to less sex outside of the main relationship and better SSC than among other Latino couples (Ashburn et al., 2008).

Women's beliefs and attitudes towards safe sex were reported to influence SSC in this study, as well as past studies. Particularly, an attitude of not wanting to talk about these topics (Alvarez & Villarruel, 2015) or not wanting to know if their partner was being unfaithful (Alvarez & Villarruel, 2013) were found to be barriers for other groups of Latina women. Additionally, negative attitudes toward condoms was associated with Latina women feeling ambivalent about using them, resulting in inconsistent negotiation of condom use with their partner (Pulerwitz & Dworkin, 2006).

SSC as a form of women's vulnerability to HIV/STIs. Discussing sexual topics to get to know one's partner at the beginning of the relationship was one approach to safe sex for women in our study and others with Latina women (Pulerwitz & Dworkin, 2006). For example, one study found that women would ask their new partner how many sexual partners he has had to determine whether he is likely to have an STI (Alvarez & Villarruel, 2013). Also, like the Dominican women in this study, other Latina women have reported using the phrase *cuídate* with their husbands to encourage safe sex practices outside of their relationship (Barrington & Kerrigan, 2014; Pulerwitz & Dworkin, 2006).

A study conducted with Latina women in the US found methods similar to our study to be helpful during safe sex conversations. For example, showing men affection and avoiding accusations, as well as talking about using condoms in the context of preventing pregnancy. Starting with an anecdote of another couple or something that directly happened to the woman, also enabled women to reflect with their partner on aspects of sexual risk in their relationship (Pulerwitz & Dworkin, 2006).

Using indirect methods and vague messages such as *cuidate* to communicate appears to be one of the most comfortable and common ways to talk about sexual risk and risk reduction among women in the DR, unlike research with other populations that found communication to be comprehensive and specific among stable partners (Sivaram et al., 2005). Furthermore, past research with Dominican men has found that encouragement to use condoms from anyone in their social network was not associated with condom use (Barrington et al., 2009). Also, as was found in our study, despite women's efforts to negotiate safe sex, men still often had the last word (Davila, 2002; McQuiston & Gordon, 2000). A better understanding is needed of what

communication methods and messages, as well as who could effectively motivate men in the DR to reduce sexual risk behavior.

Limitations. Although efforts were made to reduce bias among the research team members, qualitative data analysis requires some level of subjectivity related to the methods judged to be most accurate, findings considered most appropriate, and the communication of conclusions. One of the main limitations of this study was respondent bias. Because the researcher who conducted the interviews was not of the same cultural or ethnic background and sensitive information was being discussed, participants may have been more likely to withhold information to protect their privacy or not reveal unpleasant truths.

Conclusion

Communication about safe sex in the context of a relationship is complex and often challenging for women in the DR. Improving and encouraging its use could be a viable method of reducing risk of HIV and STIs among women with stable partners in the DR. However, it must be addressed within the context of close relationships and the sexual culture in the DR. Future research should examine which factors have the greatest influence on SSC and the role of the male partner in these interactions.

Chapter four: Psychosocial correlates of safe sex communication for women with stable partners living in the Dominican Republic

Chapter four addresses aims three (describe participant characteristics related to sexual power within relationships and safe sexual communication (SSC) and four (assess correlations between SSC and characteristics related to sexual power within relationships) of the dissertation using survey data collected between October 2016 and January 2017.

Abstract

The proportion of human immunodeficiency virus (HIV) cases in the Dominican Republic (DR) that are women has increased from 27% in 2003 to 51% in 2013. SSC may be a feasible and effective method of HIV prevention for women with stable partners in the DR, but more information about which factors influence SSC among this population is needed. The purpose of this study was to describe characteristics related to sexual division of power, sexual division of labor, cathexis and SSC and assess the correlation between SSC and these characteristics. In this cross-sectional survey study guided by the Theory of Gender and Power, 100 adult Dominican women in stable heterosexual relationships were recruited from a comprehensive care clinic in La Romana, DR and interviewed. Logistic regression was used to identify correlations between SSC and various factors of sexual power in relationships. Mean age of participants was 35.7 years, average relationship length was 8.5 years, and 46.9% were living with HIV. The most parsimonious multiple regression model yielded two independent variables with significant associations with SSC: SSC self-efficacy (*OR* = 0.12, 95% confidence interval = 0.04 – 0.37) and difference in age between partners (*OR* = 12.38, 95% confidence interval = 0.2.23.8668 – 0.). Future HIV and sexually transmitted infection (STI) prevention research that focuses on SSC between Dominican women and their stable partners should aim to better

understanding how to improve SSC self-efficacy, particularly among women in relationships in which there is a significant age gap between partners.

Background

In 2015, 1% of adults in the DR were living with HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2015). Women in the DR are especially vulnerable to HIV (M. Padilla et al., 2008; Rojas et al., 2011) as evidenced by a shift in the burden of HIV from men to women. In 2003, 27% of all recorded HIV cases in the DR were among women (UNAIDS, 2004), as compared with 51% in 2013 (UNAIDS, 2013).

Despite having risk for HIV and other STIs, women in stable heterosexual relationships have not received adequate attention in past HIV/STI prevention efforts in the DR. Up to 38.7% of Dominican men, including those in a stable relationship, report more than one sexual partner in the previous twelve months, compared to 7.8% of Dominican women (Centro de Estudios Sociales y Demográficos [CESDEM] & ICF International, 2014). At the same time, as few as 0.4% - 4% of married or cohabitating partners (CESDEM & ICF International, 2014; Halperin, de Moya, Perez-Then, Pappas, & Garcia Calleja, 2009) report using condoms compared to non-married, non-cohabitating men and women who report condom use 68% and 40% of the time (Halperin et al., 2009). Low rates of condom use among stable partners may be related to the commonly held belief among Dominicans that condoms should be used with causal sexual partners and sex workers, but not in relationships where trust has been built (Kerrigan et al., 2003; Kerrigan et al., 2006; Perez-Jimenez et al., 2009).

Improving safe sex communication (SSC) may be a more feasible and effective method than condom use for women to reduce their risk of HIV within their relationships. SSC refers to verbal or non-verbal relaying of information to one's partner regarding methods of HIV/STI

prevention. It includes activities such as negotiating condom use, sharing one's sexual history or asking about a partner's sexual history, discussing HIV/STI testing and results, and notifying a partner of a new HIV/STI diagnosis or other concurrent sexual partners. Researchers have reported that SSC is associated with increased HIV testing among husbands (Manopaiboon et al., 2007), as well as reduced HIV transmission (Saul et al., 2000) and increased condom use (El-Bassel et al., 2003; Noar et al., 2006) among stable partners.

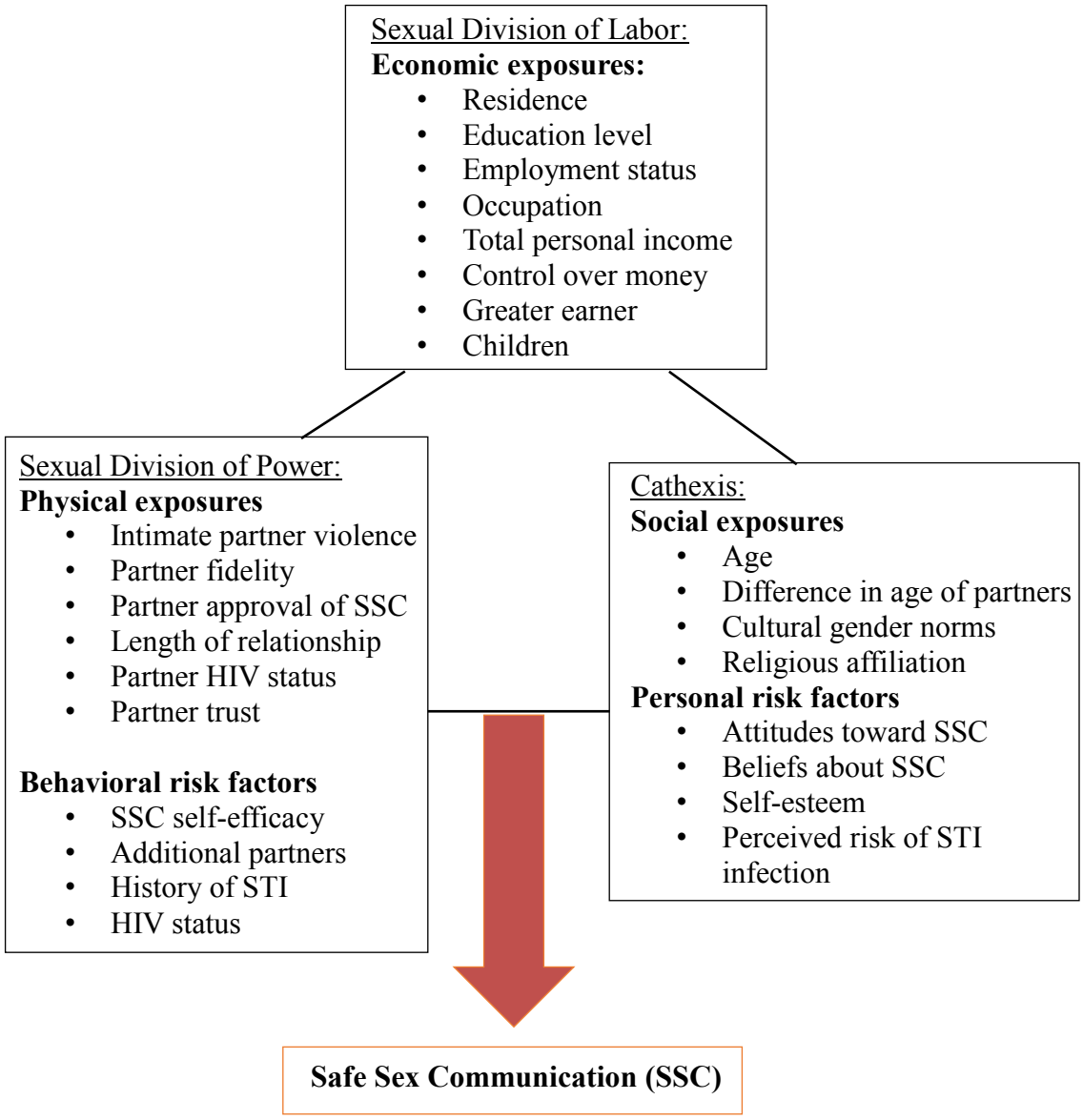
A preliminary qualitative study elucidated multiple barriers and facilitators of SSC among women in stable relationships living in the DR (see chapter 3). However, it remains unclear which factors are most related to SSC among this population. Therefore, the aims of this cross-sectional survey with Dominican women who are in stable heterosexual relationships are to: (1) describe characteristics related to sexual division of power, sexual division of labor, cathexis (structure of affective attachments and social norms), and SSC and (2) assess the correlation between SSC and these characteristics.

Conceptual Framework

This study is grounded in Wingood and DiClemente's adaptation of the Theory of Gender and Power (2000, 2002), which is specific to both women and the risk of HIV and STIs. It proposes that women's vulnerability to HIV and STIs is influenced by culturally bound gender roles that favor men and lead to decreased power over sexual risk for women. In this study, we examine SSC, particularly poor SSC, as one form of vulnerability to HIV/STIs. The inequalities proposed in this theory are perpetuated by three structures: sexual division of labor, sexual division of power, and cathexis (affective attachments and social norms). Sexual division of labor refers to economic factors that influence SSC. Sexual division of power refers to physical exposures and behavioral factors that affect SSC. Cathexis includes social exposures and

personal factors that affect SSC. This theory guided the selection of variables (Figure 4.1), development of the survey, and data analysis methods.

Figure 4.1 Study variables according to the Theory of Gender and Power



Methods

This study was approved by the Director of La Clínica de Familia in La Romana (Clínica de Familia), the study site, as well as the Columbia University Medical College (CUMC) Institutional Review Board (IRB) (protocol #AAAP2405) and the DR Consejo Nacional de Bioética en Salud (CONABIOS) (protocol #015-2015).

Study site and research team. Data were collected from October through November, 2016 at Clínica de Familia, located in the southeastern region of the DR. In 2015, Clínica de Familia had over 48,000 patient visits, providing services that included HIV care, STI care, primary care, pediatrics, cardiology, diabetes, gynecology and obstetrics, and family planning services, among others. The clinic provided over 46,383 services to over 8,500 clients in 2015 (Annual Report 2015 - Clinica de Familia, 2015). I have been collaborating with Clínica de Familia since January 2015, and worked closely with clinic personnel to plan the development and implementation of this study. The research team for this study was comprised of the principal investigator (PI) and a Dominican health promotor, who has nine years of experience working in various areas within Clínica de Familia, including nursing and data entry. Both the PI and health promotor have had previous training and experience conducting surveys with clinic clients.

Study sample and recruitment procedures. Convenience sampling was used. Women were eligible to participate if they: (a) were clients of Clínica de Familia, (b) were 18 years of age or older, (c) were born in the DR and/or self-identified as Dominican, (d) reported they are in a stable heterosexual relationship (three months or more with the same male partner), and (e) provided informed consent to participate. To recruit participants, the health promotor collaborated with physicians, nurses, and social workers at the Clinic following a brief

recruitment script to invite potentially eligible clients to participate in the study (Appendix A.11 and A.12). If the clients expressed interest, they were referred to the health promotor, who provided a more detailed verbal and written description of the purpose of the study, requirements of participation, and voluntary nature of participation, and asked if participants had any questions. If participants wanted to participate, the health promotor verified eligibility and obtained verbal consent (Appendix A.13 and A.14).

A power analysis on the primary outcome variable, level of SSC, indicated that with 100 participants, a medium effect size (~0.6 *SD*) would be identifiable with 84% power. Therefore, recruitment continued until 100 eligible women completed the survey.

Variables and measurement. The *main dependent (outcome) variable*, SSC, was measured by a tool containing seven items, created by combining items from existing psychometrically tested scales (Alvarez, 2012; Alvarez & Villarruel, 2015; Moore et al., 1995; Saul et al., 2000). An example item is, "Have you ever talked with your partner about the risk of sexually transmitted infections?" Response options were dichotomous, "Yes" or "No". For the item that asked, "Have you ever asked your partner to change his behavior to not get a sexually transmitted infection?", if the participant replied "Yes", she was then asked to specify, "What have you asked him to do or change?". A single summed score (range 0-7) was calculated by adding the number of "Yes" responses for each of the seven items.

Independent (predictor) variables were risk factors proposed by the Theory of Gender and Power, corresponding to sexual division of labor (economic exposures), sexual division of power (physical exposures and behavioral risk factors), and cathexis (social exposures and personal risk factors). Variable selection was also informed by findings from the previous qualitative study (chapter 3) and results from the integrative review on the psychosocial

correlates of SSC between Latina women and their stable male partners (chapter 2). Table 4.1 summarizes characteristics of the items and measures used to assess each variable.

Table 4. 1 Description of items and scales used to measure included variables

Variable	Source/Name	# Items, Example	Type of Scale	Response Options	Scoring
		Primary Outcome			
Level of safe sex communication	Newly developed	• 7 • "Have you ever talked with your partner about the risk of sexually transmitted infections?"	Dichotomous	Yes/No	• Single summed score • Range: 0-7 • Final scores recategorized as "Discussed all SSC topics" (score = 7) & "Discussed some or no SSC topics" (score = 0 – 6)
		Sexual Division of Labor: Economic Exposures			
Residence	DR DHS*	• 2 • "In what province do you live?"	Categorical	Open-ended	• Scores recategorized as "La Romana" & "Other"
Education level	DR DHS*	• 1 • "What grade did you reach in school?"	Ordinal	No Formal education (0) – Post-secondary (3)	• Higher score = greater level of education

Employed in past 12 months	DR DHS*	• 1 • "Have you worked in the past 12 months?"	Dichotomous	Yes/No	NA
Occupation	DR DHS*	• 1 • "What type of work you do?"	Categorical	Open-ended	• Responses categorized using content analysis into "service" or "business/sales"
Total personal monthly income	Newly developed	• 1 • "How much do you earn each month in Dominican pesos?"	Continuous	Open-ended	• Scores recategorized as ≤ $210 or > $210
Control over participant's money	DR DHS*	• 1 • "Who generally decides how to spend the money that you earn"	Categorical	You, your partner, both or other	• Scores recategorized as "Herself" or "her partner or both"
Greater earner in household	DR DHS*	• 1 "Would you say that the money you earn more than, less than, or the same as what your partner earns?"	Categorical	More than, less than, or same as what your partner earns, or partner does not have income	• Scores recategorized as "Herself or partner does not have income" and "her partner"
Number of dependent children	Newly developed	• 2 • "How many children live with you?"	Ordinal	Fill in the blank	NA

Sexual Division of Power: Physical Exposures					
Intimate partner violence	Women Abuse Screening Tool – Short Form (WAST-SF) (Fogarty & Belle Brown, 2002)	• 2 • "Do you ever feel frightened by what your partner says or does?"	Ordinal	Often, Sometimes, Never	• Positive responses scored as 1; negative responses scored as 0. • Single summed score • Range: 0-2 • Scores of 1 or 2 are considered positive for abuse
Partner trust	Dyadic Trust Scale (Larzelere & Huston, 1980)	• 8 • "Your partner treats you fairly and justly"	Ordinal	• 5-point Likert Scale • Completely disagree (5) – Completely agree (1)	• Items 3,4,5,7, 8 reverse scored • Single summed score • Ranges: 8-40 • Lower score = greater partner trust
Possibility partner has sex outside of relationship	Sexual Relationship Power Scale (SRPS) (J. Pulerwitz et al., 2000)	• 1 "Your partner could be having sex with someone else"	Categorical	• Yes, No, Do not know	NA
Partner approval of SSC	Modified Perceived	• 7	Ordinal	• 5-point Likert	• Single mean score

	Partner Approval about Sexual Communication Scale (Alvarez, 2012)	• "How much would your partner accept talking about the risk of sexually transmitted infections?"		• A little (1) – A lot (3)	• Higher score = more positive perceived partner approval
Length of relationship	Newly developed	• 1 • "How long have you been together?"	Continuous	Fill in the blank	NA
Know partner's HIV status	Newly developed	• 1 • "Do you know the HIV status of your partner?"	Dichotomous	Yes/No	NA
Source of information of partner HIV status	Newly developed	• 1 • "Did you find out from your partner or someone else?"	Dichotomous	Partner/Someone else	NA
		Sexual Division of Power: Behavioral Risk Factors			
SSC self-efficacy	Modified Sexual Communication Self-efficacy Subscale (Quinn-Milas et al., 2015)	• 7 • "How capable do you feel to talk with your partner about the risk of sexually transmitted infections?"	Ordinal	• 5-point Likert • Not capable (1) – Very capable (5)	• Single mean score • Range: 1-5 • Higher scores = higher SSC self-efficacy
Number of sex partners in past year	DR DHS*	• 1 • "In the past 12 months, including your partner, with how many different people have you had sex?"	Ordinal	• Fill in the blank	NA

Last sex sexual activity with partner	Newly developed	• 1 • When was the last time you had sex with your stable partner?	Ordinal	• Fill in the blank	NA
History of STI	DR DHS*	• 1 • "In the past 12 months, have you had a sexually transmitted infection"	Dichotomous	Yes/No	NA
HIV status	2 items from DR DHS* 1 newly developed item	• 3 • "Have you ever had a test to see if you have HIV, the virus that causes AIDS?"	• Dichotomous • Ordinal • Dichotomous	• Yes/No • Fill in the blank • Positive/Negative	NA
Cathexis: Social Exposures					
Age	DR DHS*	• 1 • "How old are you"	Continuous	Fill in the blank	NA
Age difference between partners	Newly developed	• 1 • "How old is your partner?"	Continuous	Fill in the blank	• Subtract age of participant from age of partner • Scores recategorized as "Woman is older or same age" and "Woman is younger"
Gender norms for sexual behavior	Sexual Gender Norms Scale	• 15 • "Women like for men to take control during sex"	Ordinal	• 5-point Likert • Strongly disagree (1) –	• Single mean score • Range: 1- 5

	(Alvarez, 2012; Perez-Jimenez, Varas-Diaz, Serrano-Gracia, Cintron-Bou, & Cabrera-Aponte, 2004)			Strongly agree (5)	• Higher scores = greater credence in sexual gender norm stereotype
Religious affiliation	DR DHS*	• 1 • "What religion do you belong to?"	Categorical	None, Evangelic, Adventist, Catholic, Protestant, Other	NA
		Cathexis: Personal Risk Factors			
Attitudes about SSC	Modified Attitude Toward Sexual Health Communication Subscale (Alvarez, 2012)	• 7 • "Talking with your partner about the risk of sexually transmitted infections is…"	Ordinal	• 3-point Likert Scale • A bad idea (1) – A good idea (3)	• Single mean score • Range of 1-3 • Higher scores = more positive attitudes towards SSC
Beliefs about SSC	Modified Behavioral Beliefs Subscale (Alvarez, 2012)	• 4 • "If you asked your partner to use a condom, he would think you are having sex with other people"	Ordinal	• 5-point Likert Scale • Completely agree (1) – Completely disagree (5)	• Single mean score • Range: 1-5 • Higher scores = less belief in negative outcomes from talking to one's

					partner about safe sex
Self-esteem	Rosenberg Self-esteem Scale (RSE) (Martín-Albo, Núñez, Navarro, & Grijalvo, 2007)	• 10 • "On the whole, you are satisfied with yourself"	Ordinal	• 4-point Likert Scale • Strongly agree (1) – Strongly disagree (4)	• Items 2, 5, 6, 8, 9 are reverse scored • Single summed score • Range:10-40 • Higher scores = higher self-esteem
Perceived risk of STI	Modified Partner Specific Risk Perception Scale (Reisen & Poppen, 1999)	• 1 • "How likely do you think it is that you would get a STI if you had sex with your partner without using a condom?"	Ordinal	• 5-point Likert Scale • Not at all likely (1) – Extremely likely (5)	• Higher scores = higher perceived vulnerability • Scores recategorized as "Very likely (likely, very likely, extremely likely)", "somewhat

likely”, “not at all likely”

Notes: DR = Dominican Republic; DHS = Demographic health survey; STI: = Sexually transmitted infection; HIV = Human immunodeficiency virus; NA = Not applicable; *(CESDEM & ICF International, 2014)

Development of the Study Instrument. Measures and items included in the survey were organized according to guidelines provided by Dillman and colleagues (Dillman, Smyth, & Christian, 2014). For example, grouping similar questions, starting with "interest getting" questions relevant to the purpose of the study, placing sensitive questions towards the end, asking questions in the order that events occurred, and asking general questions before specific questions.

Prior to administering the survey, it was reviewed by two staff members from Clínica de Familia who had experience collecting survey data from the clinic population and expertise in the content of the survey and meet eligibility criteria for the study. First, they independently examined the flow, order, clarity, and face validity of the survey. Second, the researcher met with both women together to solicit their feedback and reach consensus on any changes the women thought needed to be made. This same process was conducted with a committee comprised of a physician and two directors from Clínica de Familia who had experience conducting surveys with the study population. The PI and health promotor then pilot tested the instrument with five clinic clients who met eligibility requirements for the study.

Ultimately, the wording of some questions and response options were modified to be more understandable or improve face validity, and response options for some items were reduced. For example, the item from the self-esteem scale, "You feel you do not have much to be proud of" was re-written in a positive format, "You feel you have much to be proud of", and corresponding response options were reverse coded. SSC self-efficacy items and response options were modified to ask "How capable do you feel…", as opposed to "How difficult is it for you….". Also, all items phrased in the first person (i.e., "I feel I can trust my partner completely") were changed to be phrased in second person (i.e., "You feel you can trust your

partner completely"). Response options were reduced and simplified for the following items: education level, partner sex outside of their relationship, partner attitude about SSC, and participant attitudes about SSC. Additionally, the survey was re-organized to end with some basic demographic questions. Table 4.2 summarizes development methods and psychometric properties of the original measures, as well as modifications made to the measures for use in this study. The final version of the full survey can be found in Appendix A.15 and A.16.

Test-rest reliability of the survey was examined. We created a shortened version of the survey (Appendix A.17 & A.18) with variables perceived to remain stable over time (i.e., number of dependent children, religion, monthly income, control over participant's money) and ten women who completed the full survey completed the short version of the survey from two to five weeks later. Percent agreement was calculated between participant responses to the same question at the two time points. Because most measures were modified substantially to reflect the aims of this study and there was little correlation between items within the measures since each of the items measured different constructs, internal consistency testing (Cronbach's alpha) of the modified scales among this study population was not appropriate.

Table 4. 2 Development, modification, and psychometrics of included items and scales

Variable	• Scale name • Language	• Development of original scale • Sample • Modification	Internal consistency	Validity	Use
Level of safe sexual communication	• Newly developed • Spanish	• *Development:* Combined items from existing scales (C. Alvarez & A. Villarruel, 2015; Alvarez, 2012; Moore et al., 1995; Saul et al., 2000), with new items based off of qualitative findings with similar sample	*NA*	• Content experts and key informants consulted	*NA*
Intimate partner violence	• Women Abuse Screening Tool – Short Form (WAST-SF) (Fogarty & Belle Brown, 2002) • Spanish	• *Development:* Items correlated most with full scale included in final scale • *Sample:* Latina women from Texas, Mexico, Puerto Rico, Latin America, and the US • *Modification:* A positive response to either question was considered positive for abuse	• □ = .91	• 94% specificity • 89% sensitivity	(Díez et al., 2009; Fogarty & Belle Brown, 2002)
Possibility partner has sex outside of relationship	• Sexual Relationship Power Scale (SRPS) (J. Pulerwitz et al., 2000) • Spanish	• *Development:* Exploratory factor analysis on newly developed items based on Theory of Gender and Power, Social Exchange Theory, and focus group findings • *Sample:* Women in the US, majority Latinas	• □ = .88 *	• Items and scale based on theory • Construct validity correlations (All $p < .01$): 1. History of physical violence	(Matsuda, McGrath, & Jallo, 2012)

		• *Modification:* Only one item from the scale used for proposed study		2. Current IPV 3. Satisfaction with current relationship 4. Consistent condom use	
Partner approval of SSC	• Modified Perceived Partner Approval about Sexual Communication Scale (Alvarez, 2012) • Spanish	• *Development:* Exploratory factor analysis on items taken from existing scales • *Sample:* Latina women in the US • *Modification:* Removal of sexual pleasure items, addition of STI risk communication items, responses reduced and changed to: a lot, indifferent, a little	• □ = .79 **	NR	(Alvarez, 2012)
SSC self-efficacy	• Modified Sexual Communication Self-efficacy Subscale (Quinn-Milas et al., 2015) • English	• *Development:* Exploratory factor analysis on items developed from literature review and content experts • *Sample:* Male and female adolescents in the US • *Modification:* Addition of STI risk communication items; removal of contraceptive communication and positive/negative sexual messages items, items and responses changed to scale capability instead of difficulty talking about topics	• □ = .82 - .83 **	• Consultation with content experts and key informants	(Quinn-Milas et al., 2015)

Gender norms of sexual behavior	• Sexual Gender Norms Scale (Perez-Jimenez et al., 2004) • English	• *Development:* NA • *Sample:* Latina women in the US	□ = .70	NR	(Alvarez, 2012; Perez-Jimenez et al., 2004)
Partner trust	• Dyadic Trust Scale (Larzelere & Huston, 1980) • English	• *Development:* Exploratory factor analysis of borrowed and adapted items • *Sample:* Men and women in the US of various ethnicities	• □ = .93	• Construct validity correlations: 1. Social desirability: r = .02, p >.05 2. Generalized trust: r= .05, p >.05 3. Love: r = .47, p < .001	(Larzelere & Huston, 1980)
Attitudes towards SSC	• Modified Attitude Toward Sexual Health Communication Subscale (Alvarez, 2012) • English	• *Development:* Factor analysis on items taken existing scale • *Sample:* Latina women in the US • *Modification:* Addition of STI risk communication items, response options reduced to: bad idea, not a good or bad idea, a good idea	• □ = .74 *	NR	(Alvarez, 2012)
Beliefs about SSC	• Modified Behavioral Beliefs Subscale (Alvarez, 2012) • English	• *Development:* Factor analysis on items taken existing scale • *Sample:* Latina women in the US • *Modification:* Added question from SRPS (J. Pulerwitz et al., 2000)	• □ = .63 *	NR	(Alvarez, 2012)

Self-esteem	• Modified Rosenberg Self-esteem Scale (RSE) (Martín-Albo et al., 2007) Spanish	• *Development:* Translation of English version • *Sample:* College students in Spain • *Modification:* Item, "I feel I do not have much to be proud of" changed to positive wording	• □ = .85 - .88 Test-retest = .84	Construct validity correlations: Self-concept dimensions: r = .28-.5, $p < .01$	(Martín-Albo et al., 2007)
Perceived risk of STI	• Modified Partner Specific Risk Perception Scale (Reisen & Poppen, 1999) • English	• *Development:* Two new items developed • *Sample:* Latino men • *Modification:* Removed item specific to HIV	• □ = .93 **	• Construct validity correlations (both $p < .01$): 1. Global risk perception 2. Partner's sexual history	(Reisen & Poppen, 1999)

* entire scale; ** original scale; IC = Internal Consistency; CV = Construct Validity; IPV = Interpersonal Violence; HIV = human immunodeficiency virus; STI = sexually transmitted infection; NR= Not Reported
Note: Two internal consistency calculates for original Sexual Communication Self-efficacy instrument reflect two subscales

Translation procedures. Measures already available and validated in Spanish were used where possible. Tools not available in Spanish were translated using a combination of translation methods (Brislin, 1970; Cha, Kim, & Erlen, 2007). First, the items were translated from English to Spanish by the PI. Then, a committee of four bilingual individuals with combined expertise in Dominican culture and linguistics reviewed the entire survey, discussed the translation, and decided upon a final translation (L.L.N, H.C., M.H, L.T.). This process involved cultural decentering, where the goal of translation was to maintain the meaning and objective of items and content across language and culture, as opposed to direct translation. Then, two monolingual Spanish speaking female Dominican consultants provided additional feedback on phrasing and word choice for survey items.

Data collection and management. The health promotor from Clínica de Familia collected all survey data. Prior to data collection, she received comprehensive training on survey methods including a presentation on interviewing skills, as well as role playing with the actual survey. The PI observed administration of the pilot surveys and then periodically throughout the two months of data collection, to provide feedback and assure fidelity to the interviewing methods.

All surveys were administered in Spanish in private offices at the clinic. A study conducted with the HIV positive population found that only 30% of clients at Clínica de Familia are health literate (Stonbraker et al., 2016). Therefore, the survey, which required approximately one hour, was administered verbally and responses recorded in writing, using a unique identification number. Participants were not compensated, but light refreshments were provided. Survey data were then entered into a secure web-based application designed to support data

capture for research studies (REDCap) (Harris et al., 2009), via a password protected, encrypted desktop computer at Clínica de Familia.

Analytic plan. First, we examined frequencies among categorical variables. To preserve the stability of the regression model, we recategorized the following variables to provide a greater number of responses in each category: perceived risk of STI from partner, greater earner in household, control over participant's money, education level, and province of residence. Because the outcome variable, SSC, was not normally distributed with little variation in responses, it was categorized dichotomously as "Discussed all SSC topics" (score of 7; 61% of participants) and "Discussed some or no SSC topics" (score of 0-6; 39% of participants). We then examined the distribution of continuous variables by analyzing histograms, calculating skewness and kurtosis, and conducting Student's t tests and Kolmogrov-Smirnov tests. We found monthly income to be quadratically distributed, and therefore dichotomized the variable using the median as the cut-off point.

Aim 1: Describe characteristics related to sexual division of power, sexual division of labor, cathexis, and SSC. Frequencies were calculated for categorical variables and means and standard deviations for continuous variables. Content analysis was used to categorize open ended responses to items inquiring about occupation and specific behaviors women have asked their partners to change to avoid an STI.

Aim 2: Assess the correlation between SSC and characteristics related to sexual division of power, sexual division of labor, and cathexis. First, bivariable analyses were conducted to assess the relationship between each predictor variables and SSC. We considered predictor variables with a relationship of $p < .10$ with SSC eligible for inclusion in subsequent multivariable models. Second, we assessed multicollinearity between independent variables,

conducting Chi squared tests between categorical predictor variables, Pearson correlations between continuous independent variables, and Kruskal-Wallis H test tests between categorical and continuous independent variables. We considered predictor variables that were significantly related at a level of $p < .05$ for removal, especially where we found groupings of variables measuring similar constructs within the Theory of Gender and Power. Third, we determined that with a sample size of $N = 100$ and proportion of positive cases (discussed all SSC topics) in the population equal to 0.4, the logistic model would be reliable with a maximum of between 4 (9 events per variable) and 8 (5 events per variable) predictor variables (Vittinghoff & McCulloch, 2007).

Then we fitted a preliminary multivariable model, examined Wald 95% confidence intervals and Chi Squared test results, and then dropped predictor variables that did not significantly contribute to the model ($p < .05$). Finally, to determine the most parsimonious model, we fit a new, reduced model with only significant predictor variables and checked for continued statistical contribution to the model. We checked model fit of the reduced model using the Hosmer-Lemeshow Goodness of Fit Test statistic (Hosmer & Lemesbow, 1980). SAS 9.4 was used for all statistical analyses

Results

Among the 10 women who completed the test and subsequent retest, the percent agreement between responses to 20 different items ranged from 70% - 100% ($M = 91.8\%$, $SD = 8.82$). Table 4.3 summarizes descriptive statistics among women who reported discussing all SSC topics, some or no SSC topics, and all women. Unadjusted odds ratios and corresponding 95% confidence intervals of each variable from the univariable analysis are also presented. Table 4.4 summarizes participant responses to “What [behaviors] have you asked him to change

Table 4.3 Percent or mean of Dominican women in stable relationships reporting having discussed all safe sex topics with their partner compared to some or no safe sex topics, by select characteristics of power in relationships, and unadjusted odds ratios (and 95% confidence intervals) from univariable logistic regression analysis assessing predictors of SSC

Characteristic	All topics discussed *N* % or *M* (*SD*)	Some/no topics discussed *N* % or *M (SD)*	Total *N* % or *M (SD)*	Unadjusted *OR* (95% CI)
Sexual Division of Labor: Economic Exposures				
Province of residence	61	39	100	
Other – San Pedro, Higuey, Seibo	14.75	79.49	17	
(ref)	85.25	20.51	83	1.49
La Romana				(0.52 – 4.23)
Education level	61	39	100	
None or primary (ref)	43.43	51.28	41	
Secondary	54.10	33.33	46	2.42*
				(1.00 - 5.87)
Post-secondary	11.48	20.51	13	1.11
				(0.32 – 3.88)
Employed in past 12 months	61	39	100	
No (ref)	42.62	56.41	48	
Yes	57.38	43.59	52	1.74
				(0.77 – 3.92)
Occupation	31	17	48	
Business/Sales (ref)	41.94	29.41	37.5	
Service – i.e. nurse, domestic work, education	58.06	70.59	62.5	0.58 (0.16 – 2.04)
Total personal monthly income[a]	60	37	97	
≤ $210	41.67	70.27	52.58	3.31**
> $210	58.33	29.73	47.42	(1.38 – 7.91)
Control over participant's money	61	39	100	
Her partner or both (ref)	50.82	51.28	51	
Herself	49.18	48.72	49	1.02
				(0.45 – 2.28)
Greater earner in household	61	39	100	
Her partner (ref)	78.69	92.31	84	
Herself	21.31	7.69	16	3.25*

				(0.86 - 12.26)
Number of dependent children	61	39	100	
	1.754	1.436	1.63	1.25
	(1.22)	(1.26)	(1.24)	(0.88 – 1.76)
Sexual Division of Power: Physical Exposures				
Intimate partner violence score	61	39	100	
Negative (ref)	54.10	43.59	45	
Positive	45.90	56.41	55	0.91
				(0.41 – 2.05)
Partner trust score	61	39	100	
	27.61	28.92	28.12	0.96
	(5.56)	(5.41)	(5.51)	(0.89 – 1.03)
Possibility partner has sex	61	39	100	
outside of relationship	24.59	38.21	26	
Do not know (ref)	34.43	28.21	32	1.40
Yes				(0.48 – 4.07)
	40.98	43.59	42	1.08
No				(0.40 – 2.91)
Know partner's HIV status	61	39	100	
Yes (ref)	93.44	94.87	94	
No	6.56	5.13	6	1.30
				(0.23 – 7.45)
Partner approval of SSC score	61	39	100	
	2.26	2.27	2.26	0.95
	(0.47)	(0.43)	(0.45)	(0.39 – 2.32)
Length of relationship (years)	61	39	100	
	8.88	7.93	8.51	1.02
	(7.07)	(7.22)	(7.14)	(0.96 – 1.08)
Sexual Division of Power: Behavioral Risk Factors				
SSC self-efficacy score	61	39	100	
	4.183	3.604	3.957	4.60***
	(0.454)	(0.853)	(0.696)	(1.97 – 10.74)
Number of sex partners in past	61	39	100	
year	1.38	1.44	1.40	0.93
	(0.80)	(1.02)	(0.89)	(0.59 – 1.45)
Last sexual activity with partner	61	39	100	
(days)	15.48	7.62	12.41	1.01
	(59.13)	(15.81)	(47.22)	(0.99 – 1.02)

History of STI	61	39	100	
Yes (ref)	27.87	7.69	20	
No	72.13	92.31	80	0.22** (0.06 – 0.80)
HIV status	50	31	81	
Positive (ref)	40	58.06	46.91	2.08
Negative	60	41.94	53.09	(0.84 – 5.16)
Cathexis: Social Exposures				
Age difference between partners				
Woman is older or same age (ref)	61	38	99	
Woman is younger	26.23	7.89	19.19	4.15*
	73.77	92.11	80.81	(1.12 – 15.37)
Age	61	39	100	
	37.13	33.51	35.72	1.05*
	(8.35)	(9.85)	(9.09)	(1.00 – 1.10)
Gender norms for sexual	61	39	100	
behavior score	2.54	2.65	2.58	0.44
	(0.33)	(0.41)	(0.36)	(0.14 – 1.37)
Religious affiliation	61	39	100	
None (ref)	32.79	35.90	34	
Evangelic Christian	37.70	41.03	39	1.01 (0.40 – 2.56)
Other – Catholic, Reformed church, Adventist	29.51	23.08	27	1.40 (0.49 – 4.01)
Cathexis: Personal Risk Factors				
Attitudes about SSC score	61	39	100	
	2.87	2.74	2.82	22.11***
	(0.18)	(0.23)	(0.21)	(2.45 – 199.84)
Beliefs about SSC score	61	39	100	
	3.402	3.346	3.38	1.38
	(0.36)	(0.50)	(0.42)	(0.52 – 3.66)
Self -esteem score	61	39	100	
	19.07	19.59	19.27	0.95
	(3.26)	(3.36)	(3.29)	(0.84 – 1.08)
Perceived risk of STI from	61	39	100	
partner	9.84	23.08	15	
Not likely (ref)	62.30	46.15	56	3.17*
Somewhat likely				(0.98 –
	27.87	30.77	29	10.26)
Very likely				2.13 (0.60 – 7.57)

Notes: SSC = Safe sex communication, STI = Sexually transmitted infection; HIV = Human immunodeficiency virus; [a] reported in US dollars
* $p < .1$, ** $p < .05$, *** $p < .01$, **** $p < .001$

Table 4.4 Specific behaviors women have asked their partner to change to not get a sexually transmitted infection, $N = 114$

Behavior	%
Use condoms (with other women or in general)	23.7
Be careful/spend less time in *la calle* (the street)	16.7
Treat her with more kindness	14.0
Drink or smoke less	13.2
Cuídate (take care of yourself)	11.4
Do not have sex with other women	10.5
Be more responsible	6.1
Other (get more sleep, eat better, get medical check-up)	4.4

Note: N refers to the number of responses not the participant sample size

Table 4.5 displays a comparison between characteristics of this study sample to the Southeastern region of the DR where La Romana is located, and to the DR as a whole.

Table 4. 5 Comparison of characteristics between study sample, south-eastern region of the DR, and the DR as a whole

Characteristic	Study Sample (N = 100)	South-eastern DR (N = 996)	DR (N = 9,372)
Age structure of women, %			
15-24	16	NA	24.88[a]
25-54	84		53.29[a]
55+	0		21.63[a]
Religion, %			
Catholic	23	25.5	48.4
Evangelic	39	33.3	20.4
Adventist	3	1.7	1.5
None	34	38.5	27.8
Other	1	1	1.8
Education level, %			
No education	2	2.4	2.4
Primary	39	36.9	30.2
Secondary	46	44	41.6
Superior	13	16.7	25.4
Last sex occurred in past 4 weeks, %	95	57.9	57
Number of children, *M*	2.26	2.8	2.5
Age difference between partners, *M*	5.4[b]	NA	5.8[d]
Women with 2 or more sex partners in past 12 months, %	24	6.4*	5
Ever had an HIV test, %	96	78.8	76
HIV positive, %	46.9[c]	1	0.7
Not employed in past 12 months, %	48	45.1	42
Partner is greater earner in household, %	84	NA	65
She decides how to spends her money, %	49	49	50

Notes: DR = Dominican Republic, HIV = human immunodeficiency virus; NA = Not available, [a] N = 23,384, [b] N = 99 , [c] N = 81, [d] N = 3,828,191, *Highest of all regions in the DR, all data retrieved from DHS DR Demographic and Health Survey report (2013) except age structure retrieved from the Central Intelligence Agency (2016) and age

difference between partners retrieved from DHS Comparative Report (2003) ; Average incomes for women are not readily available and therefore it was not possible to determine whether these women varied from the norm

Nine variables were significantly associated with SSC ($p < .1$): education level, monthly individual income, greater earner in household, SSC self-efficacy, history of STI, age difference between partners, age of participant, SSC attitudes, and perceived risk of STI from partner. We omitted education and greater earner from the group of variables considered for inclusion in the model because they were correlated with multiple other predictor variables and we considered both to be a similar form of economic exposure to SSC as monthly income. Table 4.6 compares results from the full and reduced multiple logistic regression models. Seven predictor variables were then tested together, and two continued to contribute significantly to the model ($p < .05$): SSC self-efficacy and age difference between partner. Predictors that did not contribute to the model were dropped and a model with only SSC self-efficacy and age difference between partners was tested. Both predictors remained significant in the reduced three parameter model which had a good fit (Hosmer-Lemeshow Goodness of Fit Test, χ^2 (8, N = 96) = 5.56, p = .696.

Among women with stable male partners in the DR, the odds of having discussed some or no SSC topics with one's partner compared to having discussed all SSC topics were less among women with greater SSC self-efficacy and higher among women who were younger than their partner compared to older or the same age as their partner. Specifically, (1) for every 1 point increase in self-efficacy score the odds of having discussed some or none of the safe sex topics with one's partner compared to all safe sex topics is 88.3% less (95% confidence intervals = 63.5% - 96.3%) when adjusting for age difference between partners, and (2) the odds of

having discussed some or none of the safe sex topics with one's partner compared to all safe sex topics is 12.38 times greater for women who are younger than their partner compared to women who are the same age or older than their partner (95% confidence interval = 2.23 times - 68.86 times greater) when adjusting for SSC self-efficacy.

Table 4.6 Adjusted odds ratios (and 95% confidence intervals) from multivariable logistic regression analysis of full and reduced models assessing predictors of having discussed all safe sex topics compared to some or no safe sex topics with one's partner, by selected characteristics

	Full Model Adjusted *OR* (95% CI)	**Reduced Model** Adjusted *OR* (95% CI)
Total personal monthly income[a]		
≤ $210 (ref)		
> $210	0.78 (0.28 – 2.20)	
SSC self-efficacy score	0.11 (-.03 – 0.45)**	0.12 (0.04 – 0.37)***
History of STI		
Yes (ref)		
No	0.38 (0.09 – 1.63)	
Age difference between partners		
Woman is older or same age (ref)		
Woman is younger	13.31 (1.62 – 109.16)*	12.38 (2.23 – 68.86)**
Age	0.95 (0.90 – 1.01)	
Attitudes about SSC score	0.47 (0.02 – 9.67)	
Perceived risk of STI from partner		
Not likely (ref)	0.37 (0.08 – 1.68)	
Somewhat likely	0.35 (0.06 – 2.01)	
Very likely		

Notes: CI: confidence interval, SSC: safe sex communication, STI: sexually transmitted infection, [a] income reported as US dollars
*p<.05, *p<.01***p<.001

Discussion

Among 100 adult Dominican women in stable relationships who were surveyed about SSC and risk factors related to gender and power, higher SSC self-efficacy was significantly protective against less SSC and greater age difference between partners was significantly related to greater risk of less . The relationship between SSC and SSC self-efficacy has also been found in past research among a variety of diverse samples. In the US, SSC self-efficacy was related to communication about safer sex and HIV among college students (DiIorio, Dudley, Lehr, & Soet, 2000), low perceived ability to negotiate condoms was related to less SSC among African American female adolescents (Crosby et al., 2002), sexual assertiveness was related to health protective sexual communication among a sexually and ethnically diverse national sample (van der Straten, Catania, & Pollack, 1998), and comfort with sexual communication was related to SSC among Latino adolescents in the US (Deardorff et al., 2013). Among adolescents 16-22 years old in the United Kingdom, SSC self-efficacy was related to the frequency of sexual communication and didactic sexual communication (Quinn-Milas et al., 2015). In the Netherlands, among Afro-Surinamese and Dutch women, SSC self-efficacy was related to intention to discuss safe sex (Bertens, Wolfers, Van den Borne, & Schaalma, 2008). Finally, among South African men who have sex with men, HIV communication self-efficacy was associated with communication their HIV status (Knox, Reddy, Kaighobadi, Nel, & Sandfort, 2013).

Health care providers and researchers should assess SSC self-efficacy among individuals with low SSC and focus on helping these individuals develop their SSC self-efficacy capacity. Specifically, past research has found that knowing how to avoid HIV, having life goals, and having spoken with someone other than a family member about HIV/AIDS are related to greater

SSC self-efficacy (Sayles et al., 2006). Providers and researchers should consider the potential influence of negative beliefs about SSC (Sayles et al., 2006) and interpersonal violence (Sayles et al., 2006; Swan & O'Connell, 2012) on SSC self-efficacy among women.

The DR has the second highest average age difference (5.8 years) between partners in Latin America and the Caribbean after Haiti (6.3 years), and an average that far exceeds that of the US (2.2 years). The only other place in the world with higher mean age differences between partners is Africa (6.3 – 14.7 years) (Wellings et al., 2006). Greater age differences between partners as a result of intergenerational sex and early marriage has been found to be associated with early sexual debut, money and gifts received from partner, low self-esteem, low education, and fear of economic insecurity (Clark, Bruce, & Dude, 2006; Drakes et al., 2013).

Research regarding the association between age difference between partners and SSC is limited. A study conducted in Mali found that married girls younger than 19 years old are twice as likely to discuss HIV prevention with their husband if he is less than six years older (World Health Organization [WHO], 2006). Past research has also found associations between greater age differences between partners and HIV infection (Bearinger, Sieving, Ferguson, & Sharma, 2007; Gregson et al., 2002; Kelly et al., 2003), lower levels of contraceptive use (Barbieri, Hertrich, & Grieve, 2005), and greater odds of intercourse (Kaestle, Morisky, & Wiley, 2002). Health care providers should be prompted to further inquire about HIV risk and infection among women who report a large age difference between themselves and their partner. Researchers should focus efforts on better understanding sexual risk and risk reduction among this vulnerable population.

We also examined other risk factors within the Theory of Gender and Power that did not have a significant relationship with SSC in our study, but have in past studies. For example,

within the structure of sexual division of labor, economic exposures found to be related to SSC in previous studies include higher levels of education among Kenyan spouses (Chiao et al., 2011), control over one's money among women in the DR (Ashburn et al., 2008), and being currently employed among women in Puerto Rico (Saul et al., 2000).

Within the structure of sexual division of power, physical exposure previously found to be related to SSC are perception of partner's attitudes among American college students (Dilorio et al., 2000) or reactions among Hispanic women in the US (Diaz, Reisen, Poppen, & Zea, 2003) to SSC, and spouse having sex outside of their relationship among Kenyan spouses (Chiao et al., 2011). Behavioral exposures found to be related to SSC were if the woman has multiple partners among Hispanic women in the US (Moore et al., 1995) and greater partner intimacy/trust among Mexican American women (Castaneda, 2000).

Within the structure cathexis (i.e., social norms and affective attachments), personal risk factors previously reported to be related to SSC are attitudes and beliefs surrounding SSC among African American adolescents (Crosby et al., 2002), Latina women in the US (C. P. Alvarez & A. M. Villarruel, 2015), and college students in the US (Dilorio et al., 2000). Perceived risk of HIV was also related to HIV-related communication among Hispanic women in US (Moore et al., 1995).

It is possible that the differences between our participants and those in past studies are linked to cultural differences among influences on SSC among different populations. Multiple studies have found differences in SSC by region of birth and level of acculturation. For example, gay Latino HIV positive men from the Caribbean were less likely to reveal their HIV status compared to participants from the US and South America (Diaz et al., 2003). Among Latina women in the US, being Mexican compared to Puerto Rican or Dominican was associated with

lower levels of HIV-related partner communication (Moore et al., 1995). Similarly, among women in the US, Mexican women compared to blacks or non-Hispanic whites displayed a strong inverse relationship between sexual guilt and health protective sexual communication (van der Straten et al., 1998). Finally, higher acculturation among Latinos in the US has also been found to be related to higher levels of SSC (Alvarez & Villarruel, 2015; Guyler, 2003).

Limitations. There are limitations to this study. First, a convenience sample of volunteer participants was used, because of the limitations in resources, time, and workforce. The subjectivity in participant selection that is characteristic of this particular sampling method, reduces generalizability of findings from this sample to the larger population (Etikan, Musa, & Alkassim, 2016). Responses were based on participant self-report in surveys administered by an interviewer, leading to higher risk of social desirability bias than in self-administered surveys and participants may under-report negative responses. Additionally, use of non-random sampling methods and recruitment of women who are seeking care at a clinic that specializes in STIs and HIV care may reduce the generalizability of findings.

Despite limitations, information produced by this study has great potential to elucidate the factors that are most helpful and those that create the greatest barriers for women when talking with their stable partners about safe sexual topics. This information will assist healthcare organizations and providers working with Latina women in stable relationships throughout the globe by providing them with information they need to effectively assess and develop care plans for partner SSC as an alternative method of STIs/HIV prevention when condoms are not a realistic option.

Conclusion

We found that higher SSC self-efficacy and less difference in age between partners is related to better SSC among adult women in stable heterosexual relationships living in the DR. Health care providers should consider these factors when assessing SSC and other sexual risk behaviors among women from this population. Future research should focus on better understanding how to improve SSC self-efficacy among this population with a focus on women in relationships where there is a significant age gap between partners.

Chapter Five: Conclusions and Synthesis

The three manuscripts of the dissertation together explore safe sex communication (SSC) between adult women and their stable partners in the Dominican Republic (DR). The first manuscript is an integrative literature review that provides a basic understanding of which factors have been previously found to influence SSC between adult Latina women and their stable male partners in the US and other Latin American and Caribbean countries. The second manuscript describes findings from eleven qualitative interviews conducted with adult Dominican women who sought care at Clínica de Familia La Romana (Clínica de Familia) in the DR, about their experiences talking about safe sex topics with their stable partners. Findings are discussed within the lens of the Theory of Gender and Power (Wingood & DiClemente, 2000, 2002), The third manuscript clarifies which factors within the Theory (Wingood & DiClemente, 2000, 2002), are significantly related to partner SSC among a sample of 100 adult Dominican women in stable heterosexual relationships who sought care at Clínica de Familia. Together, these manuscripts contribute to a holistic understanding of context, experience, and influential factors of SSC between adult women and their stable partners in the DR. Findings will provide information to researchers, health care providers, and others involved in public health efforts to reduce sexual risk among Latin and Caribbean women about how to develop effective interventions in this area and what to explore in future research. In this concluding chapter, results from each of the three manuscripts included in the dissertation will be summarized and limitations and implications discussed. The chapter will close with recommendations for research, practice, and policy, and final remarks.

Summary of Results

In the first manuscript, *Psychosocial correlates of safe sex communication between Latina women and their stable male partners: An integrative review*, research previously conducted on identifying factors related to SSC with Latina women in stable relationships living in the US, Latin America, and the Caribbean was identified, appraised, and synthesized. Data synthesis revealed that factors previously found to influence SSC among Latinas in stable heterosexual relationships could be categorized as relationship factors (i.e. length, quality, and power/control), individual factors (i.e. attitudes, beliefs, background, behaviors, and intrapersonal characteristics), and partner factors (i.e. partner beliefs and behaviors). Another notable finding from this review was the relative homogeneity of populations studied and the need for future research to examine SSC among Latina women outside of the US and Latina women of different subcultures within the US

The second manuscript, *Understanding safe sex communication between women & their stable partners in the Dominican Republic: A qualitative descriptive study*, provides a summary an interview study conducted with women who shared their experiences talking about safe sex with their stable partners. Emergent content analysis of transcripts revealed two main themes that summarise the women's experiences. The theme "Context of sexual risk" encompassed the categories: meaning of safe sex for stable partners, behaviours related to sexual risk, beliefs and attitudes related to sexual risk, *confianza* (trust) between stable partners, economic power within relationships, and learning to manage safe sex within a stable relationship. "SSC between stable partners" included the categories: reasons to talk about safe sex, methods and content, influential factors, and ideas for improvement. Emergent themes, categories, and codes aligned closely with Wingood and DiClemente's adaptation of the Theory of Gender and Power (2000, 2002)

The third manuscript, *Psychosocial correlates of safe sex communication for women with stable partners living in the Dominican Republic,* presents findings from a survey study conducted with 100 adult Dominican women who seek care at Clínica de Familia. The mean age of women was 35.7 years, 46.9% were living with human immunodeficiency virus (HIV), the average length of relationships was 8.5 years, and the average age difference between partners was 5.4 years. The most parsimonious logistic regression model revealed that the odds of having discussed all SSC topics with one's partner compared to having discussed some or no SSC topics were less among women with lower SSC self-efficacy (*OR* = 0.12, 95% confidence interval = 0.04 – 0.37) and difference in age between partners (*OR* = 12.38, 95% confidence interval = 0.2.23.8668 – 0.).

Limitations

There were multiple limitations within this dissertation. For the integrative review, we did not include unpublished or grey literature, so our findings may not represent all extant literature. Only a small number of studies was found, the majority examining SSC among Mexican Americans. Therefore, it is not appropriate to generalize findings to Latina women living outside of the US or to women of all Latino subcultures. Furthermore, because both qualitative and quantitative studies were examined and multiple different forms of SSC were examined, pooled statistical correlations using a meta-analysis could not be calculated. Similarly, causation cannot be assumed from the descriptive results of the data synthesis.

For both studies that comprised the mixed methods study, the qualitative descriptive and cross-sectional survey studies, a major limitation was that Clínica de Familia is well known as the HIV clinic in town. In addition to recruiting women from a single clinic that specializes in HIV care, they were also volunteers. All of these factors may have led to sampling bias and affected the generalizability of findings from these studies to the general partnered female

population in the DR. Also, it was optional for women to report their HIV status and we did not ask for their partner's HIV status. Therefore, I was not able to identify whether couples were serodiscordant or seroconcordant or make the comparisons between factors that SSC among women in general versus women in serodiscordant relationships. Similarly, I did not collect in-depth information on HIV related or sexual health among women who reported a positive HIV diagnosis. Therefore, there may have been other variables the confounded associations with SSC or variables that may have been predictors that were not available, such as length of time living with HIV, use of PreP, use of and adherence to antiretroviral therapy, or pregnancy status.

For the qualitative descriptive interview study specifically, one of the main limitations of this study was the possibility of social desirability bias among participants, especially given that the researcher and participants were from different cultures, ethnicities, and backgrounds. For this reason and the sensitive nature of the interview topics, women who participated may have withheld information to protect their privacy or not reveal unpleasant experiences or opinions. Also, women who volunteered to participate may differ from those who did not volunteer. Finally, there was potential for bias from the research team in determining the most appropriate study methods, analysis of findings, and manner of communicating conclusions.

For the cross sectional quantitative study, the primary limitation was the reliance on self-report measures, which as is also the case with the interviews, that increases the risk of social desirability bias and under-reporting of negative responses. The small sample size and general lack of variation within the sample may have also lead to missing factors that may have otherwise had a significant association with SSC. In addition, the decision to dichotomize the outcome variable, SSC, lead to a loss of information and detail in the results of the study.

Finally, generalizability of the findings was also limited by use of non-random sampling methods in this study.

Implications

For SSC to be an effective alternative method to reduce risk of HIV/STI transmission among women in stable heterosexual relationships living in the DR, these women must be motivated to discuss these topics and be able to initiate and navigate such conversations. This dissertation contributes to our understanding of the context, experience, and influential factors of SSC among this population. As shown in the first manuscript, SSC has been found to be a safe sex behavior which is challenging among Latina women in stable relationships in the DR as well as in other Latin American and Caribbean countries and the US. However, there is evidence that factors that influence SSC may depend on the woman's Latino subculture or nationality, as well as other individual, relationship, and partner characteristics. These findings have implications for research, health care providers, organizations, and other individuals involved in efforts to reduce sexual risk among Latina women. Hence it is important to identify the subgroups of women in relationships who are most at risk and the most challenging barriers to SSC and then to work with these women to determine the most effective ways to overcome those barriers and establish SSC with their partner that effectively reduces STI/HIV risk within their relationships.

Another important implication of the findings from this dissertation is the need to consider SSC holistically, within the context in which it occurs. Context may explain some of the differences found in factors are most related to partner SSC among different groups of Latina women. Researchers, health care providers, and others involved in the effort must use extant research to inform their decision-making. But, to achieve the most effective care or intervention

outcomes, decisions must ultimately be based on what is most relevant for the specific context in which SSC is being addressed.

Recommendations for future research, practice, and policy

Research. Future research should identify which safe sex behaviors SSC is associated with (i.e. HIV testing, sexual monogamy, etc.) among Latina women with stable partners in the US, Latin America, and the Caribbean. This has been examined among other populations, but remains unclear among Latina women in relationships. Similarly, as condom use is often not a feasible option for Latina women in relationships, future research should focus on examining types of SSC other than condom negotiation. Additional research is also needed with Latina women of different subcultures and nationalities to clarify which aspects of SSC can be applied to Latina women in general and which differ between groups. Within this research, it is important to examine various individual constructs of power within relationships rather than as one combined measure of power, since identifying which aspects of power are most influential on SSC is important for determining the most effective interventions. For example, SSC self-efficacy, a construct within Wingood and DiClemente's adaptation of Theory of Gender and Power (2000, 2002), was found to be significantly related to SSC in this dissertation, while other constructs were not. From identifying this specific construct within relationship power, it is clear that future research should specifically examine how to improve SSC self-efficacy among Latina women in relationships and include relevant information and skills building exercises into interventions to improve SSC among Dominican women in stable relationships.

There is also very little known about the male partner's role and perspective in sexual risk and SSC. Therefore, future research should aim to better understand sexual risk behavior

among Latino men in stable relationships, define the male partner's role and perceptions of SSC, and determine which factors are significantly related to SSC among Latino men in stable relationships. Similarly, future research should seek to better understand how interventions could effectively work with the influence and ideas of masculinity to reduce sexual risk behaviors such as SSC and what other forms of motivation could effectively reduce risk behavior among Latino men in relationships.

To develop and test sexual risk reduction interventions for Latino couples, future research should first further clarify safe sex and SSC needs among Latino couples and determine methods of overcoming or effectively managing some of the most challenging barriers to SSC. The short and long-term effectiveness of interventions to improve SSC and reduce other sexual risk behaviors within stable relationships should be assessed. Such interventions should be aimed at couples who have especially high HIV sexual risk.

Practice. There are several implications from this dissertation that could improve practice. Past research and the findings from the second manuscript in this dissertation provide evidence that SSC is related to HIV/STI risk among Latina women in stable relationships. Therefore, healthcare providers should be educated about SSC as an STI/HIV risk reduction strategy and taught how to conduct comprehensive assessments of SSC as part of their HIV/STI risk assessments with this population. Particularly, health care providers should be aware of which characteristics may indicate high risk of inadequate SSC, as indicated in the first and third manuscripts in this dissertation. Identification of a high-risk woman should prompt a more in-depth assessment of possible reasons for inadequate SSC to inform development of a personalized care plan and/or which resources the participant will need and where she could be referred for additional support. Health care providers, particularly those who provide care to

subcultures of Latina women in relationships or in multiple Latin American or Caribbean countries, should be aware of the potential differences in context and influential factors of SSC between Latin countries and subcultures and adapt their assessments and care plans accordingly.

Policy. Women in the DR are taking on an increasing burden of HIV, and HIV/STI risk continues to be a serious health issue for Latina women across the globe. Therefore, along with implications for researchers and health care providers there are implications for policy changes from the findings of this dissertation to improve SSC among Latina women in stable relationships as a means of reducing their sexual risk. Policies could be implemented that mandate effective systems within health care centers and organizations to identify women who are at risk of inadequate SSC and connect them with appropriate resources and healthcare team members. Policies could also encourage health care centers and public health organizations to disseminate more information about SSC, especially within relationships. For example, centers and organizations develop initiatives to raise awareness regarding SSC, how it affects health, and where to find more information and support. Similarly, policies should support educational programs about SSC in relationships and enable/improve access to such programs. Such programs could be integrated into already existing programs and services for women such as family planning or pregnancy-related services and programs.

Final Remarks

SSC is an important behavior related to HIV/STI risk. Among Latina women in stable relationships, talking about safe sex topics with their partner is influenced by many factors. This dissertation holistically examined SSC between adult women and their stable partners in the DR. Results extend knowledge regarding the unique context, experience, and influential factors of

SSC between adult women and their stable partners in the DR. Findings from this dissertation may guide researchers, health care providers, and other individuals and organizations involved in HIV/STI prevention efforts to more effectively identify women with high risk of HIV/STI infection within their relationship and help provide them with the resources they need to more effectively reduce their sexual risk and improve communication within their stable relationships.

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Appendices

A.1 Published Version of Integrative Review (Chapter 2)

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Psychosocial correlates of safe sex communication between Latina women and their stable male partners: an integrative review

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Abstract

Latina women in stable relationships have risks for human immunodeficiency virus and other sexually transmitted infections. Improving safe sexual communication (SSC) could enable women to accurately assess and mitigate their risk of infection within their relationship. Literature to identify psychosocial correlates that facilitate or inhibit SSC between Latina women and their partners has not yet been synthesized. The purpose of this study was to conduct an integrative review and synthesis of empirical and theoretical research that examines psychosocial correlates of SSC among adult Latina women from the United States, Latina America, and the Caribbean with stable male partners. A systematic search of LILACS, EBSCO, and PsychInfo databases was conducted to identify qualitative and quantitative studies that investigated psychosocial correlates of SSC among adult Latina women with a stable male partner. Pertinent data were abstracted and quality of individual studies was appraised. A qualitative synthesis was conducted following Miles and Huberman's method. Five qualitative and three quantitative studies meet eligibility criteria. Factors related to SSC related to three main themes: (1) relationship factors such as length, quality, and power/control, (2) individual factors including attitudes, beliefs, background, behaviors, and intrapersonal characteristics, and (3) partner factors related to partner beliefs and behaviors. The interplay of relationship, individual, and partner factors should be considered in the assessment of SSC for Latina women with their stable partners. To inform future interventions and clinical guidelines, additional research is needed to identify which factors are most related to SSC for this population, and how comparable experiences are for Latina women of different subcultures and living in different countries.

Keywords

Sexual communication; Latinos; HIV prevention; sexual behavior; women

Introduction

Latina women in the United States, Latin America, and the Caribbean experience a disproportionate burden of human immunodeficiency virus (HIV) and other sexually

transmitted infections. In the United States, Latina women are approximately 1.5 times more likely to be infected than heterosexual Latino men (Centers for Disease Control and Prevention, 2015). In the Dominican Republic, the proportion of HIV cases that are women increased from 27% in 2003 (Joint United Nations Programme on HIV/AIDS [UNAIDS]), 2004) to 51% in 2013 (UNAIDS, 2013). In many Latin American countries, such as Mexico and Columbia, the HIV epidemic has also been found to be affecting a greater number of women than previously (UNAIDS, 2006).

Latina women in stable heterosexual relationships have risk factors for HIV infection (UNAIDS, 2006), but have received little attention in HIV prevention research compared to other populations such as female sex workers. In Latino communities, it is common for men, including those in stable relationships, to have multiple concurrent sex partners (Centro de Estudios Sociales y Demográficos [CESDEM] & ICF International, 2014; Marín, Tschann, Gómez, & Gregorich, 1998). Furthermore, a large disparity in condom use has been found between stable versus casual partners. For example, in the Dominican Republic, as low as 0.4–4% of married or cohabitating partners report using condoms (CESDEM & ICF International, 2014) compared to 68% of non-married and 40% of non-cohabitating men and women (Halperin, de Moya, Perez-Then, Pappas, & Garcia Calleja, 2009). This may be in part due to the meanings assigned to condom use among Latino partners related to trust and intimacy (Kerrigan et al., 2003, 2006; Perez-Jimenez, Seal, & Serrano-Garcia, 2009), along with religious beliefs of Catholic Latinos that prohibit contraceptive use.

Safe sexual communication (SSC) may be a more feasible and effective method of preventing HIV/sexually transmitted infections than consistent condom use among Latina women in heterosexual stable relationships. SSC includes verbal or non-verbal relaying of information to one's partner regarding methods of preventing HIV/sexually transmitted infections such as condom negotiation, sexual history, notification of new HIV/sexually transmitted infections diagnosis or other concurrent sexual partners, or discussing testing for HIV/sexually transmitted infections. Greater levels of SSC have been found to be associated with increased HIV testing among husbands (Manopaiboon et al., 2007), as well as reduced HIV transmission (Saul et al., 2000) and increased condom use (El-Bassel et al., 2003; Noar, Carlyle, & Cole, 2006) among stable partners.

To reduce risk of HIV among Latina women in heterosexual relationships by improving SSC, an adequate understanding is needed of the barriers and facilitators of SSC and what types of SSC are most commonly utilized and avoided in the context of a stable relationship. Researchers have examined which factors are related to SSC Latinas in stable heterosexual relationships, however there has not yet been a review or synthesis of these studies. Therefore, the purpose of this integrative review is to review, appraise, and synthesize empirical and theoretical research that examines psychosocial correlates of SSC among adult Latina women in stable heterosexual relationships from the United States, Latin America, and the Caribbean.

Methods

This study followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (Moher, Liberati, Tetzlaff, Altman, & Group, 2009), where possible, to increase the rigor of procedures and reporting.

Inclusion and exclusion criteria

Qualitative and quantitative primary studies of any design except interventional studies were eligible if they met the following criteria: (1) sample consisted of adult (18 or older) Latina women in a stable heterosexual relationship or included a mix of ethnicities or sexes with data on adult Latina women that could be abstracted, (2) qualitative studies with the purpose of examining Latina women's experiences of talking with their partner about different methods of preventing HIV/sexually transmitted infections OR quantitative studies with an outcome of partner SSC, (3) set in the United States, Latin America, or the Caribbean, (4) reported in English or Spanish, and (5) published as a peer reviewed journal article with full text available in the databases searched.

Studies with the following characteristics were excluded: (1) sample consisted of transgender individual or women who were involved with illicit drug use, mentally ill, or disabled, (2) examined only behavioral correlates, communication only about pregnancy prevention or contraception, sexual pleasure, or sexual act, (3) set in Spain or Brazil, or (4) published as a book chapter, review article, opinion, or dissertation. No limits were placed on date of publication.

Database and search strategy

A two-stage search strategy was used (Counsell, 1997; Dickersin, Scherer, & Lefebvre, 1994). First, a preliminary limited search of Ovid MEDLINE was conducted to identify optimal search terms. Second, a comprehensive systematic search was conducted using three databases: Literatura Latino Americana e do Caribe em Ciências da Saúde (LILACS, Latin American and Caribbean Health Science Literature), PsychInfo, and EBSCO. Within EBSCO, the following databases were searched: Chicano Database, Gender Studies Database, SocIndex, Social Work Abstracts, Family and Society Studies Worldwide, and Social Sciences Full Text.

Study selection

An online program designed to facilitate the screening process for review articles (Covidence, www.covidence.org) was used by both authors to review all articles yielded by the comprehensive search. First, all titles and abstracts were independently screened for inclusion criteria by each author. Next, both authors independently conducted a full text evaluation of potentially eligible articles independently. Throughout, both authors discussed all discrepancies and reached consensus about articles that met inclusion criteria.

Data abstraction

Two separate data collection forms for qualitative and quantitative studies were developed prior to data abstraction based on the purpose of the integrative review to facilitate

systematic examination and organization of information from included studies (Higgins & Green, 2005). The forms were then pilot tested and modified to improve the adequacy of abstracted data.

The first author abstracted the following data on an Excel spread sheet for all studies: (1) sample characteristics, (2) sampling method, (3) inclusion and exclusion criteria, (4) setting, (5) recruitment and enrolment, (6) purpose, (7) study design, (8) phenomenon of focus, (9) guiding theory or framework, (10) data collection method, (11) data analysis method, (12) major findings and reporting method, and (13) correlates of SSC. For quantitative studies, data were also abstracted pertaining to: (1) sample size calculation, (2) response rate, (3) method of measuring SSC outcome, and (4) independent variables examined. The second author verified data abstracted for each study by reviewing data in the spread sheet.

Quality assessment

Qualitative studies were appraised using the Critical Appraisal Skills Programme tool (Chenail, 2011), which examined ten aspects of the study. Response options for the specific questions were modified to include: "Yes" (2 points), "Partially" (1 point), "Can't tell" (0 points), or "No" (0 points). The assessment was scored as a percentage determined by adding the points obtained (numerator) and dividing by the total possible points (20 points). For the purpose of this integrative review, focus groups were not considered a qualitative study design, but rather a method of data collection.

Quantitative studies were appraised using a modified version of the "Quality assessment tool for observational cohort and cross-sectional studies" (National Institute of Health, 2014). Questions not applicable for cross-sectional studies were removed, as all included studies were cross-sectional. Ultimately, eight assessment criteria were used. The response options and scoring methods were modified to match those used for qualitative studies. However the total possible score was 16.

Data synthesis/analysis

Miles and Huberman's method of qualitative data analysis guided the analysis and synthesis of data (1994), as suggested by past scholars (Whittemore & Knafl, 2005). This method involves five main steps: (1) data reduction, (2) data display, (3) data comparison, (4) conclusion drawing, and (5) verification.

During the data reduction phase, we extracted significant correlations with SSC from quantitative studies and influential factors of SSC expressed by participants mentioned in qualitative studies. All findings, including conflicting findings, were included in the synthesis. During the data display phase, we combined, organized, and displayed coded data.

During the data comparison phase, we examined the summary of findings for patterns, themes, and relationships. Notes of conflicting findings were kept. During the conclusion-drawing phase, we determined a final list of categories and overall general themes and identified commonalities and differences across studies. During the verification phase, we crosschecked overall thematic categories with results from the individual included studies to

ensure that the results and interpretation of the body of evidence were grounded in data from the original primary articles.

Results

Study selection

Figure 1 provides detail regarding the literature search and selection process. Of the 1234 titles and abstracts screened for eligibility, 1177 of these articles were excluded. Of the 57 full text articles screened, primary reasons for exclusion were: wrong participant population (n = 17), no correlations with SSC explored (n = 11), and unpublished paper (n = 9). Ultimately, five quantitative (Alvarez & Villarruel, 2015; Ashburn, Kerrigan, & Sweat, 2008; Castañeda, 2000; Moore, Harrison, Kay, Deren, & Doll, 1995; Saul et al., 2000) and three qualitative studies (Alvarez & Villarruel, 2013; Davila, 2002; McQuiston & Gordon, 2000) were included in the review and synthesis.

Description of studies

Table 1 describes characteristics of the included studies. A range of purposes related to investigating SSC were reported across studies. Qualitative studies designs included qualitative descriptive (Alvarez & Villarruel, 2013), naturalistic inquiry (Davila, 2002), and unspecified qualitative design (McQuiston & Gordon, 2000). All quantitative studies utilized a cross-sectional design (Alvarez & Villarruel, 2015; Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000). Half of the studies included women only (Ashburn et al., 2008; Davila, 2002; Moore et al., 1995; Saul et al., 2000). The majority of studies reported mean participant age as low to mid-30s (Ashburn et al., 2008; Castañeda, 2000; Davila, 2002; Moore et al., 1995). The most common reported participant ethnicity was Mexicans or Mexican American (Castañeda, 2000; Davila, 2002; McQuiston & Gordon, 2000; Moore et al., 1995). All but one study (Alvarez & Villarruel, 2013, 2015; Castañeda, 2000; Davila, 2002; McQuiston & Gordon, 2000; Moore et al., 1995; Saul et al., 2000) were conducted in the continental United States.

HIV-related communication or negotiation (Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000) was the most common form of SSC investigated. Among quantitative studies, the most common independent variables examined were acculturation (Alvarez & Villarruel, 2015; Castañeda, 2000; Moore et al., 1995) and age (Ashburn et al., 2008; Moore et al., 1995; Saul et al., 2000). Correlations were primarily examined using regression methods (Alvarez & Villarruel, 2015; Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995). Unspecified methods of content analysis were primarily reported as the analysis method for qualitative data (Davila, 2002; McQuiston & Gordon, 2000). Results of the individual studies are reported in Table 1.

Study quality

Quality scores for qualitative studies ranged between 60% (McQuiston & Gordon, 2000) and 75% (Davila, 2002). Major threats to quality were inadequate reporting of the relationship between the researcher and the participants, data analysis methods (Alvarez & Villarruel, 2013; Davila, 2002; McQuiston & Gordon, 2000), and ethical considerations

(Davila, 2002; McQuiston & Gordon, 2000). Ratings for quantitative studies ranged between 68.8% (Castañeda, 2000) and 87.5% (Alvarez & Villarruel, 2015). Common threats to quality were inadequate description and reporting of psychometrics, particularly the validity, of the exposure and outcome measures (Alvarez & Villarruel, 2015; Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000), as well as lack of justification of sample size (Ashburn et al., 2008; Castañeda, 2000; Moore et al., 1995; Saul et al., 2000),

Findings of data synthesis

Table 2 provides a detailed the thematic map with corresponding categories of variables related to SSC across all included studies. Ultimately, three main themes emerged that summarize factors related to SSC between Latina women and their stable male partners: (1) relationship factors, (2) individual factors, and (3) partner factors.

Subthemes that comprised relationship factors include: relationship length, relationship quality, use of initial sexual activity to create a foundation for communication, difference in time in the use between partners, and power and control in the relationship. Subthemes within individual factors included: attitudes/beliefs, background characteristics, behaviors, intrapersonal characteristics, and skills. Subthemes that emerged under partner factors were partner's attitudes and behaviors.

Discussion

Five quantitative and three qualitative research studies that examined psychosocial correlates of SSC between adult Latina women and their stable male partners in the United States, Latina America, and the Caribbean were reviewed, appraised, and synthesized in this integrative review. Various factors were found to be related to SSC included relationship factors, individual factors, and partner factors and confirmed that while certain factors facilitate SSC between Latina women and their stable male partners, they still face many challenges.

Relationship factors have been found to be related to SSC among various populations. As in this review (Alvarez & Villarruel, 2015; Davila, 2002), past research with a sample of Latina women of mixed relationships status also found relationship power in general to be related to SSC (Davila, 1999). Similarly, among Kenyan women who are cohabitating with their male partners, participation in decision-making has been found to be positively associated with spousal communication about HIV prevention (Chiao, Mishra, & Ksobiech, 2011). Like the Latina women in studies included in this review (Davila, 2002), past research with African-American women who have stable partners has also found interpersonal violence to be related to various forms of SSC (Morales-Alemán et al., 2014). Despite evidence that relationship power is related to SSC, it remains unclear which specific aspects of sexual relationship power are most related to SSC. Future research should consider taking a more comprehensive and detailed approach to investigating constructs within sexual relationship power as they relate to SSC.

Using the initial sexual activity to create foundation for SSC was another relationship factor found to facilitate SSC for Latinas in stable relationships (Alvarez & Villarruel, 2013), as

well as among women in primary relationships of various different ethnicities (Pulerwitz & Dworkin, 2006). Gaining a better understanding of timing of SSC between stable partners may provide valuable for improving the effectiveness of this HIV prevention behavior.

Individual factors such as, specific Latino subculture (Moore et al., 1995), and acculturation level (Alvarez & Villarruel, 2015), appear to not only be related to SSC but also to condom use among stable partners, as well (Deren, Shedlin, & Beardsley, 1996; Moreno & El-Bassel, 2007). Further research on SSC is needed with Latinas of different subcultures and who are living in countries outside of the United States to facilitate comparison across Latino subcultures and country of current residence. Specifically, how comparable SSC among Latinas living in the United States is to Latinas living in Latin American or Caribbean countries, and whether level of acculturation to American culture has an influence on SSC for Latinas. Additionally, structural factors such as access and exposure to HIV/ sexually transmitted infection prevention services may also differ across countries. The possible influence of these factors on SSC among Latinas needs to be examined to determine generalizability of findings.

Like in this review, where cultural norms and gender roles were found to have an effect on SSC for Latina women in stable relationships where neither partner has HIV (Alvarez & Villarruel, 2015; McQuiston & Gordon, 2000), past research has found this to be true among Latinos in serodiscoradant relationships, as well (Orengo-Aguayo & Pérez-Jiménez, 2009). This may also be a factor that affects couples regardless of ethnicity, as previous research has also found a significant affect on SSC among an ethnically diverse sample of men and women in the United States in stable relationships (Pulerwitz & Dworkin, 2006). HIV prevention efforts for Latinas should tailor interventions to the cultural context and address culturally bound messages related to HIV prevention behaviors.

Perceived negative partner reaction to SSC also seems to be an important factor for many women in stable relationships, not only among Latinas. Among Puerto Rican women in serodiscordant relationships, fear of being judged, misunderstood or partner not taking the topic seriously inhibited SSC (Orengo-Aguayo & Pérez-Jiménez, 2009). Similarly, among a sample of predominantly white and African-American college students (Dilorio, Dudley, Lehr, & Soet, 2000), as well as a sample of African-American adolescents (Sionéan et al., 2002) perception of more positive partner attitude toward SSC was associated with greater SSC and more consistent refusal of unwanted sex.

Finally, fidelity of both the female and male partner also appears to influence SSC not just among Latina women's relationships. Among an ethnically diverse sample of young couples in the United States, it was found that if the woman has sexual partners outside of their relationship this negatively affects SSC (Albritton et al., 2014). With regards to male partners, as opposed to facilitating SSC as it was recorded among Latino couples in this review (Ashburn et al., 2008), among cohabitating couples in Kenya, if the male had other sexual partners, the couple was less likely to have discussed HIV prevention (Chiao et al., 2011).

Limitations

There are limitations to this review. We did not search for or examine unpublished or gray literature. It is possible that eligible studies were missed, despite our best efforts to develop a comprehensive search strategy. Additionally, due to the small number of studies and characteristics of the sample, it is not appropriate to generalize findings to Latina women living outside of the United States or to women of all Latino subcultures. Furthermore, results of the data synthesis are descriptive, so conclusions could not be made about pooled statistical correlations using a meta-analysis. Similarly, because all studies were qualitative or cross-sectional in design, causation cannot be assumed.

Conclusion

Multiple relationship, individual, and partner factors were reported to be related to the SSC that Latina women have with their stable male partners. More qualitative research is needed on forms of SSC other than condom negotiation. Future quantitative studies on the topic should consider a more comprehensive approach to variable selection and include more variables specifically related to the close relationship context. In addition, more research is needed with Latinas of different subcultures and with those who live outside of the United States. With this information, a more accurate and complete understanding of the needs of Latina women in stable heterosexual relationships with regards to SSC can be achieved, and recommendations for clinical practice and interventional research can be made.

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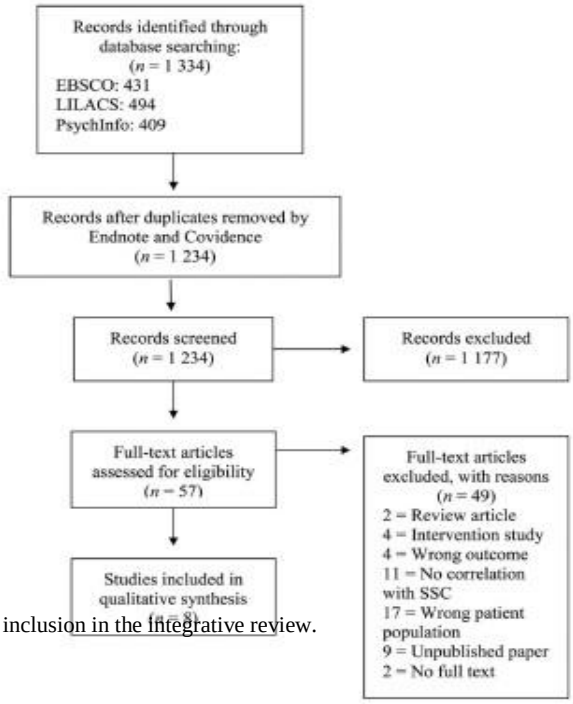

Figure 1.
Selection process for inclusion in the integrative review.

Table 1

Characteristics of included studies.

Authors (year)	Study design and purpose	Sample	Variables/phenomena	Analysis method and results	Quality score (%)
Alvarez and Villarruel (2013)	• Qualitative descriptive	• 20 Latino men and women; n = 10 women; mean age of women 24.2 years	Phenomenon: Sexual communication	• Grounded Theory (Corbin & Strauss, 2008)	70
	• To describe sexual communication among young adult Latinos	• Education: 4 high school graduate or less and 5 some college		• 5 themes: (1) Barriers to verbal communication, (2) facilitators of communication, (3) Sex and Condom use, (4) Contexts for verbal communication, (5) Non-verbal sexual communication	
		• Ethnicity: Not Reported (NR)			
		• Location: Midwest (USA)			
Alvarez (2015)	• Cross-sectional	• 220 Latino men and women; n = 111 women; mean age of women 24.28 years	• Dependent SSC variable: Sexual health communication	• Multiple regression	87.5
	• To examine the role of traditional gender norms, relationship factors, intrapersonal factors, and acculturation as statistical predictors of three different types of sexual communication in Latino women and men	• Education: NR	• Independent variables: Traditional gender norms, sexual relationship power, length of time in relationship, difference in time in US, age difference of partners, relationships status, attitudes toward sexual communication, sexual attitudes, social norms about preventative behaviors, perceived partner approval about sexual communication, subjective norms, acculturation	• Positive association: Relationship length ($\beta = .21$, $p < .05$), Relationship power ($\beta = .27$, $p < .001$), Attitudes toward sexual health communication ($\beta = .32$, $p < .001$), Subjective norms toward sexual communication ($\beta = .28$, $p < .001$), Acculturation ($\beta = 5.67$, $p < .001$)	
		• Ethnicity: NR		• Negative association: Difference in time in US ($\beta = -.18$, $p < .05$), Attitudes toward pleasure discussions ($\beta = -.29$, $p < .05$), partner approval toward sexual communication ($\beta = -.29$, $p < .05$)	
		• Location: Midwest (USA)			
Ashburn et al. (2008)	• Cross-sectional	• 273 Latina women; mean age 36.49 years	• Dependent SSC variable: HIV-related negotiation	• Multivariate logistic regression	75
	• To examine the relationship between women's empowerment and negotiation of partner's behavior change to avoid HIV	• Education: 69% some primary school	• Independent variables: Micro-credit loan participation, level of participation in women's groups, control of own money, perception of partner's monogamy, age, education,	• Positive association: Unfaithful partner (AOR = 6.39, $p < .001$), Control own money (AOR =	

Authors (year)	Study design and purpose	Sample	Variables/phenomena	Analysis method and results	Quality score (%)
	infection among partnered sexually active women in rural DR		residence, religion, number of children living at home	2.43, $p < .001$), residence in Peravia (AOR = 3.53, $p < .001$)	
		• Ethnicity: Dominican		• Negative association: Evangelical religion (AOR = 0.12, $p < .001$), no religious affiliation (AOR = 0.29, $p < .05$)	
		• Location: Southwestern DR			
Castañeda (2000)	• Cross-sectional	• 115 Latino men and women; n = 76 women; mean age 30.8 years	• Dependent SSC variable: HIV-related communication	• Hierarchical multiple regression	68.8
	• To determine the association of relationship variables to participants' HIV risk perception, use of condoms, and HIV-related communication with a relationship partner	• Education: 26% less than high school, 94.73% high school graduate	• Other dependent variables: Condom use, HIV risk perception	• Positive association: Intimacy ($\beta = .35$, $p < .02$)	
		• Ethnicity: 98.68% Mexican American, 1.3% other Latina	• Independent variables: Demographics, relationship status, commitment, intimacy, overall sexual satisfaction in relationship, sexual regulation, level of acculturation		
		• Location: Southwestern US			
Davila (2002)	• Naturalistic inquiry	• 20 Latin a women; mean age 30.7 years	Phenomenon: Condom negotiation	• Content analysis	75
	• Explore the influence of abuse on the condom negotiation attitudes, behaviors, and practices of Mexican American women involved in abusive relationships	• Education: 5–12 years (mean = 10.4 years)		• Three main categories: (1) "He beat me", (2) "He made me feel bad", (3) "He forced me"	
		• Ethnicity: Mexican American			
		• Location: South-central Texas			
McQuiston and Gordon (2000)	• Qualitative	• 31 Latino men and women, n = 16 women; age 20–29 years	Phenomenon: Condom negotiation	• Content analysis	60
	• Gain insight into (a) whether newly immigrated Mexican men and women in the Southeast discussed HIV/STD prevention with each other, and (b) how condom use was discussed	• Education: mean = 8.73 years		• Four themes: (1) Women: Communication comes first – it is safe sex, (2) Men: Trust comes first – it is safe sex, (3) Women: Machismo and Trust, (4) Men, Machismo, and Trust	

Authors (year)	Study design and purpose	Sample	Variables/phenomena	Analysis method and results	Quality score (%)
		• Ethnicity: Mexican American • Location: Southeastern US			
Moore et al. (1995)	• Cross-sectional • To determine the factors influencing Hispanic women's HIV-related communication and condom use with their primary male partner	• 189 Latina women; mean age 30 years • Education: 68% at least high school • Ethnicity: n = 44 Dominican, n = 54 Puerto Rican, n = 91 Mexican • Location: New York City, NY and El Paso Texas	• Dependent SSC variable: Level of HIV-related communication • Other dependent variables: Condom use • Independent variables: acculturation, perceived risk for HIV, conflict, sex communication, openness of communication, expected partner reactions to request for condom use, age, Hispanic subgroup, whether woman had multiple sex partners	• Ordinary least squares regression • Positive association: perceived risk of HIV infection ($\beta = .30$, $p = .0001$), openness of communication with partner ($\beta = .17$, $p = .05$) • Negative association: Mexican ethnicity ($\beta = -.36$, $p = .0003$), woman has other sex partners ($\beta = -.28$, $p = .0003$)	75
Saul et al. (2000)	• Cross-sectional • To empirically test the association between power and women's HIV-related communication and condom use with male partners	• 187 Latina women; age NR • Education: NR • Ethnicity: Puerto Rican • Location: New York City, NY	• Dependent SSC variable: HIV-related communication • Independent variables: Sexual power (education, employment, decision-making, perceived alternatives to relationship, commitment to the relationship, investment in the relationship, absence of abuse in relationship), age, relationship length	• Structural equation modeling • Negative association: Currently employed ($t(1166) = -3.32$, $p < .05$), high commitment to the relationship ($t(1166) = -3.67$, $p < .01$)	75

Note: NR, not reported.

Table 2

Thematic map of factors that facilitate or hinder SSC for Latina women in stable relationships.

Relationship factors	Individual factors	Partner factors
Relationship length	Attitudes/beliefs	Attitudes/beliefs
+ Longer relationship (Alvarez & Villarruel, 2013, 2015; McQuiston & Gordon, 2000)	+ Greater perceived risk of HIV infection (Davila, 2002; McQuiston & Gordon, 2000; Moore et al., 1995)	− Partner has greater endorsement of traditional gender roles ("Machismo") (Alvarez & Villarruel, 2013; McQuiston & Gordon, 2000)
	Skills	
	− Difficulty problem solving (Davila, 2002)	
	+ More positive attitudes or subjective norms toward SSC (Alvarez & Villarruel, 2015)	
Relationship quality	+ Greater perceived openness of partner to SSC (Alvarez & Villarruel, 2013)	Behaviors
+ Good general communication (McQuiston & Gordon, 2000; Moore et al., 1995)	− Poor attitude toward pleasure discussions (Alvarez & Villarruel, 2015)	+ Partner has other concurrent sex partners (Ashburn et al., 2008)
+ Greater intimacy (Castañeda, 2000)		+ Positive partner response to SSC (McQuiston & Gordon, 2000)
+ Mutual trust (McQuiston & Gordon, 2000)	− Feeling embarrassed (Alvarez & Villarruel, 2013)	
+ Mutual understanding (McQuiston & Gordon, 2000)	− Not wanting to know (Alvarez & Villarruel, 2013)	− Partner refuses to talk about SSC (McQuiston & Gordon, 2000)
	− Greater endorsement of traditional gender roles (McQuiston & Gordon, 2000)	− Partner substance use (Davila, 2002)
Use of initial sex activity	− High levels of trust of her partner (McQuiston & Gordon, 2000)	
+ Use of initial sexual activity to create foundation for SSC (Alvarez & Villarruel, 2013)	− Low perceived partner approval toward sexual communication (Alvarez & Villarruel, 2015)	
	Background characteristics	
Difference in time in the US	+ Residence in Peravia (compared to Azua), DR (Ashburn et al., 2008)	
− Greater difference in time living in the US between partners (Alvarez & Villarruel, 2015)	+ Greater acculturation (Alvarez & Villarruel, 2015)	
	− Mexican ethnicity compared to Puerto Rican (Moore et al., 1995)	
Power/control	− Children (Davila, 2002)	
+ Greater relationship power (Alvarez & Villarruel, 2015)	− Evangelical religion or no religious affiliation (Ashburn et al., 2008)	
+ Greater control of own money (Ashburn et al., 2008)	Behaviors	
− Currently employed (Saul et al., 2000)	+ Use of communication technology (Alvarez & Villarruel, 2013)	
− High commitment to maintaining the relationship (et al., 2000)	− Woman has other concurrent sex partners (Moore et al., 1995)	
− Feeling powerless (Davila, 2002)		
− Fear of or actual physical, psychological, and sexual abuse from partner (Davila, 2002)	Intrapersonal characteristics	
	− Poor sense of identity (Davila, 2002)	
	− Low self-esteem (Davila, 2002)	

A.2 Search Strategies Used for Intergrative Review

Lilacs

- Searched: 4/12/16
- Filters placed
    - Language: English or Spanish
    - Full text
- Number found: 495

Search strategy

("Safe sex" OR condom OR HIV OR STI OR STD OR sex$ OR "sexually transmitted infection" OR "sexually transmitted disease" OR "human immunodeficiency virus")
AND
(notification OR notify OR communicat$ OR negotiat$ OR refus$ OR discuss$ OR conversation OR convince OR ask OR respond$)
AND
(partner$ OR interpersonal OR "regular partner" OR "primary partner" OR "stable partner")

PsychInfo

- Searched: 4/12/16
- Limits placed:
    - Full text
    - Human
- Number found: 414

Search Strategy

1. AIDS/ or Safe Sex/ or safe sex.mp
2. Condoms/ or condom.mp
3. HIV/ or Sexually Transmitted Diseases/ or Sexual Risk Taking/ or Sexual Partners/ or AIDS Prevention/ or STI.mp

4. sexuality.mp. or Sexuality/
5. Sexual Attitudes/ or Sex/ or Male Female Relations/ or unwanted sex.mp.
6. Sexual Risk Taking/ or sexual health.mp.
7. 1 or 2 or 3 or 4 or 5 or 6
8. Verbal Communication/ or Communication Skills Training/ or Communication Barriers/ or communication.mp. or Nonverbal Communication/ or Interpersonal Communication/ or Communication/ or Oral Communication/ or Communication Skills/
9. negotiation.mp. or Negotiation/
10. notification.mp
11. refus*.mp.
12. Resistance/ or resist*.mp.
13. convince.mp.
14. Conversation/ or discuss*.mp
15. respon*.mp.
16. 8 or 9 or 10 or 11 or 12 or 13
17. Interpersonal Communication/ or Interpersonal Relationships/ or Interpersonal.mp. or Interpersonal Interaction/
18. partner*.mp.
19. Sexual Partners/ or "Regular Partner".mp
20. Couples/ or "Primary partner".mp
21. "Stable Partner".mp
22. Wives/ or Husbands/ or Spouses/ or Marital Relations/ or "husband and wife".mp.
23. 17 or 18 or 19 or 20 or 21 or 22
24. "Latinos/Latinas"/ or Mexican Americans/ or Latino.mp.
25. Hispanic.mp
26. "Hispanic American".mp.
27. Mexican.mp.
28. Dominican.mp.
29. "Dominican Republic".mp
30. "Puerto Rico".mp.

31. "Puerto Rican".mp.
32. Chile*.mp
33. "El Salvadorian".mp
34. "El Salvador".mp
35. Nicaragua*.mp.
36. Spain.mp
37. 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36
38. 7 and 16 and 23 and 37

EBSCO

- Searched: 4/26/16
- Databases searched:
    - Chicano Database
    - Gender Studies Database
    - SocIndex,
    - Social Work Abstracts
    - Family and Society Studies Worldwide
    - Social Sciences Full Text (H.W. Wilson).
- No limits placed
- Number found: 431

Search Strategy

S40 S36 AND S39

S39 S37 OR S38

S38 females

S37 women OR woman OR female

S36 S30 AND S35

S35 S31 OR S32 OR S33 OR S34

S34 stable partners

S33 regular partners OR stable partner OR primary partner

S32 regular partner OR (between husbands and wives) OR primary partners

S31 partner OR interpersonal OR partners

S30 S21 AND S29

S29 S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28

S28 Spanish OR Spain

S27 El Salvadorian OR Nicaragua OR Nicaraguan

S26 Chile OR El Salvador OR Chilean

S25 Puerto Rican OR Puerto Rico OR Dominican Republic

S24 Hispanic American OR Mexican American OR Dominican

S23 Hispanic-American OR Mexican OR Mexican-American

S22 Latino OR Latina OR Hispanic

S21 S12 AND S20

S20 S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19

S19 SU verbal communication OR non verbal communication OR non-verbal communication

S18 SU asking OR discussions OR responsiveness

S17 SU convince OR responding OR initiating conversation

S16 SU conversation OR asking OR convincing

S15 SU resist OR discussion OR discuss

S14 negotiating OR refusing OR refusal

S13 notification OR communication OR negotiation

S12 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11

S11 human immunodeficiency virus status OR sexual health

S10 unwanted sex OR sexual risk behavior OR HIV status

S9 use condom OR safe sexual issues OR sexual topics

S8 sexual pressure OR safe sex OR safer sex

S7 sexually transmitted disease OR condom OR sexually transmitted infection

S6 STI OR STD OR sexually transmitted infection

S5 human immunodeficiency virus risk OR sexuality OR preventing human immunodeficiency virus

S4 HIV OR HIV risk OR human immunodeficiency virus

S3 using condoms OR need for condoms OR feelings about condoms

S2 unsafe sex OR condoms OR condom use

S1 sex OR sexual OR safe sex

A.3 Clinic Staff Recruitment Script for Qualitative Descriptive Study (English)

"There is a nursing student from Columbia University in New York City, who is going to be here for the next three weeks doing interviews for a research project. She is interested in learning about women's experiences with preventing sexually transmitted infections in their main sexual relationship, with their male partner. Would you be willing to talk with her?"

A.4 Clinic Staff Recruitment Script for Qualitative Descriptive Study (Spanish)

"Hay una estudiante de enfermería de la Universidad de Columbia en Nueva York, quien estará en la clínica durante las próximas tres semanas para hacer encuestas para un proyecto de investigación. Ella esta interesada en aprender de las experiencias para prevenir las infecciones de transmisión sexual dentro de la relación de pareja. ¿Usted Estaría dispuesta a hablar con ella?"

A.5 Verbal Consent Form for Qualitative Descriptive Study (English)

Study Title: Understanding safe sexual communication between women and their stable partners in the Dominican Republic: A qualitative descriptive study

Research Purpose

The purpose of this study is to understand how being a woman affects the way women communicate with their primary sexual partners about preventing each other from HIV and STIs.

Information on Research

You are being asked to take part in a research study of what women's roles and experiences are, with regards to talking with their partners about protecting each other from human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). Taking part in this project would involve participating in a one-on-one interview and completing a demographic and sexual health questionnaire with the researcher. I am a nursing student from Columbia University School of Nursing in New York City and am asking you to take part, because you said you were interested when the clinic staff member approached you. May I audio-record the interview? If you do not want me to audio record the interview, that is OK. It will have no effect on your present or future care at La Clínica de Familia and will not affect your eligibility to participate in the study. Please listen carefully and ask any questions you may have, before agreeing to take part in this study.

What is this research study about?

The purpose of this study is to understand how being a woman affects the way women communicate with their primary sexual partners about preventing each other from HIV and STIs.

What are the eligibility requirements to be in the study?

In order to participate, you must:

1. Be 18 years or older
2. Be female

3. Be Dominican
4. Currently have a primary sex partner who is male
5. Receive care at La Clínica de Familia

What will I be asked to do?

If you agree to be in the study, we will have a single, one-on-one interview together, and I will ask you questions about:

- What it means to be a woman in your community and in a primary relationship with a male partner
- What it means to be a woman in a primary sexual relationships and that affects how women communicate with their primary sexual partner about protecting each other from HIV and STIs
- Where you think these ideas and expectations come from
- What other things affect how women communicate with their primary sexual partner about protecting each other from HIV and STIs

The interview will take between 30 and 60 minutes. With your permission I would like audio record the interview.

Confidentiality

How will the information I share be kept confidential?

The Columbia Institutional Review Board (IRB) and the Dominican Republic Consejo Nacional de Bioética en Salud (CONABIOS) have approved this study. These two organizations are in charge of protecting the rights of people who participate in research. Steps will be taken to protect your rights and privacy during all parts of this research project. Your name will not be recorded on your survey or interview information. Instead, the documents will be assigned a number. Your information will also be combined with the information from other women, so there will be no way to trace the information you share, back to you. The interview audio recordings and electronic files will be kept in an encrypted computer and flash drive that requires a password to be accessed. The computer and flash drive, and printed questionnaire documents

will be stored in a locked file cabinet in the medical directors office at La Clínica de Familia in La Romana. Voice recordings will be coded as an electronic list of individuals who participated in the interviews, which will be stored in an Excel file on the password protected and encrypted laptop and flash drive.

After all data has been collected, the password protected and encrypted laptop and flash drive, and the print questionnaire data will be carried to Columbia University Medical Center in New York, by the researcher, Heidi Castillo. When transported to CUMC, the printed questionnaire data will have no identifying information that could link participants to the data. The audio files may have identifying information, because time restraints will not make it possible to transcribe and de-identify information in the audio files before the researcher returns to New York. However, the audio files will be stored securely on the encrypted, password protected laptop and memory stick while being transported to New York. Once the data has arrived at CUMC, the print questionnaire data will be transferred to a locked metal file cabinet in the researcher's office at CUMC. After the audio files have been transcribed, the electronic transcripts will be stored on a secure multi-user CUMC system, the School of Nursing P drive (3959), and the encrypted password protected laptop and memory stick. As soon as the transcripts have been reviewed and approved by a senior researcher, the audio files from the interview will be destroyed. This will be done as soon as possible, but is estimated to take place between one and four months after the interviews take place. No data analysis will take place before transcripts have been produced that have removed all identifying information. Finally, in any sort of report that I make public, the researcher will not include any information that will make it possible to identify you.

Aside from Heidi Castillo, the following will have access to the interview and questionnaire information: Dr. Elaine Larson, Dr. Jennifer Dohrn, and Samantha Stonbraker. Authorities from the following agencies will also have access to the interview and questionnaire information: Columbia University, New York-Presbyterian Hospital, the CUMC Institutional Review Board, the Dominican Republic CONABIOS, and The Office of Human Research Protections ('OHRP').

Risks

What are the risks if I participate?

Participating in this study poses minimal risk to you. However, you may find some of the questions about your sexual history or what you do to prevent HIV and STIs to be sensitive. If you don't want to answer a question, just tell me and we will skip it. There is also a risk of breach in confidentiality, but we are taking great care and precaution to be sure that is very unlikely. Finally, participating will require your time.

Benefits

What are the benefits for me if I participate?

There are no direct benefits to you if you participate. But, the information that you share could improve the HIV prevention services and programs offered to women at La Clínica de familia and in your community.

Compensation

You will not receive any payment or other reward for taking part in this study.

Additional Costs

There will be no costs to you for being in this study.

Voluntary Participation

Do I have to participate?

Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer and you can stop the interview at any time. If you decide to take part in the study, you can withdraw at any time. There will be no offense taken or penalty if you decide to do any of these things. It will not affect your current or future care at La Clínica.

Alternative Procedures

The only alternative to participating in the study, is not participating in the study.

Additional Information

Who do I contact if I have questions?

The researchers conducting this study are Heidi Castillo, RN and Dr. Elaine Larson PhD, RN, FAAN, CIC. Please ask any questions you have now. If you have question later, about the study, you may contact:

- Heidi Castillo: hsc2138@cumc.columbia.edu
- Dr. Elaine Larson: ell23@cumc.columbia.edu or (212) 305-0722

If you have question later, about your rights as a participant, you may contact:

- Columbia University Institutional Review Board: irboffice@columbia.edu or (212) 305-5883
- Dominican Republic Consejo Nacional de Bioética en Salud (CONABIOS): sespas@conabios.gob. do or 809-544-2812 extensiones 2260 / 2261

This form is for you to keep for your records.

Do you have any questions about the information that we just covered?

If you consent to participate in this study, could you please repeat the following:

"I have read this consent form and the research study has been explained to me. I agree to be in the research study described above. A copy of this information sheet will be provided to me. By agreeing to participate, I have not given up any of the legal rights that I would have if I were not a participant in the study."

A.6 Verbal Consent Form for Qualitative Descriptive Study (Spanish)

Titulo del estudio: Entendiendo comunicación sobre el sexo seguro entre mujeres y sus parejas fijas en la Républica Dominicana

Yo le pido a Usted ser parte de este proyecto de investigación sobre los papeles de mujeres, y como ellas protegen a sí mismas y a su pareja sexual principal de las infecciones de transmisión sexual, incluso el virus de inmunodeficiencia humana (VIH). Si usted participa en este proyecto, vamos a llenar formularios cortos sobre su historia en general y su salud sexual. También, usted haría una encuesta individual con la investigadora. Yo soy enfermera y estudiante de doctorado en la Universidad de Columbia en la Ciudad de Nueva York, y yo le pido participar, porque Usted dijo que tenía interés cuando habló con la personal de la clínica.

¿Me permitirías audio grabar la encuesta? Si no, realmente no hay problema. Su decisión ser parte del estudio o no ser parte del estudio no afectará la atención medica que usted y su familia recibe de la clínica en este momento ni en el futuro. Tampoco afectará su elegibilidad para participar en el proyecto.

Por favor, escuche con atención a algunas cosas que voy a leer alrededor del estudio y después, usted va a tener la oportunidad hacer cualquier pregunta que usted tenga antes de continuemos.

¿Sobre qué es este proyecto?

El propósito de este estudio es entender cómo el ser mujer afecta la manera en la cual las mujeres intentan protegerse a sí mismas de las infecciones de transmisión sexual en sus relaciones de pareja.

¿Yo encajo bien en este proyecto?

Para ser parte de este estudio, Usted tiene que:

1. Ser mayor de 18 años
2. Ser mujer

3. Ser Dominicana
4. Actualmente tener una pareja sexual principal del sexo masculino
5. Recibir atención de La Clínica de Familia

¿Qué necesito hacer?

Si usted está de acuerdo en ser parte de este proyecto, usted y yo, nos reuniremos para hacer una encuesta y llenar unos formularios, y yo le haré preguntas sobre:

- ¿Cuál es el papel de las mujeres dentro de una relación de pareja?
- ¿Cuál es el papel de la mujer en protegerse a sí misma y a su pareja de las infecciones de transmisión sexual?
- ¿Qué más afecta la manera en la cual las mujeres intentan a protegerse a sí mismas y a sus parejas de las infecciones de transmisión sexual?
- ¿Cómo aprenden las mujeres de lo que se debe o no hacer en las diferentes áreas de su vida?

La reunión durará entre 60-90 minutes. Si usted lo autoriza me gustaría grabar la encuesta.

¿Cómo será mantenida confidencial la información que yo comparto durante la encuesta?

Los comités de ética de la Universidad de Colombia y la República Dominicana, el Institutional Review Board y el Consejo Nacional de Bioética en Salud (CONABIOS), ya han aprobado este proyecto. Las dos organizaciones tienen la responsabilidad de proteger los derechos de las personas que participan en proyectos de investigación. Durante este proyecto, serán tomadas medidas especiales para proteger los derechos y la privacidad de usted. Su nombre no será anotado en los documentos de su encuesta. En vez de su nombre, los documentos tendrán un número. La información que Usted comparta será combinada con la información de otras participantes, entonces, no habrá ninguna manera de rastrear su información personal.

Todos los datos, incluyendo la encuesta, la grabación de la encuesta, los archivos electrónicos y las transcripciones de las grabaciones serán guardados en una computadora y memoria flash USB encriptada que requiere de un código de acceso. Esta computadora y todos los documentos

impresos con datos serán guardados en un archivo cerrado con candado en la oficina de la directora médico en La Clínica de Familia en La Romana, o en un archivo cerrado con candado en mi oficina en la Universidad de Columbia en Nueva York.

Aparte de yo, las siguientes personas tendrán acceso a la información de la entrevista y los formularios: Dr. Elaine Larson, Dr. Jennifer Dohrn, and Samantha Stonbraker. Autoridades de las agencias siguientes también tendrán acceso a la información de la entrevista y los formularios: La Universidad de Columbia University, New York-Presbyterian Hospital, el IRB de CUMC, el CONABIOS de la Rep. Dom., y La Office of Human Research Protections ('OHRP').

Yo destruiré los archivos audios de la encuesta tan pronto las transcriba. Por último, en cualquier reporte que yo comparta con el público, no incluirá ninguna información que pudiera identificarla a Usted.

Le hacemos notar que Usted puede cambiar de opinión y retirar esta autorización en cualquier momento por cualquier razón. Para retirar esta autorización, Usted tiene que contactar a la investigadora principal, Dra. Elaine Larson por correo electrónico: ell23@cumc.columbia.edu o por teléfono: (212) 305-0722. Sin embargo, incluso si Usted retira esta autorización, los investigadores podrían seguir usando y revelando la información que ya tomaron, pero no será colectada nueva información para este propósito de investigación. Su autorización HIPPA caducará al fin de esta investigación.

¿Cuáles son los riesgos para mi al colaborar con este proyecto?

Colaborar con este proyecto le supone a usted un mínimo riesgo. Sin embargo, es posible que algunas preguntas sobre su salud sexual le parezcan un poco incomodas. Pero, si usted no desea responder solo déjemelo saber y pasaremos a la siguiente pregunta. También hay un riesgo que estaría un incumplimiento de su confidencialidad, pero estamos tomando mucho cuidado y precaución para hacerlo que no es probable que sucede. También el ser parte de este proyecto requerirá su tiempo.

¿Cuáles son los beneficios para mi al colaborar con este proyecto?

No hay ningún beneficio directo para usted al participar en este proyecto, pero la información que usted comparta conmigo podría ayudar a la Clínica y a su comunidad para que puedan apoyar a las mujeres a mejorar su salud sexual.

¿Cómo me va a compensar?

Usted no va a recibir compensación por participar. Pero, tampoco no hay ningún costo para ser parte del proyecto.

¿Tengo que participar?

Participar de este proyecto es completamente voluntario. Por lo cual usted puede pedirme que terminemos la encuesta en cualquier momento o no contestar cualquier pregunta. No habrá ninguna consecuencia negativa ni afectará los servicios que usted obtiene de la Clínica en este momento ni en el futuro.

¿Cuál es la alternativa de participar?

No existe otra alternativa para participar, además de no participar.

¿A quién puedo contactar si tengo alguna pregunta?

Las investigadoras que hacen este proyecto son Heidi Castillo, RN y Dra. Elaine Larson PhD, RN, FAAN, CIC. Por favor, siéntase en libertad de hacerme cualquier pregunta que Usted tenga en este momento.

Si Usted tuviera preguntas sobre el proyecto, más adelante, puede contactar a:

- Heidi Castillo: hsc2138@cumc.columbia.edu
- Dra. Elaine Larson: ell23@cumc.columbia.edu o (212) 305-0722

Si Usted tuviera preguntas sobre sus derechos como participante, más adelante, puede contactar a:

- El Institutional Review Board de la Universidad de Columbia: irboffice@columbia.edu o (212) 305-5883

- Consejo Nacional de Bioética en Salud (CONABIOS) de la República Dominicana: sespas@conabios.gob.do o 809-544-2812 extensiones 2260 / 2261

Este formulario es para su record personal.

Declaración de consentimiento:
¿Usted tiene más preguntas sobre lo que acabamos de hablar?

Si usted está de acuerdo en ser parte de este proyecto, podría, por favor, repetir lo siguiente:

"He leído este formulario de consentimiento y el estudio de investigación me ha sido explicado. Estoy de acuerdo en ser parte del estudio de investigación que fue descrito anteriormente. Una copia de esta formulario de información será proporcionada a mí. Por aceptar participar, no he renunciado a ninguno de los derechos legales que tendría si no fuera una participante en el estudio."

A.7 Interview Guide for Qualitative Descriptive Study (English)

Safe sex and sexual risk

Before beginning, I would like to remind you that the questions I am going to ask you refer to your current main partner.

- What does "safe sex" **mean** to you?

- How much risk do you think you have of getting a sexually transmitted infection within your relationship?
    - What makes you think that?

- Do you think your partner is only having sex with you?
    - What makes you think that?

- What do you or your partner do that reduces or increases your risk for sexually transmitted infections?

Managing sexual risk

- How often do you think about protecting yourself from sexually transmitted infections within your relationship?
    - What kind of things could a main partner do that would lead a woman to talk with them about topics that have to do with preventing sexually transmitted infections within their relationship?

- Do you remember the last time you thought about talking with your partner about avoiding sexually transmitted infections?
    - What lead you to want to talk about that topic with your partner?
    - What did you want to talk about?
    - Could you tell me about the thoughts you had in that moment?

- What fears did you have?
- What did you hope would happen?
- Did you end up saying something to your partner?

Verbal Communication

- How did your most recent conversation with your partner about safe sex unfold? What did you talk about?
  - How did the conversation start?
  - When did it happen?
  - What was your partner's reaction when you brought up the topic?
  - What thoughts passed through your mind during the conversation?
  - What did you do or say that seemed to help the conversation?
  - What didn't help the conversation?
  - When did the conversation end?
  - What were your thoughts at the end of the conversation?
  - Was there a positive of negative change in your relationship after the conversation?

- Have there been occasions when your partner didn't want to talk about a certain topic that had to do with protecting yourselves from sexually transmitted infections?
  - What was it that he didn't want to talk about?
  - What thoughts or feelings did you have when this happened?
  - Despite him not wanting to talk, did you still have the conversation at that time? Or in the future?
    - How did that conversation go?
    - How did it end?
    - What was the result of the conversation?

- Has there been a conversation you had about this topic that went especially well? Could you please tell me about that conversation?

    - What specifically was good about it?
    - Were there things you were able to achieve by talking with your partner about these topics?

- What difficulties or challenges have you had with respect to talking with your partner about safe sex?
    - Could you please tell me about a conversation when things did not go how you would have liked?
    - What didn't work well?
    - Have you ever experienced negative repercussions as a result of talking with your partner about how to avoid sexually transmitted infections? Could you please tell me about the last time this happened?

Non-verbal Communication

- Can you remember the last time that you wanted to talk with your partner about a topic related to safe sex, but you didn't say anything?
    - What lead to that situation?
    - What influenced your decision to not talk about it?
    - What did you want to talk about?
    - Could you tell me what your thoughts or feelings where in that moment?
    - What fears or worries did you have?
    - What hopes did you have?

- Has there ever been a time when you suspected that you were at risk of getting a sexually transmitted infection from your partner, but you still decided to not talk about the topic with him?
    - Could you talk to me about this?
    - What lead you to decide to not talk about it with your partner?

- If you decide to not talk about the topic with your partner, what other things have you done to protect yourself from getting a sexually transmitted infection from your partner?

- How easy or difficult has it been for you to talk about safe sex topics with your partner?
    - What things can make it easier or more difficult to talk about safe sex topics with a main partner?
    - What topics related to safe sex are the most difficult or easy to talk about with a partner?
    - How does the experience of talking about safe sex topics with a main partner compare to talking about these topics with a casual sex partner?

Gender roles and their origins

- Being a women, what expectations did you grow up with as a child or adolescent with respect to talking with a main partner about safe sex?
    - What positive or negative mesages did or do you hear with regards to women talking with their partners about safe sex with their main partners?
    - What expectations for women give or take away power from women to talk about topics that have to do iwth safe sex?

- How have these expectations for women infleuced the way in which you talk with you partner about safe sex?

- For women, what is the source of information for how to talk about safe sex with a main partner?

End

- What could have helped you or could help you currently to communicate better with your partner about safe sex?

    - In your opinion, what would have to happen for women to feel completely comfortable and capable of talking effectively with their main partner about safe sex topics?

- Is there anything else you would like to talk about that has to do with this topic that you think is important or that I haven't asked you about?

A.8 Interview Guide for Qualitative Descriptive Study (Spanish)

Sexo seguro y riesgo sexual

Antes de empezar, quiero aclarar que las preguntas que la hago refieren a su pareja estable actual

- Para Ud, ¿**Qué significa** ¨sexo seguro¨ o sexo sin riesgo?

- ¿A **cuánto riesgo** cree Ud. que puede estar expuesta dentro de su relación de pareja para conseguir una infección de transmisión sexual?
    - ¿Qué es lo que la hace creer eso?

- ¿Piensa, Ud. que su pareja **solamente tiene relaciones sexuales con Ud**.?
    - ¿Qué la hace pensar así?

- ¿Qué hacen Ud. o su pareja para que **disminuya o aument**e su riesgo para las ITS?

El manejar del riesgo sexual

- ¿**Qué tanto piensa** Ud. en el protegerse a si misma de las infecciones de transmisión sexual dentro de su relación de pareja?
    - ¿ Cuales **cosas pudiera hacer una pareja de confianza** que empujaría a la mujer tocar alguna tema relacionada al prevenir las ITS dentro de su relación de pareja?

- ¿Ud. recuerda cuándo fue la última vez que pensó hablar con su pareja sobre como evitar las ITS o algo similar?
    - ¿**Qué le llevo a Ud. desear tocar el tema** con su pareja?
    - ¿Sobre qué quería hablar?
    - ¿Podría contarme sobre los pensamientos que tenía en ese momento?
    - ¿Cuáles temores o miedos tenía?
    - ¿Qué esperaba Ud. que sucediera?
    - ¿**Le dijo algo** Ud a su pareja?

Comunicación verbal

- ¿**Cómo se desarrolló** la conversación mas reciente sobre sexo seguro entre Uds.? ¿Qué hablaron?
    - ¿Cómo **inició** la conversación?
    - ¿**Cuándo** sucedió?
    - ¿Cuál fue **la reacción** de su pareja cuando Ud. tocó el tema?
    - ¿Cuáles pensamientos pasaron por su mente durante esta conversación?
    - ¿Qué hizo o dijo Ud. que **ayudó a** la conversación?
    - ¿Hubo algo que **no ayudó**?
    - ¿**Cuándo terminó** la conversación?
    - ¿Cuáles pensamientos tuvo Ud. cuando concluyó la conversación?
    - ¿**Hubo algún cambio** positivo o negativo en su relación después de la conversación?

- ¿Hubo ocasiones en que **su pareja no quiso hablar de algún tema relacionado al protegerse** ?
    - ¿Sobre qué no quiso hablar él?
    - ¿Qué pensamientos o sentimientos tenía Ud.?
    - ¿A pesar de que él no quería hablar, **aún asi se dió la conversación entre Uds**. En ese momento?¿En el futuro?
        - ¿Cómo les fue en la conversación?
        - ¿Cómo terminó?
        - ¿Qué resultó de la conversación?

- ¿Hubo una conversación **que le fue muy bien**? ¿Me cuenta Ud. sobre una conversación en la que le fue bien?
    - ¿Específicamente qué estuvo bien?
    - ¿Hay cosas que Ud. ha podido lograr por haber hablado con su pareja sobre estos temas?

- ¿Qué tipos de **desafíos o dificultades** ha tenido Ud. con respecto al hablar con su pareja sobre el sexo seguro?
    - ¿Me puede contar sobre una conversación que no le gustó como se dieron las cosas?
    - ¿Qué no le funcionó bien?
    - ¿Alguna vez Ud**. experimentó repercusiones negativas** por tocar el tema de cómo evitar las ITS con su pareja? ¿Me contaría sobre la última vez cuando esto le sucedió?

Comunicación NO verbal

- ¿Ud. puede recordar la última vez cuando quiso hablar con su pareja sobre algún tema relacionado al sexo seguro, pero **Ud. no dijo nada?**
    - ¿Qué **pasó para provocar** esta situación?
    - ¿**Qué influyo su decisión de no hablarlo?**
    - ¿Sobre qué quería hablar?
    - ¿Me podría decir cuáles fueron sus pensamientos o sentimientos en ese momento?
    - ¿Cuáles temores o miedos tenía?
    - ¿Cuáles esperanzas tenía?

- ¿Alguna vez **sospechó que había un alto riesgo** de conseguir una infección de transmisión sexual de su pareja, pero Ud. no quiso tocar el tema con su pareja?
    - ¿Me podría hablar sobre esto?
    - ¿Cuáles fueron los pensamientos que la llevaron a decidir a no hablar de esto con su pareja?

- Si Ud. decide no tocar el tema de sexo seguro con su pareja, **que cosas otras hace Ud**. para protegerse a si misma de conseguir una infección de transmisión sexual de su pareja?

- ¿Qué tan **fácil o difícil** ha sido para Ud tocar el tema de sexo seguro con su pareja?
    - Cuáles **cosas lo puede hace más fácil o difícil** tocar la tema de cómo evitar los ITS con una pareja?
    - ¿**Cuáles temas** relacionadas al sexo sin riesgo son las más difíciles o fáciles de tocar con una pareja de confianza?
    - **¿Cómo compara la experiencia de tocar temas sobre el sexo sin riesgo con una pareja de confianza comparado con un compañero sexual casual?**

Papeles y sus orígenes

- ¿Por ser hombra, **Cuáles expectativas** sentió Ud durante su niñez y adolescencia con respeto al hablar con una pareja sobre el sexo sin riesgo?
    - ¿Cuáles fueron los **mensajes positivos o negativos** que Ud. ha recibido por ser hembra con respeto a….?
    - ¿Cuáles expectativas para mejers **les da o les quita poder** para tocar temas relacionadas al sexo sin riesgo?

- ¿**Cómo la han afectado** la manera en que Ud. comunica con su pareja sobre el sexo sin riesgo, estas expectativas?

- ¿Para las mujeres, **cuál es o era la fuente de información** sobre como comunicarse con una pareja sobre el sexo sin riesgo?

Fin

- **Que le pudiera haber ayudado** o le podría ayudar comunicarse mejor con una pareja sobre el sexo sin riesgo?

    - En su opinión, ¿qué **tendría que pasar** para que las mujeres pudieran sentirse completamente cómodas y capaces para comunicarse de una manera eficaz con sus parejas estables sobre el sexo seguro?

¿Hay algo más sobre esta tema que todavía no la he preguntado de que Ud. Piensa qu

A.9 Demographic and Sexual Health Form (English)

PP#_____ Date:_____ Consent:_____ Permission to record:_____

Eligibility	
Are you a woman?	Yes No
How old are you?	
Are you from the Dominican Republic or a different country?	Yes No
Which country?	
Are your ancestors from the Dominican Republic or a different country?	Yes No
Which country?	
What is your marital status?	Married Not married to partner Widow Divorced Separated Single
Do you have someone who you consider to be you main partner?	Yes No
Are they male, female, or transgender?	Male Female Transgender
How long have you been together?	_____
When was the last time you were sexually active? (Vaginal, anal, or oral sex)	_____
Sometimes, even when women have their main partner, they also have sex with other people outside of their main relationship. Do you have any other sexual partners?	Yes No
Have you lived in or traveled to the United States?	Yes No
When was the last time?	_____ **NA**
How often do you travel between the Dominican Republic and the United states?	_____ **NA**
	Qualify **Do not qualify**

Based on this information, you qualify/don't qualify for the study

Demographic Information: To begin, I would like to ask you some general questions about your history

Do you identify with a specific religion?		
	Yes	No
Could you tell me which?	_____	**NA**
Do you have children?	Yes	No
How many children do you have?	_____	**NA**
What was the highest grade you completed in school?	_____	
What do you do to make money?	_____	
Is there anything else you do for money?	Yes	No
What else?	_____	**NA**
Havey ou ever exchanged sex (oral, vaginal, anal) and or your company for money, drugs, food, or a place to stay?	Yes	No
Could you tell me what your monthly income is?	_____	**NA**
Do you know the annual income of your entire household?	Yes	No
Could you tell me how much you estimate to be the monthly income of your entire household?	_____	**NA**
Is there someone in your home who provides the majority of financial support in your household?	Yes	No
Could you tell me who that is?	_____	**NA**

Sexual Health: Now I would like to ask you a couple of questions about your sexual health. Again, all of the information that you share with me is strictly confidential.

Do you drink alcohol?	Yes	No	
How many drinks do you have per week? (How many small beers, cups of wine, or shots of hard liquor)			
Do you use any drugs?	Yes	No	
Which do you use?	_____	**NA**	
How many days in the past month did you use drugs?	_____	**NA**	
Are you currently pregnant?	Yes	No	Don't know
Are you currently trying to become pregnant?	Yes	No	
What is your reason for coming to the clinic today?	_____		
Have you ever had a sexually transmitted infection or do you currently have one?	Yes	No	
Have you ever had a HIV test?	Yes	No	
When was the last time?	_____		
What was the result?	Positive	Negative	
Do you use condoms with your main partner during vaginal and/or anal sex?	Yes	No	
During the past three months, did you use condoms every time you had anal and/or vaginal sex?	Yes	No	
Do you use condoms with your main partner during oral sex?	Yes	No	NA
During the past three months, did you use condoms every time you had oral sex?	Yes	No	NA
Earlier, you told me that you have sex with other people. How many other people, aside from your main partner, are you currently having sex with?	_____	**NA**	
Men, women, or both?			

	Men	women	Both
Do you use condoms with your other partners during vaginal and/or anal sex?	Yes	No	NA
During the past three months, did you use condoms every time you had anal and/or vaginal sex?	Yes	No	NA
Do you use condoms with your other partners during oral sex?	Yes	No	NA
¿During the past three months, did you use condoms every time?	Yes	No	NA

A.10 Demographic and Sexual Health Form (Spanish)

PP#_____ Fecha:_____ Consentimiento:_____ Permiso para grabar:_____

Elegibilidad	
¿Ud es mujer?	Sí No
¿Cuántos años tiene Ud.?	Sí No
¿Usted es de la República Dominicana o de otro país? ¿Cuál país?	Sí No
¿Sus ancestros son de la República Dominicana o de otro país? ¿Cuál país?	
¿Cuál es su estado civil?	Casada Con Pareja Viuda Divorciada Separada Soltera
¿Tiene alguien que Ud. considera su pareja principal?	Sí No
¿Es hombre, mujer o trans-género?	Hombre, Mujer Trans-género
¿Cuánto tiempo llevan juntos?	_____
¿ Cuándo fue la última vez que Uds. fueron sexualmente activos? (Sexo vaginal, oral o anal)	_____
A veces, incluso cuando una mujer tiene su pareja principal, también tiene relaciones sexuales con otros compañeros, fuera de su relación o fuera de la casa. ¿Usted tiene otros compañeros sexuales?	Sí No
¿Ud. Ha viajado o vivido en los EEUU?	_____ **NA**
¿Cuándo fue la última vez?	_____ **NA**
	Califica **No califica**

¿Con qué frecuencia Ud. viaja entre La Rep. Dom. Y Los EEUU?

Basado en esta información Ud. califica/ no califica para el proyecto

Información Demográfica: Para empezar, me gustaría hacerle unas preguntas sobre su historia general.

¿Usted se identifica con una religión específica?	Sí	No
¿ Podría decirme con cuál?	_____	**NA**
¿Usted tiene hijos?	Sí	No
¿Cuántos hijos tiene Usted?	_____	**NA**
¿Hasta que grado de estudios llegó en la escuela?	_____	
¿Qué hace Ud. para ganar dinero?	_____	
¿Hay algo más que Ud. hace para ganar dinero?	Sí	No
¿Qué más hace?	_____	**NA**
¿Alguna vez, Ud. ha intercambiado sexo (oral, vaginal, anal) y o su compañía por dinero, drogas, comida, o un lugar para quedarse?	Sí	No
¿ Podría decirme cuál es su ingreso mensual?	_____	**NA**
¿Usted sabe el ingreso anual de su hogar?	Sí	No
¿Podría decirme cuál es su estimado del ingreso mensual en su hogar?	_____	**NA**
¿Hay alguien en su hogar quien provee la mayor cantidad de ingreso en su hogar?	Sí	No
¿ Podría decirme quién es?	_____	**NA**

Salud sexual: Ahora, me gustaría hacerle unas preguntas sobre su salud sexual. Quiero asegurarle que toda la información que usted comparta conmigo será estrictamente confidencial.

¿Ud. bebe alcohol?	Sí	No	
¿Cuántas bebidas toma cada semana? (como cuantas cervezas pequeñas, vasos de vino o tragos de otro alcohol)			
¿ Ud. usa alguna droga?	Sí	No	
¿Cuáles usa?	_____		**NA**
¿ Cuántas días Ud. usó drogas durante el último mes?	_____		**NA**
¿Ud. está embarazada actualmente?	Sí	No	No sabe
¿Ud. está tratando de quedar embarazada actualmente?	Sí	No	
¿Cuál es el motivo de su visita a la clínica el día de hoy?	_____		
¿Usted ha tenido una infección de transmisión sexual en el pasado o tiene una en este momento?	Sí	No	
¿Alguna vez Ud. se ha hecho una prueba para VIH?	Sí	No	
¿Cuándo fue la última vez?	_____		
¿Qué fue el resultado?	Positivo		Negativo
¿Usted usa condones con su pareja estable (de confianza) durante sexo vaginal y anal?	Sí	No	
¿Durante los últimos tres meses, Usted usó condones cada vez que tuvo sexo vaginal y anal?	Sí	No	
¿Usted usa condones con su pareja estable durante el sexo oral?	Sí	No	NA
¿Durante los últimos tres meses, Usted usó condones cada vez que tuvo el sexo oral?	Sí	No	NA

Ud. me dijo que tiene otro(s) compañeros sexuales. ¿Cuántos tiene actualmente aparte de su pareja estable?	_____ **NA**		
¿Hombres, mujeres o los dos?	Hombres	mujeres	los dos
¿Usted usa condones con sus otros compañeros sexuales durante sexo vaginal y anal?	Sí	No	NA
¿Durante los últimos tres meses, Usted usó condones cada vez que tuvo sexo vaginal y anal?	Sí	No	NA
¿Usted usa condones con sus otros compañeros sexuales con el sexo oral?	Sí	No	NA
¿Durante los últimos tres meses, Usted usó condones con cada vez que tuvo el sexo oral con sus otros compañeros sexuales	Sí	No	NA

A.11 Clinic Staff Recruitment Script for Cross-sectional Survey Study (English)

"There is a nursing student from Columbia University in New York City, who is going to be here for the next couple of months doing interviews for a research project. She is interested in learning about women's experiences communicating with their partner about sexual health topics. Would you be willing to complete an interview with her?"

A.12 Clinic Staff Recruitment Script for Cross-sectional Survey Study (Spanish)

“Hay un estudiante de enfermería de la Universidad de Colombia en Nueva York, quien va a estar en la clínica durante la próxima par de meses para hacer encuestas para un proyecto de investigación. Ella esta interesada en aprender sobre la comunicación que mujeres tienen con sus parejas sobre la salud sexual.¿Usted estaría dispuesta para llenar un formulario con ella?”

A.13 Verbal Consent Form for Cross-sectional Survey Study (English)

Title of Study: Psychosocial correlates of safe sexual communication for women with stable partners living in the Dominican Republic

Research Purpose

The purpose of this study is to understand how women communicate with their stable partners about sexual health and what influences this communication.

Information on Research

You are being asked to take part in a research study about the communication that women have with their partners about sexual health. Taking part in this project would involve completing and interview with the researcher that involves questions about the communication you have with your partner, as well as your general and sexual health history.

I am a nursing student from Columbia University School of Nursing in New York City and am asking you to take part, because you said you were interested when the clinic staff member approached you. Your decision to participate or not participate in this study will not affect your present or future care at La Clinica de Familia.

Please listen carefully and ask any questions you may have, before agreeing to take part in this study.

What is this research study about?

The purpose of this study is to understand how women communicate with their stable partners about sexual health and what influences this communication.

Am I a good fit for the study?

In order to participate, you must:

1. Be 18 years or older

2. Be female

3. Be Dominican

4. Currently have a stable male partner

5. Receive care at La Clinica de Familia

What will I be asked to do?

If you agree to be in the study, we will have a single, one-on-one interview together, and I will ask you questions about:

- Which sexual health topics you do or do not talk with your partner about
- What things influence this communication with your partner
- You general and sexual history

The interview will take between 60 and 90 minutes.

Confidentiality

The Columbia Institutional Review Board (IRB) and the Dominican Republic Consejo Nacional de Bioetica en Salud (CONABIOS) have approved this study. These two organizations are in charge of protecting the rights of people who participate in research. Steps will be taken to protect your rights and privacy during all parts of this research project. Your name will not be recorded. Instead, you will be assigned a number. Your information will also be combined with the information from other women, so there will be no way to trace the information you share, back to you.

Data will be entered directly into a secure online data capture application through the use of a password protected and encrypted tablet, at the time of our interview. The tablets will be stored in a locked file cabinet in the medical directors office at La Clinica de Familia in La Romana, or in a locked file cabinet in my office at Columbia University.

Aside from me, the following will have access to the interview information: Dr. Elaine Larson, Dr. Jennifer Dohrn, and Samantha Stonbraker. Authorities from the following agencies will also

have access to the interview and questionnaire information: Columbia University, New York-Presbyterian Hospital, the CUMC Institutional Review Board, the Dominican Republic CONABIOS, and The Office of Human Research Protections ('OHRP').

In any sort of report that I make public, I will not include any information that will make it possible to identify you.

Please note that you may change your mind and revoke "take back" this authorization at any time for any reason. To revoke this authorization you must contact the Principal Investigator, Dr. Elaine Larson by email: ell23@cumc.columbia.edu or by phone: (212) 305-0722. However, even if you revoke this authorization, the researchers may continue to use and disclose the information already collected, however new information will not be collected for this research purpose. Your HIPAA authorization will expire at the end of this research.

Risks

Participating in this study poses minimal risk to you. However, you may find some of the questions about your sexual history or the safe sexual communication you have with your partner to be sensitive. If you don't want to answer a question, just tell me and we will skip it. There is also a risk of breach in confidentiality, but we are taking great care and precaution to be sure that is very unlikely. Finally, participating will require your time.

Benefits

There are no direct benefits to you if you participate. But, the information that you share could improve the HIV prevention services and programs offered to women at La Clinica de Familia and in your community.

Compensation

You will not receive any payment or other reward for taking part in this study.

Additional Costs

There will be no costs to you for being in this study.

Voluntary Participation

Your participation in this study is completely voluntary. You do not need to answer any questions that you do not want to answer and you can stop the interview at any time. If you decide to take part in the study, you can withdraw at any time. There will be no offense taken or penalty if you decide to do any of these things. It will not affect your current or future care at La Clinica

Alternative Procedures

The only alternative to participating in the study, is not participating in the study.

Additional Information

Who do I contact if I have questions?

The researchers conducting this study are Heidi Castillo, RN and Dr. Elaine Larson PhD, RN, FAAN, CIC. Please ask any questions you have now.

If you have question later, about the study, you may contact:

- Heidi Castillo: hsc2138@cumc.columbia.edu
- Dr. Elaine Larson: ell23@cumc.columbia.edu or (212) 305-0722

If you have question later, about your rights as a participant, you may contact:

- Columbia University Institutional Review Board: irboffice@columbia.edu or (212) 305-5883
- Dominican Republic Consejo Nacional de Bioetica en Salud (CONABIOS): sespas@conabios.gob. do or 809-544-2812 extensiones 2260 / 2261

This form is for you to keep for your records. Do you have any questions about the information that we just covered?

If you consent to participate in this study, could you please repeat the following:

"I have read this consent form and the research study has been explained to me. I agree to be in the research study described above. A copy of this information sheet will be provided to me. By agreeing to participate, I am not renouncing any of my legal rights that I would have if I was not a participant in the study"

A.14 Verbal Consent Form for Cross-sectional Survey Study (Spanish)

Título: Las influencias en la comunicación sobre la salud sexual entre mujeres y sus parejas estables en la República Dominicana

¿Sobre qué es este proyecto?

El propósito de este estudio es entender cómo las mujeres se comunican con sus parejas fijas sobre la salud sexual y que factores afectan esta interacción en esta relación.

Información sobre este proyecto de investigación

Hola, Mi nombre es Heidi, yo soy enfermera y estudiante de doctorado en la Universidad de Columbia en la Ciudad de Nueva York, y yo le pido participar, porque Usted dijo que tenía interés cuando habló con la personal de la clínica. Su decisión ser parte del estudio o no ser parte del estudio no afectará la atención medica que usted y su familia recibe de la clínica en este momento ni en el futuro.

Yo le pido a usted ser parte de este proyecto de investigación sobre cómo es la comunicación sobre salud sexual que las mujeres tienen con sus parejas. Si usted participa en este proyecto, vamos a llenar un formulario sobre algunas informaciones sobre usted en general, la comunicación que Ud. tiene con su pareja, y su salud sexual.

Por favor, escuche con atención a algunas cosas que le voy a leer sobre el estudio y después, usted tendrá la oportunidad de hacer cualquier pregunta que usted tenga antes de continuemos.

¿Yo encajo bien en este proyecto?

Para ser parte de este estudio, Usted tiene que:

1. Ser mayor de 18 años
2. Ser mujer
3. Ser Dominicana
4. Actualmente tener una pareja estable que sea hombre

5. Recibir atención de La Clínica de Familia

¿Qué necesito hacer?

Si usted está de acuerdo en ser parte de este proyecto, usted y yo, nos reuniremos para llenar un formulario que tiene preguntas sobre:

- Cuáles temas de la salud sexual Ud. toca o no toca con su pareja
- Cuáles cosas influyen esta comunicación con su pareja
- Su historia general y de salud sexual

La reunión durará entre 60-90 minutes.

Confidencialidad

¿Cómo será mantenida de forma confidencia la información que yo compartiré durante la encuesta?

Los comités de ética de la Universidad de Colombia y la República Dominicana, el comité de ética de investigación y el Consejo Nacional de Bioética en Salud (CONABIOS), ya han aprobado este proyecto. Las dos organizaciones tienen la responsabilidad de velar que los derechos de las personas que participan en proyectos de investigación sean protegidos. Durante este proyecto, serán tomadas estrictas medidas de seguridad para proteger los sus derechos y su privacidad. Su nombre no será anotado en los documentos de su encuesta. En vez de su nombre, los documentos tendrán un número. La información que Usted comparta en los formularios será juntada con los formularios de otras participantes, en un orden aleatorio, entonces, no habrá ninguna manera de rastrear su información personal.

Sus datos serán digitados directamente a una aplicación seguro en la red por el uso de una tableta encriptada que requiere un código de acceso. Esta tableta será guardada en un archivo cerrado con seguro en la oficina de la directora médico en La Clínica de Familia en La Romana, o en un archivo cerrado con seguro en mi oficina en la Universidad de Columbia en Nueva York.

Aparte de mí, las siguientes personas tendrán acceso a la información de la entrevista y los formularios: Dr. Elaine Larson, Dr. Jennifer Dohrn, and Samantha Stonbraker. También Las autoridades de las agencias siguientes tendrán acceso a la información de las entrevistas y los formularios: La Universidad de Columbia University, New York-Presbyterian Hospital, el IRB de CUMC, el CONABIOS de la Rep. Dom., y La Oficina de protección de investigación en Humanos de Los Estados Unidos (Office of Human Research Protections o 'OHRP' por sus siglas en inglés).

En cualquiera de los reportes que yo comparta con el público o en publicaciones, no se incluirá información que pudiera identificarle.

Le hacemos notar que Usted puede cambiar de opinión y retirar esta autorización en cualquier momento por cualquier razón. Para retirar esta autorización, Usted tiene que contactar a la investigadora principal, Dra. Elaine Larson por correo electrónico: ell23@cumc.columbia.edu o por teléfono: (212) 305-0722. Sin embargo, incluso si Usted retira esta autorización, los investigadores podrían seguir usando y revelando la información que ya tomaron, pero no será recolectada información nueva para este propósito de investigación. Su autorización sobre el uso de sus datos según la ley de Portabilidad y Contabilidad de Seguros de Salud en Los Estados Unidos o regla de privacidad de datos de salud (HIPPA por sus siglas en inglés) caducará al fin de esta investigación.

Riesgos

¿Cuáles son los riesgos para mí al participar en esta investigación?

El colaborar con este proyecto de investigación le expone a usted a un mínimo riesgo. Sin embargo, es posible que algunas preguntas sobre su salud sexual le parezcan un poco incomodas. Pero, si usted no desea responder solo déjemelo saber y pasaremos a la siguiente pregunta. También hay un riesgo que estaría un incumplimiento de su confidencialidad, pero estamos tomando mucho cuidado y precaución para evitar que esto suceda. También el ser parte de este proyecto requerirá su tiempo.

Beneficios

¿Cuáles son los beneficios para mí al colaborar con este proyecto?

No hay ningún beneficio directo para usted al participar en este proyecto, pero la información que usted comparta conmigo podría ayudar a la Clínica y a su comunidad para que puedan apoyar a las mujeres a mejorar su salud sexual.

Compensación y costos adicionales

¿Cómo me va a compensar?

Usted no va a recibir compensación por participar. Pero, tampoco no hay ningún costo para ser parte del proyecto.

Participación voluntaria

¿Tengo que participar?

Participar de este proyecto es completamente voluntario. Por lo cual usted puede pedirme que terminemos la encuesta en cualquier momento o no contestar cualquier pregunta. No habrá ninguna consecuencia negativa ni afectará los servicios que usted obtiene de la Clínica en este momento ni en el futuro.

Alternativas

¿Cuál es la alternativa de participar?

No existe otra alternativa para participar, además de no participar.

Información adicional

¿A quién puedo contactar si tengo alguna pregunta?

Las investigadoras que hacen este proyecto son Heidi Castillo, RN y Dra. Elaine Larson PhD, RN, FAAN, CIC. Por favor, siéntase en libertad de hacerme cualquier pregunta que Usted tenga en este momento.

Si Usted tuviera preguntas sobre el proyecto, más adelante, puede contactar a:

- Heidi Castillo: hsc2138@cumc.columbia.edu
- Dra. Elaine Larson: ell23@cumc.columbia.edu o (212) 305-0722

Si Usted tuviera preguntas sobre sus derechos como participante, más adelante, puede contactar a:

- El Institutional Review Board de la Universidad de Columbia: irboffice@columbia.edu o (212) 305-5883
- Consejo Nacional de Bioética en Salud (CONABIOS) de la República Dominicana: sespas@conabios.gob.do o 809-544-2812 extensiones 2260 / 2261

Este formulario es para su record personal.

Declaración de consentimiento:

¿Usted tiene más preguntas sobre lo que acabamos de hablar?

Si usted está de acuerdo en ser parte de este proyecto, podría, por favor, repetir lo siguiente:
" He leído este formulario de consentimiento y el estudio de investigación me ha sido explicado. Estoy de acuerdo en ser parte del estudio de investigación que fue descrito anteriormente. Una copia de esta formulario de información será proporcionada a mí. Por aceptar participar, no he renunciado a ninguno de los derechos legales que tendría si no fuera una participante en el estudio."

A.15 Interviewer Administered Survey for Cross-sectional Study (English)

Sexual Health Communication Survey	
Please complete the survey below	
Thank you!	
First, I am going to make sure that you are eligible	
Are you a woman?	Yes No
Are you an adult (18 years or older)?	Yes No
Are you Dominican?	Yes No
Do you have a stable partner than is a man?	Yes No
Did you provide informed consent?	Yes No
Date of the survey	
Data collected by:	Sonia Heidi
We are going to start with some general questions	
How old are you?	
How old is your partner?	
How long have you been together?	Years Months Weeks
Indicate how many years	
Indicate how many months	
Indicate how many weeks	
How many children to you have all together (with your current partner and any past partners)?	
How many children live with you?	
The following questions are about certain topics with your partner	
First, I am going to ask you some question about the risk of sexually transmitted infections. Sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Talking with your partner about the risk of sexually transmitted infections is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
How much would your partner accept talking about the risk of sexually transmitted infections?	A lot Not a lot nor a little, or

	A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to talk with your partner about the risk of sexually transmitted infections?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner about the risk of sexually transmitted infections?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now, I am going to ask you some questions about sexually transmitted infections, with respect to your partner. Remember that sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Talking with your partner about whether he has ever had a sexually transmitted infection is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
How much would your partner accept talking about whether he has ever had a sexually transmitted infection?	A lot Not a lot nor a little, or A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to talk with your partner about whether he has ever had a sexually transmitted infection?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner about whether he has ever had a sexually transmitted infection?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to talk about your partner and sexual partners he has had in the past	
Talking with your partner about the sexual partners he has had in the past is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer

How much would your partner accept talking about the sexual partners he has had in the past?	A lot Not a lot nor a little, or A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to talk with your partner about the sexual partners he has had in the past?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner about the sexual partners he has had in the past?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to talk about your partner having sex with other people outside of your relationship	
Talking with your partner about whether he is currently having sex with other women or men outside of your relationship is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
How much would your partner accept talking about whether he is currently having sex with other women or men outside of your relationship?	A lot Not a lot nor a little, or A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to talk with your partner about whether he is currently having sex with other women or men outside of your relationship?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner whether he is currently having sex with other women or men outside of your relationship?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to talk about tests for sexually transmitted infection. Remember that sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Asking your partner to get tested for sexually transmitted infections is…	A bad idea Not a good idea nor a bad idea, or A good idea

	(Do not read) Don't know (Do not read) Refuse to answer
How much would your partner accept you asking him to get tested for sexually transmitted infections?	A lot Not a lot nor a little, or A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to ask your partner to get tested for sexually transmitted infections?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever asked your partner to get tested for sexually transmitted infections?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now lest talk about changing your partner's behavior to avoid a sexually transmitted infection. Remember that sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Asking your partner to change his behavior to not get a sexually transmitted infection is …	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
How much would your partner accept you asking him to change his behavior to not get a sexually transmitted infection?	A lot Not a lot nor a little, or A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to ask your partner to change his behavior to not get a sexually transmitted infection?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever asked your partner to change his behavior to not get a sexually transmitted infection?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
What have you asked him to do or change?	
Now let's talk about condoms	

Asking your partner to use a condom with you so that you do not get a sexually transmitted infection is …	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
How much would your partner accept you asking him to use a condom with you so that you do not get a sexually transmitted infection?	A lot Not a lot nor a little, or A little (Do not read) Don't know (Do not read) Refuse to answer
How capable do you feel to ask your partner to use a condom with you so that you do not get a sexually transmitted infection?	Very capable Capable More or less capable Not very capable, or Not capable (Do not read) Don't know (Do not read) Refuse to answer
Have you ever asked your partner to use a condom with you so that you do not get a sexually transmitted infection?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
The following questions or statements that I am going to read are opinions about certain topics that you can talk about with your partner. For each, please tell me if you completely agree, agree, neither agree nor disagree, disagree, or completely disagree.	
1. If you were to talk to you partner about sex it would be disrespectful	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
2. If you talk to your partner about sex you will feel embarrassed	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
3. You would not tell your partner how many people you've had sex with because it's none of your partner's business	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer

4. If you asked your partner to use a condom, he would think you're having sex with other people	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
The following questions are about trust in relationships. For each statement that I read to you, could you please tell me if you completely agree, agree, neither agree nor disagree, disagree, or completely disagree.	
Your partner is primarily interested in his own welfare	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
There are times when your partner cannot be trusted	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
Your partner is perfectly honest and truthful with you	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
You feel that you can trust your partner completely	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
Your partner is truly sincere in his promises	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer

You feel that your partner does not show you enough consideration	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
Your partner treats you fairly and justly	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
You feel that your partner can be counted on to help you.	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
Now, we are going to continue with some questions about your health. The following questions are to see how you feel about yourself. For each statement that I read, could you please tell me if you strongly agree, agree, disagree, or strongly disagree	
On the whole, you are satisfied with yourself	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
At times you think you are no good at all.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You feel that you have a number of good qualities.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You are able to do things as well as most other people.	Strongly agree Agree Disagree, or

	Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You feel you have much to be proud of.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You feel useless at times.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You feel that you're a person of worth, at least on an equal plane with others.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You wish you could have more respect for yourself.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
All in all, you are inclined to feel that you are a failure.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
You take a positive attitude toward yourself.	Strongly agree Agree Disagree, or Strongly disagree (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to continue with some questions that have to do with sexual health	
In the past 12 months, including your partner, with how many different people have you had sex?	
When was the last time you had sex with your stable partner?	Days Weeks Months

	Years (Do not read) Don't know (Do not read) Refuse to answer
Indicate how many days	
Indicate how many weeks	
Indicate how many months	
Indicate how many years	
In the past 12 months, have you had a sexually transmitted infection (Chlamydia, gonorrhea, syphilis, herpes, human papilloma virus)?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Have you ever had a test to see if you have HIV, the virus that causes AIDS?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
When is the last time you took the test?	
Are you willing to share the result?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
What was it?	Negative Positive (Do not read) Don't know (Do not read) Refuse to answer
Do you know the HIV status of your partner?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Did you find out from your partner or someone else?	Partner or Someone else (Do not read) Don't know (Do not read) Refuse to answer
This question refers to how much risk you think you have of getting a sexually transmitted infection within your relationship, tell me	
How likely do you think it is that you would get a STI if you had sex with your partner without using a condom?	Not at all likely Somewhat likely Likely Very likely, or Extremely likely (Do not read) Don't know (Do not read) Refuse to answer
The following question is about your partner and other women	
Your partner could be having sex with someone else	Yes or No (Do not read) Don't know

	(Do not read) Refuse to answer
The following question are about how you feel within your relationships with your partner	
How often do you feel frightened by what your partner says or does?	Often Sometimes Never (Do not read) Don't know (Do not read) Refuse to answer
How often does your partner abuse you emotionally? (e.g. call you names, make fun of you, or make you feel bad about yourself)	Often Sometimes Never (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to continue the survey with some questions about sex, men, and women. For each statement, please tell me if you strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree	
Men only want to have sex that involves the penis going inside the vagina or anus	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men prefer sex that is not planned	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Women prefer men that are sexually experienced	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
If a man gets tired of the sex he has with his partner, it is ok for him to have sex with other people	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Women like for men to take control during sex	Strongly disagree Disagree

	Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men should always be ready to have sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
A woman should always be ready to sexually satisfy a man	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
It is harmful to a man if he "gets hard" and does not "come"	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
It does not look good for a woman to talk about her sexual desires	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men can not control their sexual desires	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men need to have sex more frequently than women do	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree

	(Do not read) Don't know (Do not read) Refuse to answer
For women, sex without the penis going in the vagina or anus is not sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
A real man is a man who can get any woman to have sex with him	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men should be in control during sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Women should wait for men to ask for sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to end with some general questions about you	
In what province do you live?	
In what municipality, Batey, or community do you live?	
What religion do you belong to?	None Evangelic Adventist Catholic Protestant or Other, specify please (Do not read) Don't know (Do not read) Refuse to answer
What grade did you reach in school?	No formal education Primary (initial or basic) High school

	Post-secondary (Bachelors, Masters, Doctoral) (Do not read) Don't know (Do not read) Refuse to answer
Have you worked in the past 12 months?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
What kind of work do you do?	
How much do you earn each month in Dominican Pesos (Do not read: indicate without dollar sign)	
Are there other things that you do to get money or other people who give you money like your partner, siblings, or a friend?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
How much do you get each month in Dominican Pesos (Do not read: indicate without dollar sign)	
Who generally decides how you spend the money that you earn or get?	You Your partner Both or Other: indicate who decides (Do not read) Don't know (Do not read) Refuse to answer
Would you say that the money you get or earn is	More than what your partner earns Less than what your partner earns The same as what your partner earns Partner does not have income (Do not read) Don't know (Do not read) Refuse to answer

A.16 Interviewer Administered Survey for Cross-sectional Study (Spanish)

Confidential

Encuesta sobre Comunicación de Salud Sexual

Por favor completar la encuesta de abajo.

Gracias!

Primero voy a estar segura de que Usted es elegibile

¿Es mujer?
- ◯ Si
- ◯ No

¿Es adulta (18 años o mas)?
- ◯ Si
- ◯ No

¿Es dominicana?
- ◯ Si
- ◯ No

¿Tiene pareja fija que es un hombre?
- ◯ Si
- ◯ No

¿Consentimiento informado conseguido?
- ◯ Si
- ◯ No

Fecha de la encuesta _____

Datos recolectados por
- ◯ Sonia
- ◯ Heidi

Vamos a empezar con algunas preguntas generales

¿Cuántos años tiene? _____

¿Qué edad tiene su pareja? _____

¿Cuánto tiempo llevan juntos?
- ◯ Año
- ◯ Meses
- ◯ Semanas

Indique cuántos años _____

Indique cuántos meses _____

Indique cuántas semanas _____

¿Cuántos hijos tiene en total? (Con su pareja actual y cualquier pareja anterior) _____

¿Cuántos hijos viven con usted? _____

Las siguientes preguntas son sobre ciertos temas con su pareja

Primero le voy a hacer algunas preguntas sobre el riesgo de las infecciones de transmisión sexual. Infecciones de transmisión sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Hablar con su pareja sobre el riesgo de las infecciones de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja hablar con usted sobre el riesgo de las infecciones de transmisión sexual?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de hablar con su pareja sobre el riesgo de las infecciones de transmisión sexual?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez ha hablado usted con su pareja sobre el riesgo de las infecciones de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora le voy a hacer algunas preguntas sobre infecciones de transmisión sexual con respeto a su pareja. Recuerde que infecciones de transmisión sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Hablar con su pareja de si el alguna vez ha tenido una infección de transmisión sexual es ...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja hablar con usted sobre si el alguna vez ha tenido una infección de transmisión sexual?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de hablar con su pareja sobre si él alguna vez ha tenido una infección de transmisión sexual?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted ha hablado con su pareja si alguna vez ha tenido una infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a hablar sobre su pareja y parejas sexuales que él ha tenido en el pasado

¿Hablar con su pareja sobre las parejas sexuales que él ha tenido en el pasado es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja hablar con Usted sobre las parejas sexuales que él ha tenido en el pasado?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de hablar con su pareja sobre las parejas sexuales que él ha tenido en el pasado?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted ha hablado con él sobre las parejas sexuales que él ha tenido en el pasado?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a hablar sobre su pareja teniendo sexo con otras personas fuera de la relación de ustedes

¿Hablar con su pareja sobre si actualmente él está teniendo sexo con mujeres o hombres fuera de la relación de Ustedes es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja hablar con Usted de si actualmente él está teniendo sexo con mujeres o hombres fuera de la relación de Ustedes?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de hablar con su pareja sobre si actualmente él está teniendo sexo con mujeres o hombres fuera de la relación de Ustedes?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted ha hablado con él sobre si actualmente él está teniendo sexo con mujeres o hombres fuera de la relación de Ustedes?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a hablar sobre pruebas de infecciones de transmission sexual. Recuerde que infecciones de transmission sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Pedirle a su pareja que se haga pruebas para ver si tiene alguna infección de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja si le pide que se haga pruebas para ver si tiene alguna infección de transmisión sexual?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de pedirle a su pareja que él se haga pruebas para ver si tiene alguna infección de transmisión sexual?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted le ha pedido a su pareja que él se haga pruebas para ver si tiene alguna infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora hablamos sobre cambiar el comportamiento de su pareja para evitar una infección de transmission sexual. Recuerde que las infecciones de transmision sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Pedirle a él que cambie su comportamiento para no enfermarse de una infección de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja si le pide que él cambie su comportamiento para no enfermarse de una infección de transmisión sexual?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de pedirle a él que cambie su comportamiento para no enfermarse de una infección de transmisión sexual?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted le ha pedido a él que cambie su comportamiento para no enfermarse de una infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué le ha pedido hacer o cambiar? _____

Ahora hablamos sobre condones

¿Pedirle a su pareja que él use un condón con Usted para que Usted no se enferme de una infección de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tanto aceptaría su pareja si le pide que él use un condón con Usted para que Usted no se enferme de una infección de transmisión sexual?

- ◯ Mucho
- ◯ Indiferente, o
- ◯ Poco
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué tan capaz se siente de pedirle que él use un condón con Usted para que Usted no se enferme de una infección de transmisión sexual?

- ◯ Muy capaz
- ◯ Capaz
- ◯ Más o menos capaz
- ◯ No muy capaz, o
- ◯ Incapaz
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted le ha pedido que use condón con Usted para que Usted no se enferme de una infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Las siguientes frases o preguntas que le voy a leer son opiniones sobre ciertos temas que se pueden hablar con su pareja. Para cada uno por favor, dígame si Ud. está completamente de acuerdo, de acuerdo, indiferente, en desacuerdo, o completamente en desacuerdo.

	Completamente de acuerdo	De acuerdo	Indiferente	En desacuerdo	Completamente en desacuerdo	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
1. Sería irrespetuoso si Usted hablaría de sexo con su pareja	○	○	○	○	○	○	○
2. Le daría vergüenza a Usted hablar con su pareja sobre sexo	○	○	○	○	○	○	○
3. No le diría a su pareja con cuantas personas ha tenido sexo, porque no es asunto suyo.	○	○	○	○	○	○	○
4. Si Usted le pidiera a su pareja que usara un condón, él pensaría que Usted está teniendo sexo con otras personas	○	○	○	○	○	○	○

Las siguientes preguntas son sobre la confianza en la relación de pareja. Para cada frase que le leo, podría Usted decirme si esta completamente de acuerdo, de acuerdo, indiferente, en desacuerdo, o completamente en desacuerdo.

	Completamente de acuerdo	De acuerdo	Indiferente	En desacuerdo	Completamente en desacuerdo	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
Su pareja es una persona que solo se preocupa por él	○	○	○	○	○	○	○
Hay momentos en que Usted no confia en su pareja	○	○	○	○	○	○	○
Su pareja es siempre honesto y confiable con Usted	○	○	○	○	○	○	○
Usted siente que puede confiar en su pareja siempre	○	○	○	○	○	○	○
Su pareja siempre cumple con sus promesas	○	○	○	○	○	○	○
Su pareja no toma en cuenta sus opiniones	○	○	○	○	○	○	○
Usted piensa que su pareja le trata bien, de una manera justa	○	○	○	○	○	○	○
Usted siente que puede contar con la ayuda de su pareja para cualquiera cosa	○	○	○	○	○	○	○

Ahora, vamos a seguir con algunas preguntas sobre su salud. Las siguientes preguntas son para ver como Usted se siente sobre su persona. Para cada frase que le leo, ¿puede Ud. por favor decirme si está muy de acuerdo, de acuerdo, en desacuerdo, o muy en desacuerdo?

	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
En general, está satisfecha consigo misma	○	○	○	○	○	○
A veces piensa que no es buena en nada	○	○	○	○	○	○
Tiene la sensación de que posee buenas cualidades	○	○	○	○	○	○
Es capaz de hacer las cosas tan bien como la mayoría de la gente	○	○	○	○	○	○
Usted está orgullosa de muchas cosas	○	○	○	○	○	○
A veces se siente inútil	○	○	○	○	○	○
Tiene la sensación de que vale igual que los demás	○	○	○	○	○	○
Se siente que debería darse más respeto	○	○	○	○	○	○
En definitiva, Usted se siente que ha fracasado en la vida	○	○	○	○	○	○
Tiene una actitud positiva hacia si misma	○	○	○	○	○	○

Ahora vamos a seguir con unas preguntas que tienen que ver con la salud sexual

¿En los últimos 12 meses, incluyendo su pareja, con cuántas personas diferentes ha tenido usted relaciones sexuales? _____

¿Cuándo fue la última vez que Usted tuvo sexo con su pareja fija?
- ◯ días
- ◯ semanas
- ◯ meses
- ◯ años
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Indique cuántos dias _____

Indique cuántas semanas _____

Indique cuántos meses _____

Indique cuántos años _____

¿Durante los últimos 12 meses ha tenido usted una infección de transmisión sexual? (clamidia, gonorrea, sífilis, herpes, papiloma)?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez le han hecho la prueba para saber si tiene el VIH, el virus que causa el SIDA?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Cuándo fue la última vez que se hizo la prueba? _____

¿Está dispuesta a compartir su diagnostico?
- ◯ Sí
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Cuál es?
- ◯ negativo, o
- ◯ positivo
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Usted conoce el diagnostico de VIH de su pareja?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Le supo por su pareja o por un tercero?
- ◯ Pareja o
- ◯ Tercero
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Esta pregunta refiere a cuanto riesgo Usted piensa que tiene de enfermarse de una infección de transmisión sexual dentro de su relación de pareja. Dígame,

¿Qué tan probable sería enfermarse de una infección de transmisión sexual si tuviera sexo con su pareja sin un condón?

- ◯ No es probable para nada
- ◯ Más o menos probable
- ◯ Probable
- ◯ Muy probable, o
- ◯ Extremadamente probable
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

La siguiente pregunta es sobre su pareja y otras mujeres.

Su pareja podría estar teniendo sexo con alguien más:

- ◯ Sí
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Las siguientes preguntas son para saber como Usted se siente dentro de su relación con su pareja.

	Nunca	A veces	Frecuentemente	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
¿Con qué frecuencia le da miedo a Usted lo que dice o hace su pareja?	○	○	○	○	○
¿Con qué frecuencia su pareja abusa de Usted emocionalmente? (por ejemplo, insultarle, burlarse de Usted, hacerle sentir mal sobre si misma)	○	○	○	○	○

Ahora vamos a seguir la encuesta con algunas preguntas sobre sexo, hombres, y mujeres. Para cada frase, por favor dígame si está muy en desacuerdo, en desacuerdo, indiferente, de acuerdo, o muy de acuerdo

	Muy en desacuerdo	En desacuerdo	Indiferente	De acuerdo	Muy de acuerdo	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
¿Los hombres solamente quieren tener sexo con el pene entrando la vagina o el ano?	○	○	○	○	○	○	○
¿Los hombres prefieren tener sexo espontaneo?	○	○	○	○	○	○	○
¿Las mujeres prefieren hombres con mucha experiencia sexual?	○	○	○	○	○	○	○
¿Si un hombre esta cansado de tener sexo con su pareja fija, esta bien que el tenga sexo con otras personas?	○	○	○	○	○	○	○
¿Las mujeres les gusta que los hombre tomen el control durante el sexo?	○	○	○	○	○	○	○
¿Para Usted, los hombre siempre deben estar listos para tener sexo?	○	○	○	○	○	○	○
¿Para Usted, una mujer siempre debe estar lista para satisfacer a los hombres sexualmente?	○	○	○	○	○	○	○
¿Cree Usted, que le hace daño a un hombre si se le pone duro y no eycula?	○	○	○	○	○	○	○
¿Cree Usted que no se ve bien para una mujer hablar sobre sus deseos sexuales?	○	○	○	○	○	○	○
¿Cree Usted que los hombres no pueden controlar sus deseos sexuales?	○	○	○	○	○	○	○
¿Cree Usted que los hombres necesitan tener sexo con más frecuencia que las mujeres?	○	○	○	○	○	○	○
¿Para una mujer, si el pene no penetra la vagina o ano no es sexo?	○	○	○	○	○	○	○

¿Para Usted, un hombre ¨muy hombre¨ puede conseguir sexo con cualquier mujer?	○	○	○	○	○	○	○
¿Cree Usted que los hombres deben tener el control durante el sexo?	○	○	○	○	○	○	○
¿Cree Usted que las mujeres deben esperar para que el hombre le pida tener sexo?	○	○	○	○	○	○	○

Ahora vamos a terminar con algunas preguntas generales sobre Usted

¿En qué provincia Usted vive? _____

¿En qué municipio, batey, o comunidad vive Usted? _____

¿A qué religión pertenece usted?
- ◯ Ninguna
- ◯ Evangélica
- ◯ Adventista
- ◯ Católica
- ◯ Protestante, u
- ◯ Otra
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Especifique cúal por favor _____

¿Hasta qué grado Usted llegó en la escuela?
- ◯ Nunca tuvo educación formal
- ◯ Primaria inicial
- ◯ Primaria basica
- ◯ Bachiller
- ◯ Superior (Universitaria, Maestría, o Doctorado)
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Ha trabajado Usted en los últimos 12 meses?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Hay otras cosas que Usted hace para conseguir dinero u otras personas que le dan dinero como su esposo, un hermano, u un amigo?
- ◯ Sí
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué hace Ud. o quien le da dinero? _____

¿Cuánto consigue Usted mensualmente en Pesos RD? (NO LEA: INDICAR SIN EL SIGNO DE DOLAR) _____

¿En qué trabaja? _____

¿Cuánto gana Usted mensualmente en Pesos RD? (NO LEA: INDICAR SIN EL SIGNO DE DOLAR) _____

¿Quién decide generalmente cómo se gasta el dinero que usted gana o consigue?
- ◯ Usted
- ◯ Su pareja
- ◯ Ambos, o
- ◯ Otro
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Si sea otro, ¿quién decide? _____

¿Usted diría que el dinero que usted gana o consigue es:
- ◯ más de lo que gana su pareja
- ◯ menos de lo que él gana
- ◯ Lo mismo que gana él, o
- ◯ Pareja no tiene ingreso
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

A.17 Verification Survey for Cross-sectional Study (English)

Sexual Health Communication Survey	
Please complete the survey below	
Thank you!	
First, I am going to make sure that you are eligible	
Are you a woman?	Yes No
Are you an adult (18 years or older)?	Yes No
Are you Dominican?	Yes No
Do you have a stable partner than is a man?	Yes No
Did you provide informed consent?	Yes No
Date of the survey	
Data collected by:	Sonia Heidi
We are going to start with some general questions	
How old are you?	
How old is your partner?	
How long have you been together?	Years Months Weeks
Indicate how many years	
Indicate how many months	
Indicate how many weeks	
How many children to you have all together (with your current partner and any past partners)?	
How many children live with you?	
The following questions are about certain topics with your partner	
First, I am going to ask you some question about the risk of sexually transmitted infections. Sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Talking with your partner about the risk of sexually transmitted infections is…	A bad idea Not a good idea nor a bad idea, or A good idea

	(Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner about the risk of sexually transmitted infections?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now, I am going to ask you some questions about sexually transmitted infections, with respect to your partner. Remember that sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Talking with your partner about whether he has ever had a sexually transmitted infection is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner about whether he has ever had a sexually transmitted infection?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to talk about your partner and sexual partners he has had in the past	
Talking with your partner about the sexual partners he has had in the past is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner about the sexual partners he has had in the past?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to talk about your partner having sex with other people outside of your relationship	
Talking with your partner about whether he is currently having sex with other women or men outside of your relationship is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
Have you ever talked with your partner whether he is currently having sex with other women or men outside of your relationship?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to talk about tests for sexually transmitted infection. Remember that sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	

Asking your partner to get tested for sexually transmitted infections is…	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
Have you ever asked your partner to get tested for sexually transmitted infections?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Now lest talk about changing your partner's behavior to avoid a sexually transmitted infection. Remember that sexually transmitted infections include: chlamydia, gonorrhea, syphilis, herpes, human papilloma virus and HIV	
Asking your partner to change his behavior to not get a sexually transmitted infection is …	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
Have you ever asked your partner to change his behavior to not get a sexually transmitted infection?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
What have you asked him to do or change?	
Now let's talk about condoms	
Asking your partner to use a condom with you so that you do not get a sexually transmitted infection is …	A bad idea Not a good idea nor a bad idea, or A good idea (Do not read) Don't know (Do not read) Refuse to answer
Have you ever asked your partner to use a condom with you so that you do not get a sexually transmitted infection?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
The following questions or statements that I am going to read are opinions about certain topics that you can talk about with your partner. For each, please tell me if you completely agree, agree, neither agree nor disagree, disagree, or completely disagree.	
5. If you were to talk to you partner about sex it would be disrespectful	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer

6. If you talk to your partner about sex you will feel embarrassed	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
7. You would not tell your partner how many people you've had sex with because it's none of your partner's business	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
8. If you asked your partner to use a condom, he would think you're having sex with other people	Completely agree Agree Neither agree nor disagree Disagree or Completely disagree (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to continue with some questions that have to do with sexual health	
In the past 12 months, including your partner, with how many different people have you had sex?	
In the past 12 months, have you had a sexually transmitted infection (Chlamydia, gonorrhea, syphilis, herpes, human papilloma virus)?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
Have you ever had a test to see if you have HIV, the virus that causes AIDS?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
When is the last time you took the test?	
Are you willing to share the result?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
What was it?	Negative Positive (Do not read) Don't know (Do not read) Refuse to answer
Do you know the HIV status of your partner?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer

Did you find out from your partner or someone else?	Partner or Someone else (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to continue the survey with some questions about sex, men, and women. For each statement, please tell me if you strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree	
Men only want to have sex that involves the penis going inside the vagina or anus	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men prefer sex that is not planned	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Women prefer men that are sexually experienced	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
If a man gets tired of the sex he has with his partner, it is ok for him to have sex with other people	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Women like for men to take control during sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men should always be ready to have sex	Strongly disagree Disagree Neither agree nor disagree

	Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
A woman should always be ready to sexually satisfy a man	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
It is harmful to a man if he "gets hard" and does not "come"	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
It does not look good for a woman to talk about her sexual desires	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men can not control their sexual desires	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men need to have sex more frequently than women do	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
For women, sex without the penis going in the vagina or anus is not sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know

	(Do not read) Refuse to answer
A real man is a man who can get any woman to have sex with him	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Men should be in control during sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Women should wait for men to ask for sex	Strongly disagree Disagree Neither agree nor disagree Agree, or Strongly agree (Do not read) Don't know (Do not read) Refuse to answer
Now we are going to end with some general questions about you	
In what province do you live?	
In what municipality, Batey, or community do you live?	
What religion do you belong to?	None Evangelic Adventist Catholic Protestant or Other, specify please (Do not read) Don't know (Do not read) Refuse to answer
What grade did you reach in school?	No formal education Primary (initial or basic) High school Post-secondary (Bachelors, Masters, Doctoral) (Do not read) Don't know (Do not read) Refuse to answer
Have you worked in the past 12 months?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
What do you do for work?	

How much do you earn each month in Dominican Pesos (Do not read: indicate without dollar sign)	
Are there other things that you do to get money or other people who give you money like your partner, siblings, or a friend?	Yes or No (Do not read) Don't know (Do not read) Refuse to answer
How much do you get each month in Dominican Pesos (Do not read: indicate without dollar sign)	
Who generally decides how you spend the money that you earn or get?	You Your partner Both or Other: indicate who decides (Do not read) Don't know (Do not read) Refuse to answer
Would you say that the money you get or earn is	More than what your partner earns Less than what your partner earns The same as what your partner earns Partner does not have income (Do not read) Don't know (Do not read) Refuse to answer

A.18 Interviewer Administered Verification Survey for Cross-sectional Study (Spanish)

Encuesta sobre Comunicación de Salud Sexual

Por favor completar la encuesta de abajo.

Gracias!

Primero voy a estar segura de que Usted es elegibile

¿Es mujer?
- ◯ Si
- ◯ No

¿Es adulta (18 años o mas)?
- ◯ Si
- ◯ No

¿Es dominicana?
- ◯ Si
- ◯ No

¿Tiene pareja fija que es un hombre?
- ◯ Si
- ◯ No

¿Consentimiento informado conseguido?
- ◯ Si
- ◯ No

Fecha de la encuesta _____

Datos recolectados por
- ◯ Sonia
- ◯ Heidi

Vamos a empezar con algunas preguntas generales

¿Cuántos años tiene? _____

¿Qué edad tiene su pareja? _____

¿Cuánto tiempo llevan juntos?
- ◯ Año
- ◯ Meses
- ◯ Semanas

Indique cuántos años _____

Indique cuántos meses _____

Indique cuántas semanas _____

¿Cuántos hijos tiene en total? (Con su pareja actual y cualquier pareja anterior) _____

¿Cuántos hijos viven con usted? _____

Las siguientes preguntas son sobre ciertos temas con su pareja

Primero le voy a hacer algunas preguntas sobre el riesgo de las infecciones de transmisión sexual. Infecciones de transmisión sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Hablar con su pareja sobre el riesgo de las infecciones de transmisión sexual es...
- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez ha hablado usted con su pareja sobre el riesgo de las infecciones de transmisión sexual?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora le voy a hacer algunas preguntas sobre infecciones de transmisión sexual con respeto a su pareja. Recuerde que infecciones de transmisión sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Hablar con su pareja de si el alguna vez ha tenido una infección de transmisión sexual es ...
- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted ha hablado con su pareja si alguna vez ha tenido una infección de transmisión sexual?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a hablar sobre su pareja y parejas sexuales que él ha tenido en el pasado

¿Hablar con su pareja sobre las parejas sexuales que él ha tenido en el pasado es...
- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted ha hablado con él sobre las parejas sexuales que él ha tenido en el pasado?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a hablar sobre su pareja teniendo sexo con otras personas fuera de la relación de ustedes

¿Hablar con su pareja sobre si actualmente él está teniendo sexo con mujeres o hombres fuera de la relación de Ustedes es...
- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted ha hablado con él sobre si actualmente él está teniendo sexo con mujeres o hombres fuera de la relación de Ustedes?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a hablar sobre pruebas de infecciones de transmission sexual. Recuerde que infecciones de transmission sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Pedirle a su pareja que se haga pruebas para ver si tiene alguna infección de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted le ha pedido a su pareja que él se haga pruebas para ver si tiene alguna infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora hablamos sobre cambiar el comportamiento de su pareja para evitar una infección de transmission sexual. Recuerde que las infecciones de transmision sexual incluyen clamidia, gonorrea, sifilis, herpes, papiloma y el VIH

¿Pedirle a él que cambie su comportamiento para no enfermarse de una infección de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted le ha pedido a él que cambie su comportamiento para no enfermarse de una infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué le ha pedido hacer o cambiar? _____

Ahora hablamos sobre condones

¿Pedirle a su pareja que él use un condón con Usted para que Usted no se enferme de una infección de transmisión sexual es...

- ◯ Una mala idea
- ◯ Indiferente, o
- ◯ Una buena idea
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez Usted le ha pedido que use condón con Usted para que Usted no se enferme de una infección de transmisión sexual?

- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Las siguientes frases o preguntas que le voy a leer son opiniones sobre ciertos temas que se pueden hablar con su pareja. Para cada uno por favor, dígame si Ud. está completamente de acuerdo, de acuerdo, indiferente, en desacuerdo, o completamente en desacuerdo.

	Completamente de acuerdo	De acuerdo	Indiferente	En desacuerdo	Completamente en desacuerdo	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
1. Sería irrespetuoso si Usted hablaría de sexo con su pareja	○	○	○	○	○	○	○
2. Le daría vergüenza a Usted hablar con su pareja sobre sexo	○	○	○	○	○	○	○
3. No le diría a su pareja con cuantas personas ha tenido sexo, porque no es asunto suyo.	○	○	○	○	○	○	○
4. Si Usted le pidiera a su pareja que usara un condón, él pensaría que Usted está teniendo sexo con otras personas	○	○	○	○	○	○	○

Ahora vamos a seguir con unas preguntas que tienen que ver con la salud sexual

¿En los últimos 12 meses, incluyendo su pareja, con cuántas personas diferentes ha tenido usted relaciones sexuales? _____

¿Durante los últimos 12 meses ha tenido usted una infección de transmisión sexual? (clamidia, gonorrea, sífilis, herpes, papiloma)?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Alguna vez le han hecho la prueba para saber si tiene el VIH, el virus que causa el SIDA?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Cuándo fue la última vez que se hizo la prueba? _____

¿Está dispuesta a compartir su diagnostico?
- ◯ Sí
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Cuál es?
- ◯ negativo, o
- ◯ positivo
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Usted conoce el diagnostico de VIH de su pareja?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Le supo por su pareja o por un tercero?
- ◯ Pareja o
- ◯ Tercero
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Ahora vamos a seguir la encuesta con algunas preguntas sobre sexo, hombres, y mujeres. Para cada frase, por favor dígame si está muy en desacuerdo, en desacuerdo, indiferente, de acuerdo, o muy de acuerdo

	Muy en desacuerdo	En desacuerdo	Indiferente	De acuerdo	Muy de acuerdo	(NO LEA) No sabe	(NO LEA) Rehúsa contestar
¿Los hombres solamente quieren tener sexo con el pene entrando la vagina o el ano?	○	○	○	○	○	○	○
¿Los hombres prefieren tener sexo espontaneo?	○	○	○	○	○	○	○
¿Las mujeres prefieren hombres con mucha experiencia sexual?	○	○	○	○	○	○	○
¿Si un hombre esta cansado de tener sexo con su pareja fija, esta bien que el tenga sexo con otras personas?	○	○	○	○	○	○	○
¿Las mujeres les gusta que los hombre tomen el control durante el sexo?	○	○	○	○	○	○	○
¿Para Usted, los hombre siempre deben estar listos para tener sexo?	○	○	○	○	○	○	○
¿Para Usted, una mujer siempre debe estar lista para satisfacer a los hombres sexualmente?	○	○	○	○	○	○	○
¿Cree Usted, que le hace daño a un hombre si se le pone duro y no eycula?	○	○	○	○	○	○	○
¿Cree Usted que no se ve bien para una mujer hablar sobre sus deseos sexuales?	○	○	○	○	○	○	○
¿Cree Usted que los hombres no pueden controlar sus deseos sexuales?	○	○	○	○	○	○	○
¿Cree Usted que los hombres necesitan tener sexo con más frecuencia que las mujeres?	○	○	○	○	○	○	○
¿Para una mujer, si el pene no penetra la vagina o ano no es sexo?	○	○	○	○	○	○	○

¿Para Usted, un hombre ¨muy hombre¨ puede conseguir sexo con cualquier mujer?	○	○	○	○	○	○	○
¿Cree Usted que los hombres deben tener el control durante el sexo?	○	○	○	○	○	○	○
¿Cree Usted que las mujeres deben esperar para que el hombre le pida tener sexo?	○	○	○	○	○	○	○

Ahora vamos a terminar con algunas preguntas generales sobre Usted

¿En qué provincia Usted vive? _____

¿En qué municipio, batey, o comunidad vive Usted? _____

¿A qué religión pertenece usted?
- ◯ Ninguna
- ◯ Evangélica
- ◯ Adventista
- ◯ Católica
- ◯ Protestante, u
- ◯ Otra
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Especifique cúal por favor _____

¿Hasta qué grado Usted llegó en la escuela?
- ◯ Nunca tuvo educación formal
- ◯ Primaria inicial
- ◯ Primaria basica
- ◯ Bachiller
- ◯ Superior (Universitaria, Maestría, o Doctorado)
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Ha trabajado Usted en los últimos 12 meses?
- ◯ Sí, o
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Hay otras cosas que Usted hace para conseguir dinero u otras personas que le dan dinero como su esposo, un hermano, u un amigo?
- ◯ Sí
- ◯ No
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

¿Qué hace Ud. o quien le da dinero? _____

¿Cuánto consigue Usted mensualmente en Pesos RD? (NO LEA: INDICAR SIN EL SIGNO DE DOLAR) _____

¿En qué trabaja? _____

¿Cuánto gana Usted mensualmente en Pesos RD? (NO LEA: INDICAR SIN EL SIGNO DE DOLAR) _____

¿Quién decide generalmente cómo se gasta el dinero que usted gana o consigue?
- ◯ Usted
- ◯ Su pareja
- ◯ Ambos, o
- ◯ Otro
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar

Si sea otro, ¿quién decide? _____

¿Usted diría que el dinero que usted gana o consigue es:
- ◯ más de lo que gana su pareja
- ◯ menos de lo que él gana
- ◯ Lo mismo que gana él, o
- ◯ Pareja no tiene ingreso
- ◯ (NO LEA) No sabe
- ◯ (NO LEA) Rehúsa contestar