ABSTRACT

Title of Thesis:	CONTRACEPTIVE NEGOTIATION: THE CONTEXT OF INTIMATE PARTNER RELATIONSHIPS
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Background: Unintended pregnancy is a problem that is widely exacerbated by lack of access to and use of contraceptives. Contraceptive decision-making often occurs within the context of intimate partner relationships. This study assessed how contraceptive negotiation occurs within the context of intimate partner relationships.

Methods: Qualitative interviews were administered to a sample of 15 women recruited from family planning clinics. The analysis for this study examined themes around contraceptive negotiation.

Results: Themes represented types of negotiation ranging from open and egalitarian exchanges to closed and manipulative contraceptive negotiation. Findings demonstrate that contraceptive negotiation has no set format, and that it occurs through various contexts.

Conclusion: Results solidify the importance of contraceptive negotiation within the context of intimate partner relationships. Specifically, findings highlight the strong role that intimate partner relationships play in contraceptive decision-making. Deeper understanding of contraceptive negotiation processes is necessary to reduce unintended pregnancy and to improve health outcomes.

CONTRACEPTIVE NEGOTIATION: THE INFLUENCE OF INTIMATE PARTNER RELATIONSHIPS

by

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Chapter 1: Introduction

Statement of the Research Problem

Pregnancy and childbearing could be considered by many, some of the most joyous and monumental occasions of a lifetime. This is often complicated, however, by experiences of unintended pregnancy. In the United States around 45 out of every 1,000 women will have an unintended pregnancy every year (Singh, Sedgh & Hussain 2010). Curtailing unintended pregnancy and increasing reproductive autonomy have been key goals among decision-makers and advocacy organizations in the United States (US Department of Health and Human Services, 2010; Centers for Disease Control and Prevention, 2018). The United States Federal Government takes up this task continually with Healthy People 2020, a ten-year initiative commissioned to address and improve national health priorities. Specifically, Healthy People 2020 has a goal of improving family planning by increasing the amount of adult women using effective contraceptives by 10% and increasing instances of intended pregnancy by 10% (Office of Disease Prevention and Health Promotion, 2018). Given the potential adverse health, social, and economic outcomes associated with unintended pregnancy, it is seen as imperative to limit incidence of the phenomenon and to allow women to choose when and if they become parents. (Sonfield, Kost, Gold, & Finer, 2011; Trussell et al., 2013; Yazdkhasti, Pourreza, Pirak, & Abdi, 2015).

With the extreme importance of family planning and reproductive choice, contraceptives have emerged as an effective way to ensure that women achieve optimal holistic health and well-being. Contraceptives are furthermore seen as mechanisms to

increase women's autonomy and to allow for further achievement within communities (World Health Organization, 2018). Modern contraceptive methods such as barrier methods (e.g. condoms) and hormonal methods (e.g. the pill or the shot) are considered to be integral to ensuring prevention of unintended pregnancy (U.S. Department of Health and Human Services, 2018). Despite their demonstrated effectiveness, the uptake of contraceptives has been less than ideal, with 40% of women of reproductive age reportedly not using any method (Kavanaugh & Jerman, 2017).

Increasing uptake of these methods can be achieved through conducting research on what potentially steers women against use of contraceptives, or what leads to their incorrect use. Further understanding of factors that influence patterns of contraceptive choice is integral to promoting their use and to reducing unintended pregnancy. A potentially important dimension of contraceptive behavior is the role of the intimate partner relationship. This analysis focuses on how negotiations around contraceptive use unfold within the context of intimate partner relationships.

Research Questions

Research questions were approached through qualitative data analysis. Questions are addressed through matching with items from the interview guide used in the study.

Primary Research Question

How does contraceptive negotiation occur within the context of intimate partner relationships?

Secondary Research Questions

1. How do women describe their conversations around contraceptives and contraceptive negotiations?

2. How do women relate their contraceptive choices to their intimate partner relationships?
3. What role does the intimate partner play in a woman's family planning experiences?

Table 1: Terms and definitions

Term	Definition
Determinants of health	Differing social, environmental, personal and economic factors that influence the status of health of given people (United States Office of Disease Prevention and Health Promotion, 2018).
Unintended Pregnancy	Any pregnancy that is considered to have occurred earlier than intended (mistimed) or occurred when a pregnancy was not desired (unwanted) (Centers for Disease Control and Prevention, 2015).
Contraception	Also known as birth control, is defined as any modern method, product, or medical procedure that interferes with reproduction resulting from sexual intercourse (Hubacher, 2015). Examples of contraceptive methods include oral contraceptives (the pill), condoms, the hormonal patch, intrauterine devices (IUDs), the hormonal implant, the shot, and female and male sterilization (U.S. Office on Women's Health, 2018).
Intimate Partner Relationship	Intimate partner relationship refers to any relationship with a person with whom one is close that can be characterized by emotional connectedness, regular contact, ongoing physical contact, and/or sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives (Centers for Disease Control and Prevention, 2018).
Condom negotiation	Exchange between sexual partners about use of condoms (Tschann, Flores, Groat, Deardoff & Wibbelsman, 2010).
Contraceptive negotiation (adapted from condom negotiation):	Exchange between sexual partners about use of contraceptive methods (Tschann et al., 2010; Raine et al., 2010).
Sexual Script Theory	Theory of sexual behavior that posits that said behaviors derive from metaphorical scripts formed at the cultural, interpersonal and intrapersonal level (Simon & Gagnon, 1984; Wiederman, 2005).
Sexual scripts	Cognitive schema that instruct people how to act in sexual situations (Simon & Gagnon, 1984; Masters, 2013).
Cultural Scenarios	Instructional guidelines that exist in collective life; they instruct narrative requirements of specific roles and provide understanding for roles and performance (Simon & Gagnon, 1984, 1986).
Interpersonal scenarios	Interpretations to large cultural scenarios occurring with relationships that affect behavior (Simon & Gagnon, 1984; Gagnon, 1990).
Intrapersonal scenarios	Internalization of socially shared scripts and norms (Simon & Gagnon, 1984; Gagnon, 1990).

Public Health Significance

Researchers have continually looked at ways to increase the uptake of very effective methods of contraception (Pace, Ducetzina & Keating, 2016; Whitaker et al., 2016; Taub & Jensen, 2017; Karpilow & Thomas, 2017). Important factors that inform how to do this often lie in behavioral and ecologically-based analyses around what influences contraceptive use. Factors affecting contraceptive use differ among given populations and based upon varying cultural, interpersonal factors, and intrapersonal factors. These can include cost and access-related considerations, family and relationships, knowledge and beliefs about methods, and desire to use specific methods (Daniels, 2011; Kahraman, 2012; Noar,2006; Swan, 2012). This analysis focuses on contraceptive use as it is influenced by contraceptive negotiation. Specifically, it will explore contraceptive negotiation within the context of the heterosexual, non-casual, sexual, intimate partner or romantic relationship.

Intimate partners are documented to have influence on the contraceptive decision-making of their partners (Manlove et al., 2011; Sweeney, 2010). This study aims to specifically explore how the process of negotiating which contraceptive methods to use, or if they will use methods at all, occurs within the context of the intimate partner relationship. Better comprehension of contraceptive negotiation within this context is necessary to offer interpersonally-based interventions and solutions to the public health problems of low-uptake of contraceptives and more largely, unintended pregnancy. Research has shown that when women are able to plan for and space pregnancies, in addition to preventing unwanted pregnancies, they have better mental and physical health outcomes (World Health Organization, 2018; Starbird, Norton & Marcus, 2016;

Kavanaugh & Anderson, 2013). These women are also more likely to attain higher levels of education, stay in the workforce longer and enjoy higher socioeconomic status--factors all associated with better quality of life and improved health outcomes (Finer, 2015).

Chapter 2: Background

Theory

Health behavior theories are widely accepted in social science research to address and generalize patterns of human behavior. These theories give context to and explain health behaviors in addition to determining what factors can be addressed to stop or improve them (Munro, 2007). Often, having a model of health behavior to reference during exploratory research and interventions helps to contextualize behaviors and to categorize activities and findings related to the intervention or research.

Data from this study were contextualized using Sexual Script Theory, which assisted in further understanding and grounding of findings. Specifically, a critical view of relational, cultural and interpersonal aspects of sexual health behavior was achieved through using this theory (Simon & Gagnon,1984; Wiederman, 2015). Sexual Script Theory is apt to provide context and theoretical backing to an analysis centered around contraceptives and sexual behaviors, and is useful in its applications to Public Health theory and practice.

Sexual Script Theory

Sexual script theory is a theory of behavior used in study of sexual and behavioral health. In sexual script theory framework, it is posited that sexual behaviors are determined by culturally determined guidelines for behavior (Simon & Gagnon,1984). "Sexual Scripts" are defined as cognitive schema that structure how people understand and act in sexual situations. These scripts are said to guide behavior, how people interpret these behaviors, and how people form their own desires (Simon & Gagnon, 1984; Hynie, 1998). Scripts are considered to be metaphorical and abstract in nature and explain sexual

behavior within the context of ever-changing societal constructs, rules and norms (Simon & Gagnon, 1984). Sexual Script Theory posits that scripts occur within the context of three levels. Levels include: 1) cultural scenarios, 2) interpersonal scenarios and 3) intrapersonal scenarios. Each level of scripting is considered to be important in determining people's sexual behaviors and their beliefs about their sexual behaviors. The levels are additionally reciprocal in nature and influence one another (Simon & Gagnon, 1984; Hynie, 1998).

Cultural Scenarios

This level of sexual script theory consists of general societal guidelines to sexual behavior. These guidelines provide wider cues for what should be considered normative or appropriate roles and behaviors. They are often determined by culture, institutions, and societal symbols. This can come in the form of societal fixtures such as policies, governments, religion, educational and intellectual standards, and mass media (Simon & Gagnon, 1984; Wiederman, 2005). These scripts provide guidance about what should be seen as normative, strange, inappropriate, or even illegal. They influence scripting at both the interpersonal and intrapersonal level.

Interpersonal Scenarios

This level of sexual script theory refers to people's interpretations of cultural scripts and how they enact those interpretations. At this level, tailoring of behaviors occurs based on each unique scenario. During their interpersonal interactions and relationships then, individual actors use their cultural and intrapersonal scripting to

inform their behaviors and subsequently modify those cultural scripts based on the interpersonal situation. There can additionally be either similarities or discordance in the scripts that two people bring to one singular situation, which has the potential to cause tension (Simon & Gagnon, 1984; Wiederman, 2005).

Intrapersonal Scenarios

This level of scripting refers to the process of internalization of cultural and interpersonal scripting and organizing and imagining them in the way that the individual sees fit. Intrapersonal scripting is a way in which people ruminate on their interpersonal scripting and cues that they've received from society and formulate their own sexual desires, ideas, thoughts, beliefs, fears or fantasies (Simon & Gagnon, 1984; Wiederman, 2005).

With sexual scripting occurring at three different levels, it is important to acknowledge how these same scripts are impacted by societal factors that fall outside of considerations of sexual behaviors. Specifically, to fully comprehend and contextualize varying sexual scripts, one must consider the impact that gender roles and expectations play in sexual scripting and how they can inform, disrupt, reinforce, and dictate scripting.

Gendered-Traditional Scripts

Sexual scripts often exist within the context of other societal norms, including those norms governed by gender roles. Through cultural and societal level scripting and ideas about gender, scripts then begin to form themselves around gender roles. These gendered scripts have the potential to shape desire, beliefs, and behaviors around sex.

These gendered scripts can also include sexual power dynamics, which can both form and reinforce scripting (Simon & Gagnon, 1984). In traditional sexual scripting for example, society signals to women that they should be following men during sexual interactions or that they are to be chased or desired. Women can also be subject to scripting that says they should work to ensure that men have a comfortable sexual encounter, or that their needs are being met. Men on the other hand can be subject to scripting that says that they should take charge during sexual situations—both making decisions and leading women (Smith & Gagnon, 1984; Gagnon, 1990; O'Sullivan & Byers, 1992; Schwartz & Rutter, 1998). Adherence to traditional gendered sexual scripts could potentially cause individuals to act sexually in ways that do not coincide with their actual sexual desire, or to feel as though they need to make certain sexual decisions based on social standards or their partner's wishes. Considering this, discordance between or disruption of the harmony between societal scripts, interpersonal scripts and intrapersonal scripts can be imperative for promotion of healthy behaviors (Amaro, 1995; Amaro & Raj, 2000; Wingood & DiClemente, 2000).

Power and Sexual Script Theory

The role of gendered power has been explored as it relates to interpersonal interactions in relationships (Connell, 1987). This power is tied to ideas of what masculinity should be and what it should demand. It additionally prescribes ideas around how femininity should respond to this. In sexual script theory, power is known to have great impact on existing cultural, interpersonal and intrapersonal scripting (Gagnon, 1990). R.W. Connell's work additionally emphasizes the fact that gender is built upon and within many culturally informed social structures. These structures help to confine

and direct bodies and demonstrate the way that masculinity dictates bodies and sexuality (Connell, 1996). Such connects to how sexual scripting and power can impact the contraceptive negotiation process and serves as a necessary framework for this analysis.

Sexual script theory is used to address contraceptive negotiation in this study. Contraceptive negotiation fits within the context of intimate partner relationships and specifically in the dynamics influencing contraceptive use. The act of determining which contraceptive method will be used (or if a method is used at all) can occur within the exchange between the woman who will use a contraceptive method and her sexual partner. This negotiation may predict the desired health outcome of contraceptive behavior and is influenced by sexual scripting in all scenarios of the model of behavior.

Review of the Literature

Unintended Pregnancy

Quality of life has been linked to prevention of unintended pregnancy (World Health Organization, 2010). It was reported that 95% of unintended pregnancies are due to not using contraception or using it incorrectly or inconsistently (Sonfield, Tapales, Jones & Finer, 2015). Therefore, understanding what influences contraceptive behaviors is key to understanding what influences unintended pregnancy. Considerations of interest in relation to this topic is the financial burden of unintended pregnancy on both society and on individual families.

Economic Consequences

Unintended pregnancy has also been shown to be financially burdensome on individual families in its effect on their ability to earn income and to move up economically (Yazdkhasti et al., 2015). Further economic concern surrounding unintended pregnancy is the prospect of abortion. Frequently, unintended pregnancies in the United States end in costly abortion services. A 2011 analysis found that 40% of women who experienced an unintended pregnancy decided to have an abortion (Finer, 2016), and 53% of the women opting for abortion paid for the procedure out of pocket (Jerman, Jones & Onda, 2008). Putting these figures into perspective, the average cost of a first trimester abortion in the United States is around $500, with prices increasing as women get further into pregnancy (Kaiser Family Foundation, 2018). Similarly, Foster and colleagues found that women who are denied abortions that want them experience more economic insecurity and problems relating to finances than those who receive abortions that they want (Foster et al., 2018). When considering overall costs, abortion is much less expensive than the alternative of having an unintended pregnancy, which is estimated at $10,000 per child (The Brookings Institution, 2011).

Individual Consequences

The effects of unintended pregnancy tend to span beyond wider economic and social considerations. Physical health outcomes for mothers having unintended pregnancies are poorer than those who have intended pregnancies. For example, women who had unintended pregnancies were reported to be less likely to receive adequate prenatal care and more likely to have poor folic acid (a vitamin essential for the health

and wellness of pregnant women and their fetuses) consumption as compared to their counterparts who had intended pregnancies (Cheng, 2009; Singh et al., 2010). A study among women attending family planning clinics in the United States found increased potential for morbidity and mortality among women who carry their unintended pregnancies to term. Women in this study specifically had higher rates of eclampsia (high blood pressure and other symptoms associated with it) prior to giving birth, and hemorrhage after giving birth (Gerdts, Dobkin, Foster & Schwarz, 2016).

There is evidence to show that unintended pregnancy also has impacts women's mental health. Researchers have found that women who experience unintended pregnancy are more likely to smoke while pregnant and to suffer from post-partum depression (Christensen, Stuart, Perry & Lee, 2011; Vaquez, Castillo & Iribar, 2016). Abbasi and colleagues found that among a sample of first-time mothers, more mothers who experienced an unintended pregnancy matched the clinical criteria for post-partum depression (Abbasi, Chuang, Dagher & Kjerulff, 2013). Another longitudinal analysis among women who had experienced unintended pregnancy found that unintended pregnancy was strongly associated with mental health problems later in life (Herd et al., 2016).

Unintended pregnancy has been linked to stymieing of personal goals and achievements, particularly among adolescents. A review chronicling unintended pregnancy among teenagers in the United States found that the education of teen mothers is two years shorter than that of women who delay and plan pregnancies in their thirties. This same study additionally found that teenage girls who have unintended pregnancies are 12% less likely to finish high school and between 14% and 29% less likely to go to

college than their peers (Basch et al., 2011). This downstream effect can also have implications for future achievements for children of women who have unintended pregnancies. In a study that assessed long-term effects of different family planning strategies, it was found that children born to mothers who had intended to have them had higher long-term educational attainment than those who had not (Nguyen, 2018).

Rates of Unintended Pregnancy

Though the consequences of unintended pregnancy are complex in nature, their rate has seen a steady decline in recent history. As of 2011, 45% of pregnancies were unintended as compared to 2008 when 51% of pregnancies were unintended (Finer & Zolna, 2016). Furthermore, incidence of unintended pregnancy has also experienced declines among those with compounded risk. Studies have shown that unintended pregnancy has decreased in excess of 25% among youth, young adults, people living in poverty, people with lower levels of education and people cohabitating with intimate partners (Finer & Zolna, 2016; Kost, 2015). Despite these encouraging figures, unintended pregnancy remains pervasive in the United States and high relative to other developed countries (Trussel, 2007).

Pregnancies among young adults and teenagers are more likely to be unintended compared to those not among teenagers (Finer & Zolna, 2016). In fact, 75% of pregnancies among adolescent girls 15-19 years old are unintended. Teenagers are considered less able to care for their young and lack many of the resources necessary to engage in effective parenting (Goossens, 2015; Leftwich, 2017). In terms of young adults, national data show that unintended pregnancy rates among women ages 18-24 are 3-4 times that of adolescents 15-17 or women 35 and older (Finer & Zolna, 2016). Teen

pregnancies have, however, been decreasing in the United States. In 2010 the Guttmacher Institute released a report revealing that teen pregnancy had declined by more than 50% during the past 30 years (Boonstra, 2014).

Additional studies have shown that unintended pregnancy is pervasive among women of all ages. The Centers for Disease Control and Prevention (CDC) reported that among women aged 20-24 years of age, around 64% of pregnancies were unintended. These figures steadily decrease as women become older, with only 25% of women ages 25-44 experiencing unintended pregnancies (Centers for Disease Control and Prevention, 2012; National Center for Health Statistics, 2012). Though rates of unintended pregnancy are much lower among older women compared to teens, considerable numbers of women in their 30's, 40's and 50's experience unintended pregnancies due to many things including lack of use of contraceptives (Godfrey et al., 2016).

Unintended pregnancy rates vary widely among women of differing racial-ethnic backgrounds. The National Center for Health Statistics reported that 20% of Non-Hispanic white women, 35% of Latina women and 45% of Non-Hispanic Black women experience unintended pregnancies (NCHS, 2012). More recent findings suggested that the rate of unintended pregnancy among Black women was over two times the rate of white women (Finer, 2016). These differences in rates have been related to moderating factors such as poverty level, education, relationship status and age (Kim, Dagher & Chen, 2016).

Unintended pregnancy has long been considered to be both a risk factor for and a result of low levels of education. It has been reported that 41% of women with less than a high school diploma experience unintended pregnancy, in comparison to 40% of women

with at least a high school diploma, 37% of women with some college education and 17% of women with college degrees (National Center for Health Statistics, 2012). Another study found that across ethnicities, women who fail to finish high school have higher numbers of unintended pregnancy than those who do finish (Musick, England, Edgington, & Kangas, 2009). Unintended pregnancy often occurs in the presence of specific risk factors. Exploration of these risk factors is imperative to better understanding of how to prevent the phenomenon.

Intimate Partner Relationships and Risk for Unintended Pregnancy

There are numerous risk factors for unintended pregnancy including individual level and interpersonal factors. One prominent interpersonal factor associated with the outcome is intimate partner violence, with researchers having found that women who are victims of intimate partner violence have an increased risk of unintended pregnancy (Miller, Decker & McCauley, 2009; Pallitto, García-Moreno & Jansen 2013). Among a population of women who had experiences of domestic violence, it was reported that unintended pregnancy occurred as a result of a current intimate partner. These women specifically reported that they had unintended pregnancies because their partners refused to use birth control or because their partner refused to allow them to use birth control (Liu et al., 2016). Other investigations into racial factors of unintended pregnancy found that Latina women who had experienced abuse were nearly twice as likely as those who had not been abused to experience an unintended pregnancy (Cha, Masho & Heh, 2017). The notion that factors beyond those that are systemic and economic in nature can put women at increased risk for unintended pregnancy has recently received more attention in the

field of family planning. Of specific interest seems to be the way that other relationship and individual factors lend to heightened risk for unintended pregnancy.

Interpersonal risk factors for unintended pregnancy exist and have the potential for large influence on whether individuals will experience an unintended pregnancy. Considering the importance of the experiences and opinions of social networks, friends and families around individuals is pivotal for understanding health behaviors, such as unintended pregnancy. Often this can come in the form of group norms around certain health behaviors that impact the individual. This dynamic was analyzed specifically in one study that explored perceived norms, unintended pregnancy, and relationship status among a sample of young women. The study found that women's risk of unintended pregnancy is associated with and compounded by parents', friends' and partners' approval of unintended pregnancies and lack of family planning (Compernolle, 2017).

Such risk factors highlight the sheer number of things that can make women more likely to experience pregnancies that they did not intend to happen, and further highlight the importance of contraceptive use as a way to avoid this issue. Contraceptives have been identified by researchers, health professionals, and government entities as highly effective way of preventing unintended pregnancy. Emphasizing health behavior interventions and individual behavior modifications to increase uptake of these methods has been the mission of contraceptive interventions in fields of public health and family planning.

Contraceptives and Unintended Pregnancy

Studies have widely supported the position that unintended pregnancies occur in large part due to imperfect or lack of use of effective methods of contraception (Trussel et al., 2013). Due to this, public health initiatives have been initiated to increase and improve access to a range of contraceptives in the United States. Literature has established the fact that contraceptive behaviors largely determine unintended pregnancy and that when people have access to contraceptives, incidence of unintended pregnancy drops (Guttmacher Institute, 2016). Those seeking to engage in family planning have access to increasingly diverse and advanced contraceptive options, and options lend toward more autonomous and individually driven family planning behaviors. Autonomy in the family planning process is extremely important for women's health and for use of methods. Furthermore, engagement in different contraceptive behaviors often varies by sociodemographic factors including age, level of education, ethnicity, intention of future births, and marital status (National Center for Health Statistics, 2015).

Intimate Partner Relationships and Contraception

The intimate partner's impact on decisions is important in the field of family planning and their prominence in the lives of individuals. Studies have repeatedly shown that the context of intimate partner relationships is important for contraceptive behaviors (Zukoski et al., 2009; East, 2011; Chernick, Siden, Bell & Dayan, 2019; Manlove et al., 2011; Sweeney, 2010). Exploration of these relationships is essential in the field of family planning and could prove imperative in preventing unintended pregnancy.

Relationship type, stage and length have been demonstrated to have an impact on patterns of use of contraceptives. Some analyses have specifically listed relationships as

being positively associated with use of contraceptives. Manlove and colleagues (2011), for example, found that conversations about cohabitation and marriage were associated with reduced odds of using contraceptives. The same inquiry on cohabiting couples found that they tend to use effective methods of contraception--similar to those used by married couples engaging in family planning behaviors.

Other studies have analyzed the phenomenon and found an association between relationships and lower levels of contraceptive use. When analyzing relationship stage, one group of investigators found that younger adults in relationships with lesser levels of commitment and intimacy but greater levels of conflict were less likely to use contraceptive methods or to engage in dual-method use (using more than one method of contraception) (Sweeney, 2010). In line with this same thinking, among a sample of men, many expressed strong desires to avoid pregnancy in their sexual casual relationships. They also indicated less consistent contraceptive use related to lack of regard for their female sexual partners and lack of communication among the sexual couples (Raine et al., 2010). These findings lend to the idea that there are potentially intimate partner relationship-related and interpersonal qualities that can significantly affect the way that women use contraceptives. A study among African American women in Atlanta Georgia, for example, found that length of relationships, perception of relationship intimacy and trust in relationships were cited as factors that affected women's contraceptive behaviors and their pregnancy intentions (Murray et al., 2013). Bailey et al., 2012 found that intimate partner relationships that had been longer in length and were considered to be more committed were associated with less use of both condoms and hormonal contraceptives and less consistency in contraceptive use

overall. In assessing contraceptive use and less serious relationships, another study found that women in such situations had lower likelihoods of using effective methods of contraceptives as compared to those in long, consistent relationships (Upadhyay, Raifman & Raine, 2016). These studies demonstrate how the intimate partner relationship context exerts influence contraceptive dynamics and behaviors, and highlights a need for further inquiry in the area.

Much of the literature that has examined the connection between intimate partner relationships and contraception has focused on the role of intimate partner violence. Studies have repeatedly shown that violent and coercive relationships contribute to failure to use contraceptives and use of contraceptives that fail to align with women's contraceptive wishes (Peasant et al., 2018; McGrane, Mittal, Elder & Carey, 2016; Deutsch, 2018). One systematic analysis found that women used condoms and oral contraceptives less because of their intimate partner violence-related experiences. Due to loss of power in these same sexual relationships, women reported less ability to use condoms and oral contraceptives. This analysis also suggested that women who feared their partners and feared violence at the hands of their partners also used condoms and contraceptives with less frequency (Bergmann & Stockman, 2015). In 2014, an anonymous self-report survey among women found that those who had experienced reproductive coercion were also more likely to experience co-occurring violence within the same relationship (Clark et al., 2014). Some studies have ventured to delve further into dynamics around reproductive coercion among intimate partners that affects the way that women choose contraceptives, which methods they choose, and if they feel like they can negotiate with their partners around contraceptive decisions (Miller & Silverman,

2010; Miller et al., 2007; Moore, Frohworth & Miller, 2010). Negotiation and conversation concepts have been largely addressed in the literature in terms of condom negotiation, or safe and open conversations around the use of condoms. However, little research has focused on exchanges about contraceptive methods other than condoms. Within the context of these contraceptive behaviors lies the influence of interpersonal relationships. Communication within these relationships has the power to determine the trajectory of health behaviors, and better understanding of the nature of these communications could inform recommendations aimed at reducing unintended pregnancy.

Interpersonal dynamics of health communication

Communication and conversations about one's health vary by person, culture and many other important characteristics. The importance of effective communication is emphasized in public health for the prevention of sexually transmitted infections and prevention of unintended pregnancy. Interpersonal communication in terms of HIV/AIDS has been discussed as being imperative when considering personal safety and well-being (Noar et al., 2017). One study found that simple willingness to initiate a discussion about condom use is potentially important for predicting condom use leading to safe sexual interactions (McLaurin-Jones et al., 2015). In fact, many public health interventions have aimed to increase ability to communicate in order to improve sexual and reproductive health outcomes (Santa Maria, 2015; Boyas, 2012; Beckett, 2010). Studies that have been conducted, however, have often focused on the frequency and presence of conversations around condom use (Mullinax et al., 2017; Widman, Noar, Bradley & Francis, 2015), but have neglected to explore the nature of these conversations. In 2009 Zukoski and

colleagues introduced the idea of sexual dyads in which people used verbal and non-verbal communication strategies around desire to use or not to use condoms (Zukoski, Harvey & Branch, 2009). These sexual health-centered negotiations are significant and are both augmented and complicated by the context of the intimate partner relationship. The influence of intimate partners on sexual health communications and on the decisions of their partners is important for both family planning desires and prevention of sexually transmitted infections.

Condom negotiation

Condom use has long been heralded as extremely important for the prevention of sexually transmitted infections and unintended pregnancy. Given this fact, much work has been done with the goal of increasing condom use and facilitating safe sex practices among different populations. As a predictor of condom use, condom negotiation is the subject of many new investigations of how to increase the behavior in sexual relationships. Given the demonstrated importance of conversations and negotiation around choice and use of contraceptives, it is imperative to understand how conversations around using a specific contraceptive method occurs within the couple. Many studies have individually highlighted the importance of intentional conversations aimed at reaching an understanding around condom use. A 2016 cross-sectional study found that when women felt higher levels of self-efficacy related to condom negotiation, these levels often predicted consistent condom use (Nesoff, Dunkle & Lang, 2016). In line with self-efficacy in condom use affecting the behavior, a study among college students also found that condom use self-efficacy played a role in how assertive women were with their wishes to use condoms during sexual encounters. Investigators in this study

established that when women made direct requests to use condoms or chose to not engage in sexual behaviors in the absence of condom use, condom use increased (French & Holland, 2013). A study delving further into different kinds of condom negotiation found that threats of withholding sex and directly asking a partner to use a condom were significantly associated with condom use during the sexual encounter. When considering the differing relationship contexts in which negotiations happened, investigators found that these negotiation strategies were more effective in long-term, serious relationships than in casual ones (Peasant et al, 2018). Being assertive in these same situations was also shown to be negative in one study around contraceptive negotiation, with overall very high and very low assertiveness being associated with lower condom use and more moderate dimensions of assertiveness around condoms relating to more consistent use of the method (Schmid, Leonard, Ritchie & Gwadz, 2015). Additionally, condom negotiation has been found to be effective when verbal and nonverbal communication strategies to engage in risk communication prior to sexual encounters occurs (Tschann, 2010).

Investigators have further detected a link between ability to engage in condom negotiating strategies and toxic intimate partner relationships. An analysis addressing the role of condom negotiation as a mediating variable between intimate partner violence and use of condoms found that those who had been victims of intimate partner violence were less likely to engage in condom negotiation strategies (Peasant et al, 2018). Teitelman and colleagues found that women who cited engaging in unwanted unprotected sex reported that they could not engage in condom negotiation with their partners (Teitelman, Ratcliffe, Aleman & Sullivan, 2008). Further analysis on this topic found that in

relationships in which there is violence, women tend to have less confidence in their ability to negotiate condom use and thus engage in less protected sexual behavior (Swan, 2011).

Barriers aside from those relating to intimate partner violence exist in relation to women's ability to engage in to condom negotiation strategies. These barriers regularly revolve around awkward scenarios or feelings that negotiation may disrupt the intimate experience. A qualitative inquiry around the condom negotiation strategies among African-American college women found that if women previously had sex with their intimate partners, they felt it less appropriate to ask their partners to use condoms and that these same women also thought that timing of the discussion around condoms often inhibited the behavior. (McLaurin-Jones, 2016). This was mirrored by 26 women who had been previously diagnosed with sexually transmitted infections--which specifically found that many women in the sample had never engaged in condom negotiation prior to their STI diagnosis and that women experienced conflict around engaging in condom negotiation out of fear of being forced to talk about their sexual history (Cook et al., 2011).

The importance of engagement in condom negotiation is established, and well-documented. When women are able to establish understandings and engage in both verbal and non-verbal negotiations about their contraceptive desires, they are then able to advocate for themselves and effectively protect themselves from both sexually transmitted infections and unintended pregnancy. Analyses focusing on further exploring the nature and intricacies of these negotiations in intimate partner relationships is

necessary for improving the public's health. Such an analysis will be executed in this study.

Chapter Three: Methods

Overview

Qualitative research has emerged as a complex and important way to explore questions in the world of academia. It is defined as a research method that seeks to comprehend attitudes, beliefs, experiences and behaviors related to different phenomena of interest (Pathak, Jena & Karla, 2013). This kind of research has been said to "frame an issue as an entity" (Robling, Owen & Allery, 1988) and to focus on why social phenomena and personal experiences occur (Eisner, 1998). These facts around qualitative inquiry demonstrate how it allows investigators to answer questions that are considered to be unanswerable by quantitative research and allows for in-depth analysis and exploration into the nature of specific health behaviors--that which makes it indispensable in health behavior research. Given the utility of this approach of inquiry, it has grown in popularity of use in social science and was employed in this study.

Approach

The primary purpose of this qualitative study was to explore the role of depression in contraceptive behaviors. Data was collected in 2017 and 2018 for the primary study and a secondary data analysis was conducted using a subset of said data. This data analysis focused on a specific part of the interview guide and focused on one research question: How does contraceptive negotiation occur within the context of the intimate partner relationship? Investigators conducted 49 interviews total for this study, and 15 of those interviews were analyzed for the secondary research study.

Research Setting

Data collection for the larger study was conducted at several sites in Prince George's County, Maryland and in the Northeast region of Washington, District of Columbia.

Population

Prince George's County, Maryland

Demographic Data: Prince George's (PG) County, Maryland is the second largest county in the state of Maryland and is home to nearly 915,000 residents. (U.S. Census Bureau, 2018). Prince George's County has a higher-than-average median income at over $75,000 per year per household and over 9%, live at or below the federal poverty level. Less desirably,10.8% lacks health insurance, which is slightly more than those without health insurance nationally (10.2%). The education status in Prince George's County is moderately high, with 85.8% of those above the age of 25 holding a high school diploma or higher and 31.5% of people over 25 having a bachelor's degree or higher (United States Census Bureau, 2018). The county is approximately 66.6% African American, 26.8% white and 18.5% Hispanic/Latino (wish some overlap) and consists of around 6.5% children under 5 years of age, 22.2% people under the age of 18 and 12.8% people age 65 and older (United States Census Bureau, 2017).

General Health: The health status is Prince George's County Maryland is one that tends to be slightly better in comparison to the United States. The life expectancy is 79.6 years old and infant mortality rates for the county are 7.6 per 1,000 live births (Maryland Department of Health, 2018).

***Sexual and Reproductive Health**:* HIV prevalence in Prince George's County was reported to be 950 per 100,000 in 2018 and sexually transmitted infections were estimated at 680.3 per 100,000. These figures far exceed the prevalence of HIV and sexually transmitted infections in other counties of Maryland (with the exception of Baltimore City, Maryland). When considering reproductive health, it was reported that the teen birth rate in Prince George's County among females aged 15-19 is 26 per 1,000 women (County Health Rankings, 2018). In Maryland as a whole, it was reported that in 2010, 58% of the pregnancies were unplanned (Guttmacher Institute, 2017). There has additionally been data to demonstrate that prenatal care in Prince George's County tends to be worse than those for the state of Maryland. It was reported that in 2015, 10.9% of pregnant women in Prince George's County received late or no prenatal care. This is compared to 8.3% in the state of Maryland (Prince George's County Health Department, 2017). There are six Title X clinics in Prince George's county, or clinics that participate in federal grant program to receive funds for contraceptive services (Maryland State government, 2018).

Washington, DC

Demographic Data: The District of Columbia (DC) is home to 601,766 people. The median household income in DC is $72,935 and 16.6% live at or below the federal poverty line. Additionally, 4.2% of people in Washington, DC do not have health insurance. With a higher-than-average education status, 55.4% of people 25 and older in DC have earned a Bachelor's degree or higher and 90% of people have earned a High School diploma (US Census Bureau, 2017). D.C.'s population consists of 47.1% African American, 45.1% Caucasian, and 11% Latino, wish some overlap. The

population in DC additionally consists of 6.4% children under 5 years of age, 17.4% people under the age of 18 and 11.4% people age 65 and older (United States Census Bureau, 2017).

General Health Status: The life expectancy in Washington, DC at birth is similar to that of Prince George's County, Maryland, at 78 years (Virginia Commonwealth University, 2018). Infant mortality rates in Washington DC are additionally similar to those in Prince George's County, at 7.6 per 1,000 live births (District of Columbia Department of Health, 2018).

Sexual and Reproductive Health: The rate of sexually transmitted infections in Washington, DC was reported at 1,198 per 100,000 population. There was additionally a reported teen birth rate of 34 per 1,000 females aged 15-19. The prevalence of HIV in this area is 2,590, per 100,000 population (County Health Rankings, 2017.) There are stark comparisons for these figures, however, when looking at the different quadrants of DC. The highest rates of HIV in the District of Columbia are concentrated in the Northeast and Southeast regions of the area (Government of the District of Columbia Department of Health, 2016). The burden of unplanned pregnancy in the District of Columbia has been reported as being extremely high in comparison with the rest of the United States. In a 2017 Guttmacher Institute report, it was estimated that 62% of all pregnancies in DC were unplanned. It was also reported that the rate of unintended pregnancy in DC exceeded that of any other state in the country, at 48% (Guttmacher Institute, 2017). The teen birth rate in the DC was also high at 34 per 1,000 births. These problems are far reaching and bear consequences which are additionally reflected in other figures, with the percentage of babies born with low birth weights in D.C. being 10%, for

example (County Health Rankings, 2017). There are 27 Title X family planning clinics currently in the District of Columbia (Office of Population Affairs, 2018).

Interview

Sampling Procedures

Data collection occurred at three locations: a counseling clinic and family planning clinic in Prince Georges County, and family planning clinic in DC. The study aimed to enroll around 50 women and used purposive sampling methods. In qualitative research, purposive sampling is intentional sampling of those who potentially experienced a phenomenon of interest (Cresswell et al., 2011). Purposive sampling for the general study included attempting to reach women who had experiences with seeking out reproductive healthcare or mental healthcare.

Inclusion/Exclusion Criteria

Study inclusion criteria included the following: 1) women had to be of reproductive age (ages 18-49); and 2) had to be either seeking counseling for themselves (counseling clinic) or seeking reproductive health services (family planning clinics). Researchers initially limited the study to women who were not seeking abortion services, but later opened it up to abortion seeking women also. Women additionally had to be willing to meet in-person or over the phone for a longer interview. Women meeting the study criteria were recruited with an emphasis placed on recruiting women of color and those with current depression or depression history.

Recruitment

Recruitment for the general study was approached in two ways: 1) Staff at the clinics at which women were being recruited gave women information about the study and distributed short recruitment forms to interested clients or 2) research staff sat in clinic and gave women information about the study, obtained consent, and distributed short recruitment forms to clients. The consent form to be completed by interested participants requested that they read a short summary about the study's goal and potential risks and subsequently gave written consent to participate the study. Recruitment forms included basic demographic and contact information so that research staff could reach eligible women for the next phase of the interview process.

Procedure

The general study from which these data were derived involved three phases. During phase one, participants completed a short recruitment and informed consent form. Phase two was initiated after research staff determined participant eligibility. Once this determination was made, research staff conducted a brief (5-15 minute) screening interview with participants either over the phone or in-person. Phase three of the study occurred when research staff determined that potential participants met all of the inclusion criteria. Research staff conducted 30-60-minute final in-depth interviews over the phone or in-person with participants. After completing the final interview, participants were given a $50 cash incentive and those who completed the interview over the phone had their incentive mailed to their home address. Participants were also given a study debriefing letter reiterating the entire nature of the study and if requested, a

resource list containing information on behavioral health and mental health resources available in the area.

Data Management Protocol

Researchers collected paper copies of consent, recruitment, and screening forms. These forms were entered electronically into a secure excel spread sheet inside of an online-box folder, which was updated and maintained by research staff. Researchers also kept documentation of contact information and study progress of each participant of the study in a secure folder.

Final interviews were audio recorded using Tape A Call ©, an application provided by the Apple Store and transcribed by research staff or a transcription service. Researchers also took notes during longer-interviews and catalogued those notes online. Research protocol were reviewed and accepted by the University of Maryland College Park Institutional Review Board (IRB #812714-12) and participating research sites.

Instruments

Recruitment Form: The recruitment form for this study was created by the principal investigator of the study. Basic demographic information such as name, age, phone number and email were included in this form in addition to contact information for potential participants. Recruitment forms also had space where participants could indicate time-slots that would work best for a screening interview for them and a question about whether or not they have ever experienced depression, that which was germane to the general study purpose (Appendix 1).

Screening Form: The screening instrument for this study began with questions on whether participants had experienced depression recently or in the past and asked for details about those experiences. This screener included the Patient Health Questionnaire 9 (PHQ-9), a previously-validated health measure used in diagnosing depression using DSM-IV indicators of depression (Kroenke, Spitzer & Williams, 2001). This measure was initially used by the Principal Investigator to get information on any depressive experiences over the life span of the study participants. Additionally, the screening instrument included the 21-item Beck's Depression Inventory (BDI), a validated tool used to inventory depressive symptoms (Beck et al., 1961.) This instrument was used by the Principal Investigator of the project to assess the presence of current depressive symptoms among potential study participants. Following these quantitative measures, the screening document also included measures created by research personnel about pregnancy and pregnancy intention, abortion, and other demographic questions (Appendix 2).

In-Depth Interview Guide: The in-depth interview guide for this study was developed by research staff. The interview guide included sections containing questions on the following topics: thoughts, feelings, attitudes and experiences around pregnancy and motherhood; thoughts, beliefs, experiences and attitudes about contraception; information about intimate partner relationships, relationship dynamics and feelings about the intimate partner; intimate partner relationships and dynamics around contraceptives; parenthood, intimate partner relationships, contraceptives and depression; and questions on life aspirations. These sections contained numerous subsections

containing various questions and prompts. In-depth interviews ranged from thirty minutes to nearly two hours in length (Appendix 3).

Secondary Analysis

Inclusion Criteria: There were a set of criteria for determining which of the participants out of the general 49 interviews would be included in the secondary analysis of the data. The analytic sample was narrowed down due to a desire by the author to have women in the sample ages 18-30 in order to capture narratives from young adult women. The sample also only consisted of interviews from participants who had visited family planning clinics, due to the fact that women from family planning and counseling clinics sought distinctly different services. This led to the final analytic sample number of 15. In categorizing participants from the secondary analysis, the author assigned pseudonyms to each participant interview. For purposes of the secondary analysis, no participant identifiers were accessed. The study was determined to not be Human Subjects Research by the University of Maryland Institutional Review Board (Appendix 5).

Data Analysis

Qualitative data for this project was analyzed using NVivo 12©, a qualitative analysis software. NVivo 12© allows for organization and cataloguing of interview transcripts, as well as direct analysis of these transcripts using various indicators--from demographic characteristics to codes and themes designated by researchers themselves. To prepare for analysis, interview transcripts were uploaded into NVivo 12© folders.

Data analysis for this project followed the Grounded Theory approach of qualitative analysis. Grounded Theory is a set of steps of analysis that identifies key ideas

and concepts and creates theory based on findings (Corbin & Strauss, 2008). Grounded theory specifically moves from general idea identification and creates more specific ideas through inductive processes (Foley & Timonen, 2015). In line with the steps involved in Grounded Theory, analysis in this project will include a series of steps starting with analytic memo writing, open coding and axial coding. Next will be emphasis on developing the codebook and more selective coding, and analysis will end with creation of themes based on codes and theme analysis.

Analytic Memo Writing

The coding process for this secondary data began with initial readings of the transcripts. Each transcript was skimmed in order to get an appropriate gauge of its content. The author took notes in the form of writing analytic memos. These memos were used for internal reflection about the data (Charmaz, 2015) and gave a sense of what ideas were potentially present in interviews.

Open Coding

In order to begin the coding process the author commenced with a qualitative analysis strategy called open coding (commonly known as initial coding). Open coding involves breaking down interview data into parts and examining them, considering all possible theoretical explanations that can be extracted from the data (Charmaz, 2015). Each transcript was coded in its entirety and codes were catalogued in NVivo ©. While doing this, the author recorded these codes into a preliminary coding document.

Axial Coding

Axial coding is used to analyze codes found during the first coding cycle and determine which were important and not important to the research question. During this kind of coding some codes are consolidated, eliminated, and expanded upon (Kendall, 1999). This second cycle coding process was used by the author to relate codes to one another in order to establish relationships between different things that were said by participants during interviews and to start to hone in on codes to be included in the final codebook.

Codebook Creation

After doing open coding on all of the interviews and axial coding on a handful of interviews, a codebook was created with ideas that seemed to be both important and pervasive in the data. Codes were added to the codebook if they related to intimate partner relationships, sexual relationships, contraceptive decision-making, and contraceptive behaviors. The goal of adding these codes specifically to the codebook was to get firm grasps on how participants talked about their conversations and negotiations in relation to contraceptives. Sub-codes, or more specific codes applying to some general code, were also added to the codebook as they appear and if they seemed pertinent to the research questions (Appendix 4).

Selective Coding

After a codebook with a set of finalized codes was finished, the author continued to do selective coding on the remainder of the interviews using the NVivo © software. This coding process occurs when the important concepts that emerged from axial coding

are systematically related to one another. During this stage those concepts were further developed and refined, relationships between them were verified and clarified, and theory development occurred (Walker et al., 2006). When new codes or ideas arose and were deemed important to the analysis, they were added to the codebook. When each interview was coded, the author will use the Nvivo software to look at centralized compilations of codes, and how the excerpts coded in specific ways related to one another.

Second Coder

In order to establish inter-coder agreement, the author sent the codebook and two sample transcripts to a second experienced qualitative coder. This person reviewed and independently coded the documents without input from the author. The author then compared his codes against her own in order to assess whether there was divergence in their coding. It was established that both actors had been in agreeance about how excerpts were coded.

Code Consolidation and Creation of Themes

Documenting pervasive and particularly salient codes, the author began to consolidate the codes into larger ideas or themes. These themes told a specific story about women's experiences with intimate partner relationships and contraceptive negotiation and added to theory around the subject.

Categorization of Excerpts under Themes

Once emergent themes were determined, the specific excerpts that applied to these themes were categorized using NVivo 12 ©. This means that excerpts containing

codes that fell under differing themes were categorized under those themes, in able to visually see the quotes from interviews that fell under themes created.

Questions of Focus for Analysis

Primary Research Question: How does contraceptive negotiation occur within the context of intimate partner relationships?

Secondary Research Questions

1. How do women describe their conversations around contraceptives and contraceptive negotiations?

2. How do women relate their contraceptive choices to their intimate partner relationships?

3. What role does the intimate partner play in a woman's family planning experiences?

Table 2: Research Question to Interview Analysis Guide

Research Question	Corresponding Interview Guide Questions
Primary Research Question: How does contraceptive negotiation occur within intimate partner relationships?	ALL interview questions apply
1. How do women describe their conversations around contraceptives and contraceptive negotiations?	• I know you are/you are not currently in a relationship with a partner, how does your current/most recent sexual partner feel about contraception? • How has your partner affected your ability to use contraception? Which method to use? Whether you use the method consistently or correctly? • Do/did you and your current/most recent partner talk about contraception at all?
2. How do women relate their contraceptive choices to their intimate partner relationships?	• I know you are/you are not currently in a relationship with a partner, how does your current/most recent sexual partner feel about contraception? • How has your partner affected your ability to use contraception? • Do/did you and your current/most recent partner talk about contraception at all?
3. What role does the intimate partner play in a woman's family planning experiences?	• Are you currently using any method of contraception? Can you tell me about what methods you are currently using? • Do you feel/believe you and your partner have different views about contraception? • Do you think your partner makes it/would make it easier or more difficult to use contraception consistently? • What do you think an ideal relationship is? • Do/did you and your current/most recent partner talk about contraception at all?

Chapter 4: Results

Sample Characteristics

The sample used for the secondary analysis included women representing a wide variety of demographic groups. The sample was racially/ethnically diverse, with 60% of the participants identifying as African American or Black, 6.7% Caucasian, 13.3% Asian, 6.7% Hispanic, and 13.3% mixed race. Additionally, 20% of women indicated that they were between the ages of 18 and 21 years, 53.3% were between 22 and 25 years old, 13.3% reported being 26-29 years old, and 13.3% age 30.

The sample split in terms of employment status with 60% of women being employed and 40% being unemployed. The majority of the respondents (80%) were in relationships and were currently sexually active (73.3%),, 6.6% were cohabitating. A moderate amount (26.7%) reported having children and 6.6% were currently pregnant. All women in the sample reported using a contraceptive method at some point with 86.7% reporting use of hormonal contraceptives and 73.3% reporting use of condoms (with some overlap). Finally, 46.7% reported experiencing at least one unintended pregnancy.

Table 3: Analytic Sample Characteristics

		N=15 (%)
Race	Black	9 (60.0%)
	White	1 (6.6%)
	Asian	2 (13.3%)
	Hispanic	1 (6.6%)
	Mixed Race/other	2 (13.3%)
Age	18-21	3 (20.0%)
	22-25	8 (53.3%)
	26-29	2 (13.3%)
	30	2 (13.3%)
Employment		
	Employed	9 (60.0%)
Current Relationship Status		
	In a relationship	12 (80.0%)
Current Sexual Activity		
	Sexually active	11 (73.3%)
Children		
	Yes	4 (26.7%)
Pregnant		
	Yes	1 (6.6%)
Not Using Contraceptives		3 (20.0%)
Contraceptives (hormonal method)		
	Yes	13 (86.7%)
Contraceptives (Condoms)		
	Yes	11 (73.3%)
Unintended Pregnancy		
	Yes	7 (46.7%)

*Some participants cited dual method use or use both hormonal methods and condoms
*Some unintended pregnancies among participants ended in abortion

Findings as a result of the interviews were derived with consideration of major themes that emerged. Themes were derived using the grounded theory approach of qualitative research (as previously described) and are presented by research question. Many of these codes included differential levels of coding—meaning there were both parent and child codes. A total of 37 first and second-level codes were identified in the codebook. Final emergent themes were chosen using codes that had been used frequently, or that individually appeared to apply directly to the research questions of focus. A complete copy of this codebook is included in Appendix 4.

Description of Study Themes and Domains of Contraceptive Negotiation

Themes

This analysis produced eight principle themes. These themes demonstrate variation in male impact on women's contraceptive decisions and behaviors, great nuance in the male role in women's family planning experiences, and multiple mechanisms of contraceptive negotiation within the context of intimate partner relationships. Results also pointed to the idea that within the context of their relationships, communication was almost always considered to be important, but such was not always actualized in the form of contraceptive negotiation. Themes are explained as they relate to individual codes created during the grounded theory process, in addition to the specific participants describing them. Table 5 demonstrates which themes applied to each secondary research question.

Domains of Negotiation

In order to fully conceptualize the way that themes illustrate contraceptive negotiation in this study, pertinent themes were organized into domains of negotiation. These domains represent symbolic regions of negotiation described by interview participants and occasionally apply to more than one theme. Some themes did not apply to a domain because they did not represent a negotiation process (eg: *absence of conversational negotiation*, *communication value*, and *discordant narratives on partner's role in method choice/use by participant*). Though not clearly indicative of negotiation processes, these themes illustrate important aspects of the relationship and interpersonal conditions surrounding contraceptive negotiation.

There were a total of five domains of contraceptive negotiation as indicated by study themes. Domains include the following: 1) Egalitarian, open 2) Informational, open, 3) Closed, 4)Persuasion and Conflict and 5) Manipulation. Domains come together to answer the primary research question: How does contraceptive negotiation occur within the context of intimate partner relationships? Figure 1 illustrates domains of contraceptive negotiation that were described to have occurred by participants.

Figure 1: Domains of Contraceptive Negotiation

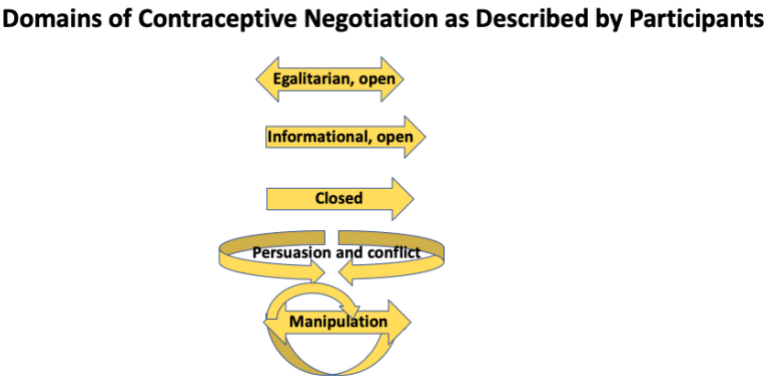

Table 4: Secondary Research Questions, Domains, Associated Themes, Respective Codes

Secondary Research Question	Domain	Theme	Respective Codes
What role does the intimate partner play in a woman's family planning experiences?	1. Egalitarian, open 2. Informational, open	Partner supporting player in contraceptive decisions and use	Partner facilitated contraceptive use, agreeance around contraceptives, partner supported contraceptive use
	3. Closed	Male wishes/priorities paramount	Hormonal method (Reasons for use, reasons for not using), condoms (reasons for use, reasons for not using), male partner dislike, partner impact, male partner tries to avoid using condoms
	4. Persuasion and Conflict 5. Manipulation	Partner conflict around use of contraceptives	Conflict around contraceptives, false information, manipulation by partner, ideas about how men behave, conflicting messages from partner
	3. Closed	Partner not included in contraceptive choices	No effect of partner on method choice/use
How do women attribute their contraceptive choices to their intimate partner relationships?		Discordant narratives on partner's role in method use/choice by participant	Conflicting messages about partner role in contraceptive use
How do women describe their conversations around contraceptives and contraceptive negotiations?	1. Egalitarian, open 2. Informational, open 3. Closed	Negotiation around initial method initiation	Conversations around contraception (nature of conversation)
		Communication Value	Intimate partner relationship type generally (communication, woman felt that she could communicate)
		Absence of Conversational Negotiation	Conversations around contraception (did not occur)

Description of Each Domain

Domain One: Egalitarian, Open

The first domain of contraceptive negotiation as demonstrated through findings is a negotiation process that is open and that includes active and equal participation in the negotiation process by both the man and the woman in a heterosexual intimate partner relationship. This process included open exchanges among female participants and their partners where each had input in the choice and negotiations around using given methods.

Domain Two: Informational, Open

The second domain of contraceptive negotiation denotes when female participants detailed their own or their partner's initiation of the negotiation process. This functioned as one partner informing the other that they planned on using a method of contraception, while being open to input from their counterpart. Partners were given the chance to provide input on the decision, and express if they agreed or disagreed with the decision. In this domain the intimate partner often provides active support and facilitation of the contraceptive behavior and is able to engage in the negotiation process.

Domain Three: Closed

In certain instances participants described contraceptive negotiation in which 1) females notified their partners about their contraceptive use or intention/wish to use a method, but allowed for no meaningful input from them. These situations were mainly verbal in nature and in some intimate partners became aware of the choices and provided support for them, but were not allowed to change or negotiate around the choices. In other instances, 2) closed negotiation occurred on the part of male partners, or with male

partner desire in mind. This included situations in which male partners either verbalized what contraceptive actions they wanted to take and they were taken, or when female participants described their contraceptive negotiations occurring around their male's wishes or pleasure. In this domain either the male of female partner held complete control over the negotiation process, and did not consider the wishes of their counterparts.

Domain Four: Male Persuasion and Conflict

Respondents at varying points in the interviews referred to situations where their male partners would engage in persuasion or subtle insistence that they engage in certain contraceptive behaviors. They also cited situations in which actual conflict arose around contraceptive negotiation. This constituted more subversive and tension-filled contraceptive negotiation. This occurred in the form of verbal and non-verbal negotiation and domain was harmful and undesirable in that it imposed power plays and made female partners bend their contraceptive wishes and will based on her partner's insistence and discontent.

Domain Five: Manipulation

The fifth domain of contraceptive negotiation as described by participants was the least indicative of actual negotiation and most indicative of reproductive coercion, control, and violation of sexual and reproductive wishes. Such consisted of male partners removing condoms during sexual intercourse, and represented a non-verbal disruption of previous agreed upon contraceptive choices and negotiations. In essence, it is an action that can be considered criminal and constitutes reproductive coercion/control.

Themes by Research Question

Secondary Research Question 1: What role does the intimate partner play in a woman's family planning experiences?

Partner supporting player in contraceptive decisions and use (Domain 1 and 2)

In excerpts relating to this theme, women gave accounts of their partners actively supporting their contraceptive use, helping them to get contraceptives or providing methods, and agreeing with participants about methods they wanted to choose or had already chosen. Codes relating to this specific theme were referenced 16 times and were expressed by many participants.

One participant, Amy, described this kind of support by her partner in her method choice:

> *... Before I really went in and get the pills, he told me uh, what the pills might do to me, so the positive effects and stuff like that,* ***and he's like, "If you need anything, I'll be there."*** *Just the support that he would give me. Um, yeah, and also how he wants me to be safe, as safe as possible. Um, that kind of thing.*

Other participants talked about their partners encouraging their contraceptive use through reminders to use their methods daily. This was demonstrated by Priscilla in her musings about her partner's role:

> *I guess he's all for it [contraception] now, 'cause I don't think he ... I mean, we're not ready for a kid, so... He,* ***he calls, he's, like, did you take your pill?*** *Blah, blah, blah, blah, blah.*

When asked about whether her partner made it easier or more difficult to use contraceptives, Alexandra similarly described her partner's role as a supportive figure and source of accountability in method use:

> *...I would say [my partner makes it] easier**. I mean he does ask me, you know, did you take it today… um, every once in a while, so he tries to keep me accountable.***

Male wishes priority/paramount (Domain 3)

Select women discussed situations where they used certain methods based on their male partners' desires. In many of the scenarios relating to this theme, ultimate contraceptive decisions occurred based on the desires of male partners, and consisted of a closed negotiation style (domain 3) in which male partners possessed the authority over the decision. This materialized in the manner of male partners' refusal to use certain methods and insistence that some methods were better than others. The theme also applied when female participants indicated that they had chosen a certain contraceptive method based on what she felt would be best for her partner.

In some situations, male partners insisted that the woman use contraceptives. One participant, Dominique, describes a situation in which her partner insists that she use a certain method of contraceptive, and how she subsequently decided to go along with his wishes:

> *He was very, you know, went to Georgetown, like he's, he headed to, he was very determined on being a doctor and so ...**He would always, like, give me, like, these little statistics [on contraceptives] and like all this stuff.** Like, oh no, like, you don't really, this doesn't really happen unless this happens, and stuff like that… **And me being, you know, younger than I am now when dating him, I was just like, okay…Like, whatever, I'll take what you say**…I love you and you're not going to do anything wrong, so yeah*.

Participants also described scenarios in which their partners would specifically insist that they use hormonal contraceptives, so that the male partner would not have to use

condoms. This is described by Sasha, in her explanation of her past partner's views on using condoms and her subsequent use of a contraceptive method because of it:

> ***He was the reason why I got on birth control, because he did not like them[condoms]****, so ... Uh, now that I look back on that, that was pretty shitty, but, you know, hey.*

Other participants described their decision to use hormonal methods of contraception because their partners had reduced sensation during sex when they use condoms. This sentiment is described by Amy as she explained why she decided to use the birth control pill:

> *Mm-hmm, definitely. So um,* ***this is largely affected by my current boyfriend because he could not, 'cause he had his organ cut and then he couldn't really, uh, I guess enjoy the process if he wears a condom. And that's the way that I normally, that I used to do. So I didn't really take birth control, um, uh, methods before I met him.***

Partner not included in Contraceptive Choices (Domain 3)

Participants occasionally described scenarios in which they used contraceptives without notifying their intimate partners, and did not allow for input from their intimate partners around contraceptive use. This constituted a closed style of negotiation and reflected women as the sole source of control in contraceptive decision-making. Such was described by Lynn in her response to interviewers about her partner's feelings concerning her use of birth control:

Interviewer: Okay. And so how does your current sexual partner feel about birth control?

Lynn: Um, ***I didn't really tell him I started taking the pill****.*

Intimate Partner Conflict in Negotiation around Contraceptive use (Domain 4 and 5)

In some cases, women reported conflicts arising between themselves and their intimate partners during negotiations around which contraceptive methods would be best to use. This conflict types included verbal spats and arguing about which methods to use, manipulation on the part of partners about method choice and use, and male partners giving false or conflicting information about their use of methods (such as condoms). Participants also elicited ideas around how they thought conflict would arise when asking men to use contraceptives, such as condoms (domain 4). These scenarios negotiation were contentious, and represented discordance between wishes of participants and their partners, and even coercive and violent disruption of previously agreed upon contraceptive plans (domain 5)—which often were established during initial negotiations.

Nicole described domain four of persuasion and conflict that occurred when she asked her past partner to use condoms. She also discussed her ideas about how men create conflict and act negatively when asked to use condoms:

> *...I've had one that was, didn't want to use it.* ***You know, got upset when I asked him to put it on, but he didn't have a choice, or he wasn't going to have sex.***
>
> *I mean nowadays,* ***these guys, they will definitely try to have sex with you without a condom****. You have to be the one to tell them, "No, put the condom on," because they are the ones that are irresponsible. Um, and they are not like us females. They don't get checked as much, and um,* ***they-they are definitely the ones that-that will go with a female without the protection of a condom.*** *So I've had guys try…*

Alexandra described a similar scenario in which the same domain of negotiation occurred. She additionally described how she made contraceptive decisions based on the nature of the relationship:

> ***But I find that, um, all of my partners have been male, that they always try and get out of using them [condoms].*** *And depending on the nature of the relationship, you know, if it's like serious, I'm like, okay, you know, that's something that we can look into.*

Jade recounted conflict that arose with her intimate partner around his perceptions of certain methods of contraception:

> *Like, I know I was dating this guy ... Right. (laughs) I was dating this guy before and he was way more traditional than I actually thought he was…****Um, but he judged me so hard when I told him that I was on the pill. Like, even before we started dating and stuff. And it freaked him out for some reason. I'm like, 'Wait, what?' You know, he just wasn't, like, about that. He associated like contraceptives with being slutty.***

In other cases women illustrated more subtle, coercive behaviors by intimate partners around contraceptive use. These behaviors consisted of male persuasion to use methods and manipulation around method use (domain 5). Domonique described the persuasion and conflict domain of contraceptive in reference to one of her past partners:

> *…He would do things in a way* ***where it was really his decision but it would make it seem like it was mine, does that makes sense****? So, um, it was, yeah, so basically there would be a conversation where, you know, I would decide that we should* ***and he would suddenly convince me that that wasn't the right choice.***

This same participant also recounted manipulative negotiation processes, where male partners disrupted the contraceptive negotiation process:

There was a few, who, of course didn't like it. Um, some who were just like, yeah, no, definitely. Then ***some who like, try to pull the trigger, like "Oh, you know it doesn't fit" or try to take it [the condom] off in the middle.***

Another participant, Nicole, reference the same kind of situation:

...he actually had a condom on the night that I got pregnant, but ***somehow, some way he took it off.***

Secondary Research Question 2: How do women relate their contraceptive choices to their intimate partner relationships?

Discordant Narratives on Partner's role in Method Use/Choice by Participant

In many instances women in the interviews elicited ideas about their partner's impact on the contraceptive methods they chose, or whether they would decide to use a method at all. At times, however, participants noted that their partners had little or no role in their contraceptive decision-making processes and behaviors, and later in the same interviews talked about experiences in which their partners did indeed have impact on those same behaviors. Women appeared to not be completely cognizant, in some cases, of their partners' actual roles in their contraceptive and family planning behaviors. Male persuasion around method use appeared to have an impact on method use and some women did not recognize that open negotiation had not actually occurred, or that they were being influenced by their partners.

Nicole described her partner as both being supportive of her contraceptive decisions and as holding the same views on contraceptives as she did.

> *Interviewer: Do you think that you and your partner have different views about contraception, or that they're pretty similar?*
>
> *Nicole:* ***Oh, I think they're pretty similar.***

she later described how her partner removed the condom during sexual intercourse (as previously mentioned in other themes) which resulted in an unintended pregnancy:

> *...he actually had a condom on the night that I got pregnant,* ***but somehow, some way he took it off.***

Sasha describes her partner's impact on her contraceptive life in differing ways when asked at different points in the interview. In a response about her partner's feelings on contraception, she said the following:

> ***Uh, he's completely fine with whatever, like, I choose to do.*** *Uh, he kind of, like, agreed with me on ... When he- when he heard about, like, you know, how, like, the hormones can kinda shift your mood sometimes, like at the very beginning or something like that, and, like, just my reasons to, like, wanna do, like, more, natural forms…*

Later in the interview, as shown in themes above, she reflects on how this same partner affected these decisions:

> ***Uh, he, uh- the reason- he was the reason why I got on birth control, because he did not like them [condoms],*** *so ... Uh, now that I look back on that, that was pretty shitty, but, you know, hey.*

Secondary Research Question 3: How do women describe their conversations around contraceptives and contraceptive negotiations?

Negotiation around Method Initiation (Domains 1, 2 and 3)

Participants in the study described engaging in many activities that could be considered contraceptive negotiation, having an exchange around contraceptive behaviors. In many cases, women reported conversations with their intimate partners around initiation of method use. This came in the form of both women and their partners initiating method use, and often was described as a brief, negotiation process. In some cases, women described this as an open dialogue where one partner engaged negotiation looking for open discussions around method use, while others talked about the negotiation being more closed off and one partner informing the other of their contraceptive intentions. Maria described this closed process (domain 3) when asked about how negotiation occurred in her intimate partner relationship:

> *I approached it, um, as soon as we started, um, becoming more sexually active. I- I addressed the fact that I was on contraception and that, um,* ***this was something that I would do just, you know- just as a- as a- as a FYI to him****. Not that he needed to influence my decision on it, but it was, um, just to let him know that I was on it.*

Alexandra also described a dynamic where she simply notified her partner of which method she planned to use, but did not intend on including him in the process:

> ..There wasn't like a lot of pushback [around using birth control] or anything or that, you know, there would need to be a huge discussion**. It's like okay, this is what we're gonna do, and I guess he kinda trusted me to make, because I'll make those decisions regardless and do what I need to do**.

On occasion, participants discussed their contraceptive negotiation around method initiation, while also indicating that their intimate partners wanted to have those discussions in order to make their wishes known. This presents a dynamic where open negotiations occurred (domain 1 and 2), in which decisions were made in line with the desires of the male partner. One example of this is shown below by Amy:

> *Actually several times before I really went in and got the pills.* ***He was the one who brought it up, like I said****, because he wanted me to be safe, and it's not really possible, or not possible but ... like,* ***he would not wear condoms just for the sake of the enjoyment and stuff. Um ... so yeah, he was the one who brought it up,*** *and was all the way supportive, and I was the on who was actually um, more hesitative towards it. But now we're good on it. Like, now problem solved 'cause we're both happy.*

Absence of Conversational Negotiation

During the interview processes, women sometimes discussed how and why they did not engage in conversational negotiation processes. This theme encompassed women who both described not having has substantive conversations around making contraceptive decisions and not having any kind of communication or negotiations about

it all. Codes that came together to make this theme were referenced eight times total and women who responded this way also gave reasoning about why they did not engage in negotiation processes. One participant, Ashley, described why she and her partner did not routinely engage in conversations around method use before sexual activity. She additionally indicated that she did want to commence negotiations around contraceptive use, which has been precipitated by her recent unintended pregnancy.:

***Like I said we have been doing it [contraceptive use] the same way, a couple times**, since my daughter. Um... but it is a discussion that we need to have now that we got pregnant unexpectedly this time. I think it's worth a conversation.*

Another participant, Kate, referenced the casual nature of her intimate partner relationship when asked why she did not engage in contraceptive conversations with her partner:

Um, it wasn't a really like serious, long term thing at all. ***So we just didn't kind of [discuss contraception].***

Finally, Tamara who was using a long-acting reversible contraceptive at the time, discussed how she and her partner no longer had conversations around contraception:

*..**Not anymore**. No. But when I make my decision about what I'm going to do ... Like so, in two years, we'll talk about it [contraception], but not like today*

.

Communication Value

Women were asked about what they valued in an intimate partner relationship and what they felt constituted an ideal relationship. As a response, many women in the sample noted that they believed that communication was important within the context of this relationship. Specifically, 9 out of 15 women described a relationship in which they could communicate with their partner as being a semblance of an ideal relationship.

Women described this in many ways and noted general communication as being the marker of a healthy relationship. When explaining her response to these prompts, Priscilla--a participant who was in a relationship at the time of the interview-- said the following:

> *Just trust, and if you ever have con-, um, communication with. Somebody, that should be, like, if you're going' somethin', do somethin' that you need, besides your best friend. The next person you can talk to about your problems and just be able to,* ***yeah, like trust and communicate****. That's what my biggest things are.*

Dominique--who was not in a relationship--echoed this same sentiment when describing her ideas of an ideal relationship and emphasizing the importance of mitigating conflict with potential intimate partners:

> ***Uh, being open with one another, communication. I'm big on communication****…You don't necessarily have to agree, you can agree to disagree. Like, all that drama and arguing and stuff like that. A good healthy amount of arguing is okay, but like, arguing 24/7 is a no go.*

Sasha, who was in a relationship at the time of the interview, talked about her actual experiences with communication in her current relationship. She conveyed positive ideas about her partner, which were in part influenced by the way they were able to communicate with one another:

> *Well, he is, like super-supportive, um, and just, like, super-loving, like, super- ... I don't know, like, super-everything that you would want in a- in a partner.* ***Like, the communication is awesome. Like, we can literally talk about anything at any point. He's just, like, yeah, communication is, like, everything to me.*** *I mean, and, like, he's hella attractive.*

Jade, who was also in a relationship, lastly talked about the importance of having open lines of communication in a relationship. She honed in on both clarity of desires and wishes of each partner as being important in communication specifically:

Um ... I would say, yeah. ***Like, definitely open communication,*** *like, um, not hiding things from them, um, being clear about, like, what you want, what you don't kind of.*

Chapter 5: Discussion

This secondary qualitative analysis endeavored to understand contraceptive negotiation within the context of the intimate partner relationship. In considering the role that the male partner had in participants' contraceptive decisions and family planning experiences, participants recounted a number of scenarios relating to their partners both directly and indirectly impacting the ways they accessed contraceptives, if accessed at all, and which methods they chose to use. Identified themes included: 1) Partner supporting player in contraceptive decisions; 2) Partner conflict around use of contraceptives; 3) male wishes/priorities paramount; 4) Partner included in contraceptive choices 5) discordance in narratives on partner's role in method choice and use; 6) negotiation around initial method initiation; 7) communication value; and 8) absence of conversational negotiation. Five domains of contraceptive negotiation contextualized the themes derived in the study and illustrate areas of negotiation described by participants. These domains include 1) Egalitarian, open 2) Informational, open, 3) Closed, 4) Persuasion and Conflict and 5) Manipulation. Themes and domains demonstrate that contraceptive negotiation is complex. For some participants, negotiation seemed to be a direct and for others it seems to be more subtle and implied. Study findings showed that negotiation did not occur at all in some instances, but that conversely participants still reported communication as being imperative in the relationship. Negotiation domains and themes are presented as they related sexual scripting, and underscore the importance of power, gender, and society in contraceptive negotiation.

Domain One: Open, Egalitarian

Themes: Partner Supporting Player in Contraceptive Decisions and Use; Negotiation around Method Initiation

In illustrating contraceptive negotiation within intimate partner relationships, the first type of negotiation as alluded to by participants was an open exchange that occurred between both actors in the intimate partner relationship around contraceptive use. Select excerpts from study themes "partner supporting player in contraceptive method choice/use" and "negotiation around method initiation" include participants referring to open and equal negotiation processes, but in reality many negotiations included some directionality and dimensions of power. Previous scholars have described open and equal processes as ideal for promoting effective contraceptive use. In the "negotiation around method initiation" theme, open egalitarian discussions were recounted participants as situations in which partners sat down together in order to determine how they would initiate use of contraceptives. Participants described each partner here as having equal impact on the thought process around choosing a method and an open exchange between the two was facilitated. In themes that talked about partners as supporting players, partners were demonstrated as providing input on contraceptives both beforehand and during the process of using methods and allowing for open, egalitarian exchanges around method use in the context of partner support. Scholars in the fields of family planning and STI prevention have gestured to the utility of these open negotiation processes.

French and Holland found that open and assertive negotiation between both partners in intimate partner relationships was associated with increase in use of condoms. This domain broadens the scope of French and Holland, to include negotiation around all methods of contraception (2013). Similar studies have stressed the importance of an open

exchange between partners and partner support as ways to increase method use and ensure that said method use coincides with the wishes of both partners (Nesoff, Dunkle & Lang, 2016; McLaurin-Jones, Lashley & Marshall, 2015; Schmid et al., 2015). The open negotiation style as referenced by participants in this study shows situations in which this negotiation was possible because both partners were engaged in the process were portrayed as having equal participation and stake in it being successful.

Other public health scholars demonstrated that this kind of negotiation was desirable in public health practice by exploring the importance of dyads in which people used verbal and non-verbal communication strategies around desire to use or not to use condoms. They concluded that these open negotiation styles were associated with lower rates of unintended pregnancy and STI transmission (Zukoski, Harvey & Branch, 2009; East, Jackson, O'Brien & Peters, 2011). Open and egalitarian negotiation style is an example of the kind of communication as described in past analyses and builds upon their findings through its affirmation of the utility of open contraceptive negotiation. Of importance to note, however, is the fact that though many participants alluded to their negotiations being open and equal, there were always directional and power-related aspects in negotiation processes in this study that made them inherently non-egalitarian.

This domain of contraceptive negotiation reflects an idealized picture of healthy interpersonal scripting. In specific, this represents an agreeance present between each individual actor's scripts, and harmony between interpersonal and intrapersonal sexual scripts as described by the seminal work of sexual script theorists (Simon & Gagnon, 1984; Wiederman, 2005). In this domain of negotiation gendered power dynamics are minimal because both the male and female partner assert equal action in the process. In turn, in this

domain participants and their partners were able to actualize their own wishes in addition to their intimate partner's wishes in their contraceptive behaviors.

Domain Two: Informational, Open

Themes: Partner Supporting Player in Contraceptive Decisions and Use; Negotiation around Method Initiation

Results demonstrated how participants described negotiation that occurred as they were in the progress of solidifying which method of contraception they would use. As shown in some excerpts in the themes "negotiation around method initiation" and "partner supporting player in contraceptive decisions and use" some participants consulted with partners about what methods they would use and engaged in an open negotiation process, allowing for partner input about the method they had been considering. This kind of negotiation has been marginally referenced in the literature, but has not been explicitly described qualitatively in the way that this study does.

Open verbal and non-verbal communication strategies are considered to be extremely be effective when engaging in risk communication prior to sexual encounters with partners. These negotiations include risk communication that entails exchanges around contraceptive method use, and are indicative of family planning behaviors (Tschann et al., 2010; Peasant et al., 2018). Negotiations in which one partner informs the other what method they are interested in using and allows for input is an example of this negotiation as described in the literature. Though fully initiated by one partner, this strategy can be a useful tool in preventing unintended pregnancy in that it still contains dyadic components (Wingood, DiClemente, 1997; Baele, Dusseldorp & Maes, 2001).

This type of negotiation furthermore demonstrated that women acted upon a potential degree of self-efficacy around negotiating method use, which has been previously found to be associated with higher condom use. Such was also explored by investigators who established that when women felt higher degrees of self-efficacy in their ability to initiate conversations around which methods they wanted to use, condom use increased (Crosby et al., 2013). Additional investigators have arrived at similar findings in their relation of condom (and contraceptive) negotiation to self-efficacy (Longmore, Manning, Giordano & Rudolph, 2003; Van Horne et al., 2009; Black et al., 2011). Findings as a result of this analysis provide context to the literature through their qualitative demonstration of how women operationalized that self-efficacy through vocalizing their contraceptive wishes and allowing for input, and expansion of the negotiation process to include negotiation around all contraceptive methods.

In the type of contraceptive negotiation described in this domain, both intrapersonal and interpersonal sexual scripting occurred. Categorically, this occurred as the female partner initiated negotiations around contraceptive use with her own scripts in mind, but how she also was willing to engage in the exchanging of sexual scripts around contraceptive use with her partner. In these situations, women were more open to melding their scripts with the partners', with the goal of a mutually agreed upon method choice. This domain demonstrated each partner bringing their scripts in at the interpersonal level through negotiation, and an agreeance about method choice based on the interaction (Simon & Gagnon,1984; Wiederman, 2005).

Domain Three: Closed

Closed (Woman-Centered)

Themes: Partner not Included in Contraceptive Choices, Negotiation around Method Initiation

In this domain, female participants notified their male partners that they intended to use a contraceptive method but were clear about the fact that they did not want male input on the decision. The themes "negotiation around method initiation" and "partner not included in negotiation processes" comprised this domain of negotiation. In said themes participants described initiating contraceptive method use and making it clear to their partners that they would have no role and reporting to interviewers that they used a method but had not told their partners. This kind of closed negotiation was less harmful than men's closed negotiation in that it was more indicative of reproductive autonomy and choice. These findings coincide with similar styles of negotiation as described in other scholarship about woman-centered negotiation.

As a positive implication in previous studies, Peasant and colleagues established that negotiation styles where women were extremely assertive about what they wanted in terms of contraceptive method use, the likelihood of method use that coincided with the woman's wishes was higher (Peasant et al., 2007). This level of assertiveness is not expanded upon in the literature to include instances where women allow for no meaningful input from their partners on their method choice (as described by participants in this study), but does seem to be considered to be more desirable in that the woman has a choice in her family planning life. Conversely, Schmid and colleagues found that when women were too strict or unwilling to compromise on contraceptive methods (or conversely when they were diffident), there was a lower likelihood of condom use (Schmid at al., 2015). Considering these findings, the type of negotiation as described

above could serve to hinder the progress of negotiation and could result in undesirable outcomes.

Cultural and intrapersonal sexual scripts seem to permeate closed, female driven contraceptive negotiation. Interpersonal scripting here is thwarted because female participants did not allow their male partners to engage, and they in turn could not sexual scripts around contraceptive use. Based on sexual scripting literature , these women's behavior could have been influenced by discomfort with cultural scripts around the male's role in women's sexual and reproductive decisions, and could have been women's attempts to break with these scripts and to take the stance that women alone should choose their contraceptive methods and should not consider the desires of males (Amaro, 1995). A similar attempt to break with or disrupt normative gendered sexual scripts can be seen in a study by Masters and colleagues (2013), which found that in intimate partner relationship dyads, female participants tried to enact sexual scripts that went against conventional male-led ideas about men's roles in contraceptive decisions. Participants in this same study described their relationships as being exempt from culture-level gender roles, and as existing within the context of new cultural sexual scripts (Masters, Casey, Wells & Morrison, 2013). Participants in this analysis echoed this same sentiment in their insistence to "do what they want" or "don't let men control them". This disruption of cultural scripting concerning normative female behavior in terms of contraceptives was employed by women in these closed negotiations.

Closed (Male-Centered)
Theme: Male Wishes/Priorities Paramount

An added dimension to this domain of negotiation is male-centered closed contraceptive negotiation. The study theme "male wishes/priorities paramount" demonstrated negotiation styles in which men gave their opinions about how they wanted to proceed with contraceptive use, and left little room for input by their female partners. This domain and theme also included situations where female partners made decisions only considering the wishes of their male partner and ignoring their own. These closed negotiations were more harmful than women's closed in that they often meant less method use. Many of these scenarios amounted to subtle reproductive control, and are important to assess in the context of previous findings.

Scholarship has explored the dimensions sexual relationships and empowerment and how they affect contraceptive negotiation. Stokes and Brody found that when women self-silenced—or put the needs and desires of male sexual partners over their own—there was an associated lower engagement in contraceptive behaviors (2019). This was specifically seen in this thesis when participants were preoccupied with their partner's satisfaction in the sexual act, and affirms Stokes and Brody's work on self-silencing. Such was similarly described by Higgins and Hirsch, who found that heavy considerations of male sexual pleasure and sensation on the part of females is associated with lower use of condoms (2018).

When looking at male power in contraceptive decisions, studies have produced results in agreeance with findings here. Foundational work on gender roles and power in society in heterosexual relationships has demonstrated that power structures both influence and reside in interpersonal relationships (Connell, 1987). This has been expanded upon in

multiple analyses that have explored power dynamics within interpersonal sex and contraceptive negotiation. One study found, for instance, that women who report lower amounts of relationship power engage in less consistent contraceptive negotiation and use (Pulerwitz, Amaro, DeJong, Gortmaker and Rudd, 2002). These women specifically indicated that they felt less able to control dynamics within their relationships, thus describing having less power. The women ascribing to said dynamic experienced a situation similar to that described by the negotiation style here, where the male partner had more power and influence in the negotiation process and negotiations revolved around his wishes. This study domain submits a specific type of negotiation that could lead to the less consistent contraceptive negotiation, as described above.

Grady and colleagues' further exploration of the topic found that the person in the intimate partner relationship who was rated as having more power often had more say in decisions around contraceptive use (Grady, Klepinger, Billy & Cubbins, 2010). Though no ratings of power were assessed in the analysis conducted here, the study domain demonstrates the implicit power of the male partner in contraceptive negotiation and affirms previous findings about power and contraceptive method choice.

Sexual scripting in closed negotiations where males have the most say demonstrates situations where interpersonal scripting is uneven. Interaction of scripts between the male and female partner does not occur and thus results in contraceptive decisions that are not in line with the female partner's intrapersonal scripts. Cultural scripts could have also influenced this negotiation style due to societal beliefs about the male as the driver in sexual and intimate relationships. These cultural scripts either give guidance to male partner signifying that he should take charge in negotiations or to signaled to the female participant

that she should consider the sexual and contraceptive wishes of her male partner as being most important. These cultural scripts are gendered and include sexual power dynamics that shaped the negotiation process in this domain (Simon & Gagnon, 1984).

Domain Four: Persuasion and Conflict

Theme: Partner Conflict around use of Contraceptives

Results of this analysis pointed to one contraceptive negotiation type in which male partners engaged in subversive persuasive actions, or reverted to outright conflict in order to get the contraceptive use that they wanted. The study theme "partner conflict around use of contraceptives" is associated with this domain, and comprises situations where negotiation that was uneven. Participants in these scenarios described their intimate partners getting upset in negotiations around using certain methods and attempting to persuade women to consider use of other methods of contraception. Dynamics similar to these have been explored by other investigators seeking to understand their impact on contraceptive negotiation and choice, and support the findings in this analysis.

Past literature has endeavored to describe these relationship dynamics in different types of intimate partner relationships. Cook and colleagues found that one factor contributing to participants' failure to engage in effective contraceptive negotiation was fear of conflict. This study demonstrated that women feared their male partners would become angry when they engaged in negotiation where they asked them to use condoms (Cook et al., 2011). In a similar vein, Bergmann and colleagues found that fear of conflict and intimate partner violence stymied the negotiation process around contraceptive use. (Bergmann et al., 2015). Such is similar to the conflict as described this domain of the

results, which showed that male partners did indeed sometimes cause conflict in relation to contraceptive negotiation.

This domain contains an aspect of reproductive coercion and control by male partners during the negotiation process. These coercive behaviors range in complexity and include male partners insistence that the female partner use a certain method and consist of direct and indirect influence from the male partner (Katz, Poleshuck, Beach & Olin, 2017; Bergmann & Stockman, 2015; Northridge, Silver, Talib & Coupey, 2017). The coercive nature here, in essence, lies in the fact that males engaged efforts to get their partners to engage in contraceptive behavior that they (men) preferred and include a strong power aspect. These coercive behaviors have been empirically shown to be linked to unintended pregnancy and intimate partner violence, and can have implications beyond these (Kovar, 2018). The domain of persuasion and conflict as described in this study supports the previous literature on reproductive control and coercion and provides a nuanced view of the phenomenon by showing a more subtle version of this coercion.

When considering persuasive actions by male partners around contraceptive use, interpersonal scripting and gendered power dynamics become important in the negotiation strategies. Male partners in these situations introduced their intrapersonal scripts about what they desired sexually and in terms of contraceptive use, and posited that above the desires of their female partners. At this juncture discordance between scripts occurred, leading to conflict and/or persuasion by the male partner. This domain furthermore demonstrated the virulence of male power in sexual scripting, and how males went to great lengths to posit their intrapersonal scripts over those of their female partners. This resulted in negotiation processes surrounding the male and his power in the

relationship. This domain of negotiation was contentious and represents a negotiation type that was extremely antithetical to female participants' desires (Simon & Gagnon, 1984).

Domain Five: Manipulation

Theme: Partner Conflict around use of Contraceptives

The last type of negotiation as derived by study findings denotes situations where male partners decided to take condoms off during the course of sexual activity. In these situations, male partners reversed the negotiation process, which typically happened before the sexual act, and broke with what was agreed upon—which is captured in certain excerpts from the study theme "partner conflict around use of contraceptives". This theme also applied when one participant manipulated/coerced her into using the method he wanted to use and made it seem like it was her own choice. Cases of partners removing condoms during intercourse or "stealthing" as it is called, have been recently identified by public health practitioners and advocates against assault as being a rape-adjacent and extremely coercive (Latimer, et al., 2018; Brodsky, 2017; Brennan, 2017). This type of reproductive coercion is considered to be one of the most extreme, and completely robs victims of having any agency in their contraceptive or sexual choices (Davis, Stappenbeck, Masters & George, 2019; Klein, 2014). Findings from this study affirm other findings around reproductive coercion and provide qualitative context on how it has occurred among different women.

In considering how sexual scripts function within this domain, the situations that participants described represented a disruption of most levels of scripting. First, interpersonal sexual scripting as established by exchanges during the negotiation process

were broken and considered to be non-important by male participants. Female participants' intrapersonal scripts and around what they desired sexually, which had been established during their contraceptive negotiation, where discounted. This domain even breaks with most cultural level scripting, around what is acceptable during sexual situations (as it can be assumed that these behaviors are seen as culturally undesirable and even punishable by law) (Simon & Gagnon, 1984). Cultural-gendered scripts however, pervaded in this domain. Male pleasure and desires were deemed as most important by male participants, and lead action that cancelled out the wishes of the female participant. I posit that this domain is one of the most extreme and harmful—as it not only constitutes behavior not in line with negotiation but generally cancels out the fact that contraceptive negotiation occurred at all.

Discordant Narratives on Partner's Role in Method Use/Choice by Participant

An added dimension that complexified results of this analysis was the theme demonstrating a disconnect between women's attributions and acknowledgements of their partner's role in their family planning processes, and the actual role of the partner in contraceptive decisions as shown in other parts of the interview. Women sometimes expressed that their male partners were supportive of their contraceptive decisions and engaged in open negotiation, but later gave examples about how their partners acted against their reproductive desires. Of concern in these situations is women's failure to identify situations in which their male partners are engaging in reproductive coercion and control. Previous work in the field of reproductive coercion and control has shown that when it does occur, women may not directly associate the behavior with the phenomenon (Grace, 2017; Miller, Decker & McCauley, 2010; Clark, Allen, Goyal, Raker, & Gottlieb,

2014). Results in this study align with other findings, and reflect a disconnect experienced by both women in this sample and in other studies. Such is dangerous given the possible negative health outcomes associated with stealthing such as unintended pregnancy and HIV/STIs (Klein, 2014; Brennan, 2018), and given the fact that it strips women of their bodily autonomy (Brodsky, 2017).

Absence of Conversational Negotiation and Communication Value

The last themes of this study pertained to the fact that some participants indicated that they do not engage in conversational negotiation, and that the large majority of participants listed communication as being most important within intimate partner relationships. Finding that some participants engaged in no conversational negotiation was expected, given other similar findings (Raine et al., 2010; Campo, Kohler, Askelson, Ortiz, & Losch, 2015; Tan, Melendez-Torres, 2016). However, this remains important given the fact that communication and negotiation around contraceptives is associated with increased use of contraceptives (Johnson, Sieving, Pettingell & McRee, 2015; Zukoski et al., 2009; East et al., 2011), and that neglecting to engage in the behavior can mean heightened risk for adverse health outcomes.

The fact that participants repeatedly cited the importance of communication in relationships was salient, in that it could have been assumed that they would see this communication as extending to sexual behavior and considerations around contraceptives. Despite this, some participants did not engage in explicit communication in the form of contraceptive negotiation. This was an interesting dynamic to note, given the explicitly stated value of communication but its lack of occurrence in the sample.

Theoretical and Practical Implications

Findings and domains derived as a result of this study can be used by in a variation of ways to inform public health research and practice. First, findings presented can be used as a basis for public health theory around contraceptive use and sexual decision-making. Domains presented as a result of emergent themes present a potential for establishment of a research framework that can be used to launch further research into the topics of contraceptive negotiation and interpersonal communications strategies. Such can also assist behavioral health theorists in extending their understanding and framework around contraceptive use. Theory development based on the domains and themes proposed here could modify scientific inquiry around the topic and influence further studies. Findings present here can also contribute to theory development about relationship factors affecting unintended pregnancy, including contraceptive negotiation domains as an important consideration.

This study is also useful in its potential applications for public health practitioners and those designing interventions aimed at reducing unintended pregnancy and increasing uptake of effective contraception. As this study furthers the theory around intimate partner relationships' role in these outcomes, interventions can be designed with components centered around enhancing contraceptive negotiation and identifying factors within intimate partner relationships that can be tackled to increase contraceptive use. Specifically, practitioners can design programs with components that enhance and facilitate the negotiation process, or that address cultural and gendered scripts in other to increase contraceptive use. Lastly, findings from this analysis can be used to inform contraceptive and relationship counseling efforts by clinicians and relationship

counselors. Professionals can use the domains of contraceptive negotiation to identify intimate partner relationships for which they should advise use of specific methods or a basis for when they should provide counseling around reproductive control/coercion or intimate partner violence. Further application of the findings outlined in this thesis should be undertaken and have the potential to improve health outcomes among women.

Study Strengths

This analysis was unique in many ways and was able to provide valuable insight into experiences around contraceptive negotiation in intimate partner relationships. This study had three principal strengths: 1) it was fairly innovative in its use of an existing qualitative dataset to explore a previously unexplored subject: contraceptive negotiation; 2) it is novel in its use of Simon and Gagnon's Sexual Script to Theory (1984) as a framework to analyze contraceptive negotiation. 3) it is qualitative, and thus able to capture women's depictions of the nature of their contraceptive negotiation in detail, which could not have been gauged quantitatively.

Innovative nature of the study: This study was the first of its kind to both define and explore the concept of contraceptive negotiation. Condom negotiation has been previously explored, principally in the field of HIV and STI prevention (Noar et al., 2017; Mullinax et al., 2017). The topic however, has not been expanded to include considerations of negotiating around all contraceptive methods, in the form of contraceptive negotiation.

Use of Simon & Gagnon's Sexual Script Theory: This study is also the first of its kind to use sexual script theory to analyze qualitative data around negotiation. Sexual script theory is a framework commonly used to analyze dynamics around sexual

behaviors (Simon & Gagnon, 1984), but has not been specifically applied to study around contraceptive negotiation. The demonstration of the importance of societal, interpersonal, and gendered-power dynamics to the negotiation process is novel and lends to the strength of the analysis.

Qualitative nature: The qualitative nature of this study is a large strength. Qualitative research is useful in the field of public health due to its ability to depict the nature of attitudes, behaviors and experiences (Pathak, Jena & Karla, 2013). Qualitative inquiry around contraceptive negotiation as a topic has not been approached by previous studies, but was achieved as a result of this study.

Study Limitations

Though novel, this study was not without limitations. Limitations of the study include the fact that 1) it was a secondary analysis of a larger dataset and 2) lack of ability to generalize study findings.

Secondary analysis: This study was a secondary analysis of a dataset from a larger project with different aims and research questions. Because the primary project was focused around another topic, interview questions did not all directly apply to the topics of contraceptive negotiation and intimate partner relationships. The interview guide also failed to include more probing questions around the topic of interest, which could have inherently limited the quality of data received from the interviews around the topic of contraceptive negotiation.

Lack of generalizability: Generalization in this study is not possible given the sample type. Participants were women from a specific age range, living in a specific geographic region (the Washington, DC metropolitan area), and were seeking the same

kinds of services. Considering this, their sentiments cannot be applied to other populations of women.

Recommendations for Future Studies

Though findings derived provide a narrative of how contraceptive negotiation may function in the context of intimate partner relationships, there are many other ways that the phenomenon can be explored.

First, future studies could investigate contraceptive negotiation outside of the context of heterosexual, cisgender relationships. Because these relationships might include different kinds of negotiation and negotiation may have impacts on different health outcomes, expansion of the scientific field to include assessments of the phenomenon in LBGTQ relationships is an important next step in the fields of sexual and reproductive health.

Future studies could also include in-depth assessments of contraceptive negotiation within defined relationship types. Past analyses have explored relationship type as it relates to contraceptive use generally (Chernick, Siden, Bell & Dayan, 2019; Sweeney, 2010; Manlove et al., 2011). Given findings from this analysis that gesture to difference in negotiation type based on power dynamics, reproductive control/coercion, and social expectations, studies around specific relationship types and associated negotiation types should be performed in order to further the realm of knowledge on the topic.

Finally, validated instruments could be created that measure the presence and degrees of contraceptive negotiation. Such instruments could be used in new quantitative studies around contraceptive negotiation and to increase scientific knowledge around the

topic. Identifying and operationalizing factors and variables that constitute contraceptive negotiation could be an important process in measuring the behaviors and investigating variables that may impact negotiation such as relationship type, intimate partner violence, or depression.

Conclusions

This study was successful in that it used qualitative data to understand the nature of a novel concept—contraceptive negotiation. Themes derived illustrated a slew of negotiation types, which occurred in different ways, by different people, and in different contexts. A number of these negotiation types had been described in previous studies, but this analysis was the first to capture detailed, qualitative views of contraceptive negotiation. This analysis also discussed negotiation in the context of sexual scripting. Scripts were demonstrated in the following ways: 1) Cultural sexual scripts permeated discourse around who should make contraceptive decisions and whose contraceptive wishes were most important—which in turn dictated types of negotiation; 2) Interpersonal scripting demonstrated how female participants and their male counterparts' intrapersonal and cultural sexual scripts interacted. These exchanges ended in either agreeance or discordance, which determined contraceptive decisions that followed the negotiation process; 3) Intrapersonal scripts were clearly held and seen as important by participants but were often cancelled out by cultural and interpersonal scripting in the negotiation process. Disruption of cultural and intrapersonal scripts sometimes occurred at the interpersonal and led to either more effective negotiation or

negotiation that was less functional. Also important to note is that all scripting at the interpersonal and intrapersonal level was influenced by gendered-traditional scripts.

This study additionally displayed the importance of gender and power dynamics in contraceptive negotiation processes. Men were shown, in many cases, to have the upper hand in contraceptive negotiation and were able to both explicitly and implicitly petition for the contraceptive decision that they wanted. Women, however, were also shown in some cases to dictate the negotiation process or to exclude their male partners. An important takeaway here is the fact that contraceptive negotiation is almost always directional, is seldom if ever egalitarian, and often includes power imbalances on the part of one partner.

Findings illustrate that contraceptive negotiation strategies are complex in nature, and occur in many different ways. Negotiation is then, shown by this study to happen even when people are not directly or verbally communicating. This study furthermore highlights the fact that communication is almost universally seen as being important in the context of intimate partner relationships, but that there is a disconnect when this comes to communication around sexual behaviors and contraception. Through the themes and domains derived as a result of this study, an established example of how contraceptive negotiation occurs can be referenced, tested, and refined in the field of public health. Further work can be done in the fields of family planning and sexual health in order to enhance actualization of egalitarian communication and negotiation strategies. This can be done to prevent unintended pregnancy, sexually transmitted infections, and to enhance agency in contraceptive decision-making.

Program competencies as required by the University of Maryland Department of Behavioral and Community Health in fulfillment of the Master of Public Health were met as a result of this Thesis. These competencies can be reviewed in Appendix 6.

Appendices

Appendix 1: Women's Health Study Recruitment Form

1. Are you willing to participate in a study on women's health in exchange for **$50** in cash? This study is being conducted by researchers outside of the Center for Healthy Families and Planned Parenthood. That you are being recruited from one of these places does not imply approval or endorsement from the clinic. The study requires that you **fill out** this form, participate in **ONE 5-15** minute phone interview and (if eligible) participate in **ONE longer in-person** interview in the School of Public Health building at the xxx **OR a phone interview** for **30 minutes to an hour** The interview will be scheduled at your convenience. You must be selected for this longer interview and complete it to get the $50. Are you willing to participate?

☐Yes ☐No

2. **If yes**, please provide your name, email, and cell phone number where we can reach you below. Please provide an email address and cell phone number where it is okay for us to refer to the "Women's Health Study".

Print Name_____

Email_____

Cell Phone_____

3. Please circle what days and times are convenient in the next week to reach you over the phone. **Specify all possible.**

☐ Monday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Tuesday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Wednesday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Thursday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Friday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Saturday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Sunday: 9 am 10 am 11 am 12 pm 1 pm 2 pm 3 pm 4 pm 5 pm 6 pm

☐ Other:

_____

4a. How old are you? _____ 4b.When is your birthdate (MM/DD/YEAR)?_____

4. What is your race/ethnicity?

   ☐Non-Hispanic White ☐Hispanic ☐African American/Black ☐Asian

   ☐Other _____

5. In the past year, have you been told by a health professional you have seen that you have depression?

   ☐Yes ☐No

6. Before the past year, have you been told by a health professional you have seen that you have depression?

   ☐Yes ☐No

Appendix 2: Screening Form

Interviewer: Hello, I am [name], calling from xxx to follow-up with you regarding the Women's Health Study that you expressed interest in participating in. Is now a good time to take 15-40 minutes to answer a few questions about your responses to that sheet? To recap from the consent form you filled out, you indicated that you are interested in participating in the Women's Health Study, which means answering some questions now about yourself and your mental health, and if eligible participating in an interview at a later date, and you will be compensated $50 should you complete both. I want to stress that you may withdraw at any time or skip any questions and your relationship with [either the Center for Healthy Families or Planned Parenthood] will not be affected. Do you still wish to participate? Is it okay if I record this interview. **[If person says yes, begin recording and say person's ID].**

Person's First Name_____ Person's ID_____

Today's date_____

1. If participant had been told had depression in past year:

You indicated that you had been told you had depression in the past year, can you remember who told you that you had depression?

- Was it your OBGYN? Primary care physician? A psychiatrist or psychologist or other mental health professional? A Nurse?

- *For researcher: Get an idea of who it is that told the person she had depression. Get as much information as possible. Get info on whether the person filled out a questionnaire or was interviewed by provider or someone else. For a participant from the Center for Healthy Families, ask the woman if it was her therapist at the Center for Healthy Families.*

2. If participant had been told had depression more than a year ago:

You indicated that you had been told you had depression more than a year ago, can you remember who told you that you had depression?

- Was it your OBGYN? Primary care physician? A psychiatrist or psychologist? A Nurse?

- *For researcher: Get an idea of who it is that told the person she had depression. Get as much information as possible.*

- Can you tell me about your depression? Would you say you have had it more than once? How many times would you say you have had it? If more than once, when was the first episode (age or month and year) and when was the most recent episode?

3. For everyone:

I am now going to read you a list of experiences or feelings you may or may not have had. When responding, please think about whether ever in your life you had a two-week period or more when you experienced the following symptoms. When thinking of this period, I will ask how often you experienced these symptoms and will include not at all, several days, more than half the days, or nearly every day for the two week period. Please let me know which response is most accurate. [Make sure and read response categories for each A-I].

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
A. Little interest or pleasure in doing things	☐	☐	☐	☐
B. Feeling down, depressed, or hopeless	☐	☐	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
D. Feeling tired or having little energy	☐	☐	☐	☐
E. Poor appetite or overeating	☐	☐	☐	☐
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H. Moving or speaking so slowly that other	☐	☐	☐	☐

people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
*I. Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

***Interviewer: If participant said several days or more than that to 3I, ask "When was the most recent time you experienced these thoughts" If the person says a time period that is within the last month, then say "I'm sorry you are feeling really down; I'm not the right person to talk to or qualified to work with you on this, but I am concerned."*

*[For the **Center for Healthy Family** Participants say] Given that you are in therapy, I suggest you speak with your therapist about this if you haven't already, and I have a hotline called Montgomery County Crisis Center that you can call at:* (301) 738-2255. *[For Planned Parenthood participants say]Are you seeing a counselor at this point? It could be helpful. In the meantime, I have a hotline called Montgomery County Crisis Center that you can call at:* (301) 738-2255.

*Then, **DON'T** assume person doesn't want to continue, ask: "Is it okay now if we continue [or do you prefer to stop]?"*

Before end interview, check-in again about this, and emphasize therapist and hotline.

Interviewer: Total Score _____

4. *Interviewer: If the person says 'several days' to at least one of the items 3A to 3I, please ask the following:*

A. Did these symptoms cause significant distress or impairment in social, work or other important areas of functioning? ☐Yes ☐ No

Interviewer: If yes, ask the participant to describe distress or impairment?

- Give examples. How? What do you mean?

B. Were the symptoms due to a medical or other physiological condition?
☐Yes ☐ No

Interviewer: If yes, ask the participant what medical or physiological condition?

C. (About) How many times have you experienced these episodes?_____

- How old were you when you experienced these symptoms for the first time?_____

- What was the month and year when you first experienced these symptoms for the first time? _____

- About, how long did this first episode last? _____

- How old were you the most recent time you experienced these symptoms?_____

- What was the month and year when you first experienced these symptoms for the most recent time? _____

- About, how long did this most recent episode last? _____

D. What do you think caused you to experience these symptoms for the first time?

E. What do you think caused you to experience these symptoms for the most recent time?

5. For everyone: Current depressive symptoms

Interviewer reads: *These next items are 21 groups of statements. Please listen to each group of statements carefully and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. If several statements in the group seem to apply equally well, select the one I read last.*

A. Sadness
0 I do not feel sad
1 I feel sad much of the time
2 I am sad all the time
3 I am so sad or unhappy that I can't stand it

B. Pessimism
0 I am not discouraged about my future
1 I feel more discouraged about my future than I used to be
2 I do not expect things to work out for me
3 I feel my future is hopeless and will only get worse

C. Past Failure
0 I do not feel like a failure
1 I have failed more than I should have
2 As I look back, I see a lot of failures

3 I feel I am a total failure as a person

D. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy
1 I don't enjoy things as much as I used to
2 I get very little pleasure from the things I used to enjoy
3 I can't get any pleasure from the things I used to enjoy

E. Guilty Feelings
0 I don't feel particularly guilty
1 I feel guilty over many things I have done or should have done
2 I feel quite guilty most of the time
3 I feel guilty all of the time

F. Punishment Feelings
0 I don't feel I am being punished
1 I feel I may be punished
2 I expect to be punished
3 I feel I am being punished

G. Self-Dislike
0 I feel the same about myself as ever
1 I have lost confidence in myself
2 I am disappointed in myself
3 I dislike myself

H. Self-Criticalness
0 I don't criticize or blame myself more than usual
1 I am more critical of myself than I used to be
2 I criticize myself for all of my faults
3 I blame myself for everything bad that happens

I. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself, but I would not carry them out
2 I would like to kill myself
3 I would kill myself if I had the chance

***Interviewer: If participant says "I have thoughts of killing myself, but I would not carry them out" or "I would like to kill myself" or "I would kill myself if I had the chance" say "I'm sorry you are feeling this way; I do just want to make sure that you are okay and you are talking to someone about these feelings. So I will send you a list of resources that may help you."*

J. Crying
0 I don't cry any more than I used to

1 I cry more than I used to
2 I cry over every little thing
3 I feel like crying, but I can't

K. Agitation
0 I am no more restless or wound up than usual
1 I feel more restless or wound up than usual
2 I am so restless or agitated that it's hard to stay still
3 I am so restless or agitated that I have to keep moving or doing something

L. Loss of Interest
0 I have not lost interest in other people or activities
1 I am less interested in other people or things than before
2 I have lost most of my interest in other people or things
3 It's hard to get interested in anything

M. Indecisiveness
0 I make decisions about as well as ever
1 I find it more difficult to make decisions than usual
2 I have much greater difficulty in making decisions than I used to
3 I have trouble making any decisions

N. Worthlessness
0 I do not feel I am worthless
1 I don't consider myself as worthwhile and useful as I used to
2 I feel worthless as compared to other people
3 I feel utterly worthless

O. Loss of Energy
0 I have as much energy as ever
1 I have less energy than I used to have
2 I don't have enough energy to do very much
3 I don't have enough energy to do anything

P. Changes in Sleeping Pattern
0 I have not experienced any changes in my sleeping pattern
1a I sleep somewhat more than usual
1b I sleep somewhat less than usual
2a I sleep a lot more than usual
2b I sleep a lot less than usual
3a I sleep most of the day
3b I wake up 1-2 hours early and can't get back to sleep

Q. Irritability
0 I am no more irritable than usual
1 I am more irritable than usual

2 I am much more irritable than usual
3 I am irritable all the time

R. Changes in Appetite
0 I have not experienced any change in my appetite
1a My appetite is somewhat less than usual
1b My appetite is somewhat greater than usual
2a My appetite is much less than before
2b My appetite is much greater than usual
3a I have no appetite at all
3b I crave food all the time

S. Concentration Difficulty
0 I can concentrate as well as ever
1 I can't concentrate as well as usual
2 It's very hard to keep my mind on anything for very long
3 I find I can't concentrate on anything

T. Tiredness or Fatigue
0 I am no more tired or fatigued than usual
1 I get more tired or fatigued more easily than usual
2 I am too tired or fatigued to do a lot of the things I used to do
3 I am too tired or fatigued to do most of the things I used to do

U. Loss of Interest in Sex
0 I have not noticed any recent changes in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely

6. Final demographic and reproductive questions

Interviewer: Now I am going to ask you some information about yourself and your prior pregnancies.

A. What is your occupation?_____

B. Are you employed? ☐Yes ☐ No

C. How many years of education have you completed?

8th grade or less	Some high school	High school graduate	Some college	College graduate	Some graduate school or a graduate degree
☐	☐	☐	☐	☐	☐

D. What was the reason for your visit to this health center?_____

- *Probe if necessary – to get contraception, for PAP smear, etc, we want to know the reason for the woman's visit*

E. Are you currently in a relationship with a male? ☐Yes ☐ No ☐ I don't know

*D1. If **No or I don't know**, have you ever been in a relationship with a male?

☐Yes ☐ No ☐ I don't know

F. Are you currently sexually active with a male? [if person needs clarification, vaginal-penile intercourse]? ☐Yes ☐ No ☐ I don't know

*F1. If **No or I don't know**, have you ever had sex with a male? [if person needs clarification, vaginal-penile intercourse]

☐Yes ☐ No ☐ I don't know

****For everyone who has had sex – those who say Yes to E or E1.

G. What was your age at first sex with a male? [if person needs clarification, vaginal-penile intercourse]_____

H. What is your marital status?

☐ Married
☐ Divorced/Widowed/Separated
☐ Currently living with partner but not married
☐ Single
☐ Other, please describe:

Interviewer: Because this study focuses on women's family planning experiences and desires, we are asking you a few questions about your previous or current pregnancies.

I. How many children do you have? _____

J. Are you currently pregnant? ☐Yes ☐ No

Interviewer: If participant says Yes to 6E above, ask E1 and E2. If participant says No, go to F.

J1. Was this pregnancy planned? ☐Yes ☐ No ☐ I don't know

J2. Will you carry this pregnancy to term? ☐Yes ☐ No ☐ I don't know

K. How many abortions have you had? _____

L. How many miscarriages have you had? _____

M. What is your total household income?

☐ Under $10,000	☐ $40,000 - $49,999	☐ $80,000 +
☐ $10,000 - $19,999	☐ $50,000 - $59,999	
☐ $20,000-$29,999	☐ $60,000- $69,999	
☐ $30,000 - $39,999	☐ $70,000 - $79,999	

N. How many people live in your household? Who is part of your household? *Note to interviewer, please include partners/spouses, children who are dependent on woman, parents, and siblings but not roommates?*

O. How much do you pay when you visit this clinic?

☐ Less than $20
☐ $20
☐ $40
☐ $60
☐ Other, please specify amount:

7. For Everyone: contacting them regarding final interview

We need to look at your responses to this form and then will contact you for the longer interview if you are eligible. Could you please let me know what is a good time to call you on the phone for a few minutes in the next week to SCHEDULE this longer interview?

In addition, we'd like to know if you are eligible, would you like to do this longer interview in person or on the phone?

☐Phone ☐ In- person ☐ Don't know

If you are not eligible, we will send you an email letting you know. Thank you for willingness to participate.

Final Interviewer: I hope you are feeling okay about this short interview. Would you like a list of places where you can seek further help to discuss any issues you may be having. If person says "Yes", tell them you will send it via email.

[Note to interviewer: If participant indicated any current suicidal thoughts, tell them you will send them a list of places where they can seek help. You don't have to say it's because of your suicidal thoughts, but you should let them know you will send some more resources so they can talk to a trained professional].

Appendix 3: Interview guide

Interviewer:

- If in person
    - Here is water for you.
    - Do you need to use bathroom beforehand?
    - Please silence your phone.

Thank you for taking the time to talk to me today about your experiences around family planning, pregnancy, contraception, motherhood, and your relationship. Some questions may be a little personal/sensitive. Please remember your responses will be kept confidential and results will never be connected with your name when disseminated. I expect the interview to take 30 minutes to an hour. If I remember correctly from the earlier forms you filled out, you have ___ children [interviewer needs to fill in number of children based on screening form]. Do you have any questions before we begin? I will be audio recording our interview and will take some notes. Thank you so much and let's begin,

Interviewer: **Begin tape recording with person's ID and piece of paper for notes with person's ID and first name**

---

1. THOUGHTS ABOUT PREGNANCY AND MOTHERHOOD

Interviewer: *Confirm parity – If person has had no children, then DON'T use what is in parentheses. If person has had children, then USE what is in parentheses.*

A. What are your thoughts about having (more) children?

1. *If wants (more) children*, ask: when do you think you might like to have (more) children?
    - *If desires pregnancy now or within the next year:* What are you doing to prepare for pregnancy?

2. *If does not desire future pregnancy within the next year or ever, ask:*
    - How important is it to you to prevent pregnancy (until you are ready)?
    - Are you doing anything to prevent pregnancy
    - Do you feel there is a possibility that you could become pregnant (again)?

3. *If unsure about having (more) children, ask:*
    - What are you doing to prevent pregnancy until you are sure?
    - What are you doing to prepare for pregnancy?

B. Do you feel that there is a possibility that you could become pregnant (again)? Why or why not? *[**Note to interviewer:** you **may** have asked this already, above depending on person's response to A, but ask again and could say "I know we touched on this some*

already but Do you feel that there is a possibility that you could be pregnant (again)? Why or Why not?"]

C. Do you think that this is a good time in your life to become pregnant (again)? Why or why not?

D. What do you think would be some of the plusses and minuses of being pregnant (again)?

- *Follow-up:* **What do you think would be some of the plusses and minuses of being a mother (again)?**

E. How important do you think it is for women to prepare for pregnancy? Can you talk a little bit more about what you mean?

- ✓ *Prompts if needed:* **What do you think preparing or planning for pregnancy entails?**

F. Medical issues sometimes impact women's thoughts and desires about pregnancy or pregnancy planning. We wanted to know if you have any physical or mental health issues (e.g., diabetes, depression, or alcohol use).

If yes: How has this physical or mental health issue/these issues influenced your decisions about whether or not to get pregnant in the future or in the past? Has it/have they influenced your thoughts about preparing or planning for pregnancy?

G. Have your feelings about having children changed over time? In what ways?

H. In general, when do you think that women are ready to have a family/what prepares them?

- ✓ *Probe if needed: What is the ideal age, life stage, factors that influence readiness, etc.*

I. [For women who have been pregnant] I know you said you have had _____*[fill in with number of abortions, miscarriages, and children the person reported in the Screener, sum of items I, J, K, and L]* **pregnancies. Can you talk about whether each pregnancy was planned? If participant reports at least one was unplanned, ask her to talk more about what she means and why she says this for each pregnancy that was unplanned?** *[For instance, was she doing anything to prevent pregnancy when she became pregnant? How did she feel when she became pregnant? What was her reaction?]*

- *Follow-up:* How has your mental health influenced your feelings or reactions to your pregnancy?

2. CONTRACEPTION

A. Are you currently doing anything to prevent pregnancy? *(Note to Interviewer: the person may have answered in A1, so be mindful of this; if person mentioned something above could say something like "I know we touched briefly on what you are doing to prevent pregnancy, but could you remind me what you are doing to prevent pregnancy?*")

- ✓ *Probe if person doesn't volunteer what they are doing:* **What are you doing to prevent pregnancy?**

B. Are you currently using any method of contraception? Can you tell me about what methods you are currently using? (*Note to Interviewer: woman may say no to this but have plans to use a method soon – it's okay for her to talk about this; it should just be clear that she isn't using a method now and plans to use this method and when she plans to use it should be specified)*

- *Follow-up:* **Are you currently sexually active? Have you been sexually active in the past?**
- *Follow-up:* **Have you used any method(s) of birth control in the past? Which ones? If NONE AND HAD DEPRESSION skip to Section 3; If NONE AND NEVER HAD DEPRESSION skip to Section 4.**

C. Tell me about your experiences with this/these method(s)? *(Note to Interviewer: only for the methods they report using in B; make sure to ask about all CURRENT AND PAST METHODS USED)*

- *Follow-up:* **What made you pick that/these method(s)?**
- *Follow-up:* **Did you have any problems with using this/these method(s)?**
- *Follow-up:* **Did you like/feel comfortable with the method(s)?**
- *Follow-up (method specific):*
  - **Pills**: *Missed/late? Taking other medications along with the pill that may have made it less effective? Side effects? How long used? How did participant remember to take it daily? Perceived effectiveness?*
  - **Patch/ring:** *Forgot to put in/insert a new one? Taking other medications? Side effects? How long used? How did you remind yourself to change patch/ring? Perceived effectiveness?*
  - **Condoms:** *Always used (get an idea of how often used, perhaps in % form)? Put on in time? Slip or come off? Partners view on using them? Perceived effectiveness?*
  - **Depo Provera:** *Did you remember to get your shot in time? Side effects? Perceived effectiveness?*
  - **Diaphragms:** *Who fitted? Use of spermicide with it? Comfortable with method? How long used? Perceived effectiveness?*
  - **IUD:** *Where did you go to have it inserted? How long have you had IUD? Have you had any problems with it? Perceived effectiveness?*
  - **Emergency contraception:** *Did you use EC? Do you keep a supply at home? Have you ever used it in the past? Perceived effectiveness?*
  - **Other method(s):** *Probe about consistency of use, perceived effectiveness, etc.*

D. Tell me about your experiences getting birth control. *[Note to interviewer, please repeat for each method of birth control the person is currently using and has used.]*

- *Follow-up:* **Where do you go to get birth control?**
- *Follow-up:* **Was/is it easy for you to get? What made it easier/harder to get it?**

E. What do you think are some of the positives and negatives about using contraception?

F. Are there things that make it difficult to use contraception consistently or correctly?

- *Follow-up:* **Is it difficult to get contraception on time? Is it difficult to use it as prescribed consistently?**
- *Follow-up:* **What makes it difficult?**

G. Has your attitude or beliefs about contraception changed over time? In what ways?

H. How has/have your physical or mental health affected your decision or ability to use contraception and/or what type of method to use? *(interviewer, be aware that people who are not depressed or have never been depressed will/may just say no, which is fine).*

I. I know you are/you are not currently in a relationship with a partner, how does your current/most recent sexual partner feel about contraception? *[interviewer needs to fill in based on screening form]*

- *Follow-up:* **Do you feel/believe you and your partner have different views about contraception?**
- *Follow-up if participant and partner have different opinions about contraception:* **Why do you and your partner have different views about contraception? **probe for reasons**

J. Do you think your partner makes it/would make it easier or more difficult to use contraception consistently? Tell me about that. (e.g., would your partner take you to clinic/doctor, do you have relationship conflict around contraception, does your partner's religious beliefs or values conflict with using contraception, has your partner thrown away birth control pills or put a whole in a condom or refused to use a condom)

- *Follow-up:* **How has your partner affected your ability to use contraception? Which method to use? Whether you use the method consistently or correctly?**

H. I know you were seeking services for _____*[fill-in with what they reported in Screener, question 6D]*, **did you discuss contraception at your visit?**

- ***If yes****, what was discussed? How did you feel about the discussion? Were you satisfied with it? Did you leave with a (new) method? How are you feeling about this (new method)?*

- ***If no****, do you wish you had discussed it and can you talk about your reason?*

3. DEPRESSION's INFLUENCE ON YOUR SEXUAL AND REPRODUCTIVE BEHAVIORS (*NOTE TO INTERVIEWER: QUESTIONS ARE FOR THOSE WHO HAVE BEEN TOLD THEY HAVE DEPRESSION RECENTLY OR IN THE PAST, OR HAVE HIGH DEPRESSIVE SYMPTOMS IN THE PAST OR CURRENTLY. CUT-OFF FOR Q3 [PHQ-9 for past depression] OF SCREENING FORM IS IF PERSON HAS A SCORE GREATER THAN OR EQUAL TO **10**; CUT-OFF FOR Q5 [BECK DEPRESSION INVENTORY OR CURRENT DEPRESSION] IS IF PERSON HAS A SCORE GREATER THAN OR EQUAL TO **17**. **DON'T GIVE A TITLE TO THIS SECTION FOR WOMEN SINCE DON'T WANT TO PRIME TOO MUCH.***

FOR THOSE WHO HAVE A SCORE ON Q3 (PHQ-9) BELOW 10 AND A SCORE ON Q5 (BDI) BELOW 17 AND THEY REPORT THAT NO ONE HAS EVER TOLD THEM THEY ARE DEPRESSED, SKIP TO SECTION 4)

A. Do you think your depression has influenced your desire for children? In what ways?

- *Follow-up:* **Has it influenced when you/when you will have children? How many you have/will have?**
- *Follow-up:* **Has it influenced who you have children with/who you will have children with?**
- *Follow-up:* **If no, what/who has influenced your desire for children? When you have children/you will have children? How many you have/will have?**

B. Do you think your depression has influenced your use of contraception? In what ways?

- *Follow-up:* **Did you use certain methods because you were depressed? Which ones?**
- *Follow-up:* **Did you NOT use certain methods because you were depressed? Which ones?**

4. MORE PARTNER INFORMATION

A. How would you describe your relationship with your current/most recent partner?

- ✓ *Probe if needed:* **How do/did you know him?**
- ✓ *Probe if needed:* **How long have/did you known him?**
- ✓ *Probe if needed:* **Are/were you close? Can/could you talk to him about things that matter?**

B. What do you think an ideal relationship is?

- *Follow-up:* **Are either you or any of your friends in an ideal relationship? What makes the relationship ideal or not ideal?**

C. Describe what you feel the role of a father should be like.

- *Follow-up:* **Do you think that your current/most recent partner fulfills or would fulfill these roles? What makes you think your current/most recent partner fulfills this role?**

D. Do/did you and your current/most recent partner talk about contraception at all?

- *Follow-up:* **What are/were your partner's views/thoughts about contraception?**
- *Follow-up if yes:* **Could you please tell us more about the discussion(s) with your partner and the decision-making process about contraception (e.g., brief, planned, not planned, comfortable, uncomfortable, engaging, dismissive)?**
- *Follow-up if no:* **Why didn't you and your partner discuss contraception?**

E. Do/Did you and your current/most recent partner talk about a potential pregnancy?

- *Follow-up if yes:* **What are/were your partner's views/thoughts about a potential pregnancy?**
- *Follow-up if no:* **Why didn't you and your partner discuss a potential pregnancy?**

F. Did your partner ever ask you not to use birth control or refuse to use a condom during intercourse?

- *Follow-up if yes:* **Can you tell me more about this?**
  - ✓ *Probe if needed about her actions and her feelings in response to her partner's behavior.*

G. In your current/most recent relationship, who is responsible for providing or using contraception?

H. How has/have your physical or mental health affected your relationships with your sexual/intimate partner(s)?

- *Follow-up: Has your physical or mental health affected your relationship conflict or support?*

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5. LIFE ASPIRATIONS

A. What things do you want to do in life? (*prompts* **– education, job, certain activities, hobbies, social world, interests)**

B. How has/have your physical or mental health affected what you want to do in life? (*prompts* **– education, job, certain activities, hobbies, social world)**

At end*: Interviewer: Thank you for your participation in the "Women's Health Study!" I wanted to provide you with a brief description of the purpose of this study since you took the time to participate. The purpose of this study was to hear from your perspective who and what has*

influenced your family planning and contraception desires, thoughts and feelings about motherhood, and sexual relationships. We were interested in the role of depression in women's family planning and contraception desires, thoughts and feelings about motherhood, and experiences of sexual relationships. Again, thank you for your participation.

Appendix 4: Codebook

Name
Conflicting or inconsistent messages
conflicting messaging about partners role in contraceptive decisions
conflicting or inconsistent messages from male partner about contraceptives
Contraceptive dynamics within relationship
Agreeance around contraception
partner supported
partner reminding participant to take method
male partner leaves choice to woman
no effect of partner on choice of method
partner careless about using contraceptives
partner facilitated process
Partner made contraceptives harder to use
Conflict around contraception
Ideas about how other men generally are in terms of contraceptives
IPV; removing condoms etc.
method choice
false information
manipulation by partner
use patterns based on male wishes
hormonal method use due to male wishes
male partner disliked condoms
Male partner tries to avoid using condoms
contraceptive use
Condoms
Reason for use
HIVSTI prevention
Other reasoning
Pregnancy prevention
Reasons for not using condoms
Monogamy
Partner impact
Hormonal Method

Name
Reasons for not using
Reasons for use
Using no method currently
conversations around contraception
brief
comfortable
Conversations around intention
conversation around potential pregnancy
negative conversation
positive conversation
conversation on ways to prevent
did not occur
long conversation
Nature of conversation
initiating contraceptive use
female partner initiated
male partner initiated
male partner ensuring woman using contraception
occurred
Reasons for type of discussion
uncomfortable
Experience of unintended pregnancy or abortion
Feelings about partner
negative feelings
positive feelings
Intimate Partner relationship type generally
intimate partner relationship values
communication
trust
understanding
woman did not feel like she could communicate
Woman felt she could communicate
Pregnancy Intentions
delayed intention

Name
Intention
no conversations around intention
no intention
Unsure

Appendix 5 HSRD Form

UNIVERSITY OF MARYLAND
INSTITUTIONAL REVIEW BOARD

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DATE:	December 9, 2018
TO:	Shaunna Newton, B.A.
FROM:	University of Maryland College Park (UMCP) IRB
PROJECT TITLE:	[1362219-1] Contraceptive Negotiation: The Influence of Intimate Partner Relationships
REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF NOT RESEARCH
DECISION DATE:	December 9, 2018

Thank you for your submission of New Project materials for this project. The University of Maryland College Park (UMCP) IRB has determined this project does not meet the definition of human subject research under the purview of the IRB according to federal regulations.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact the IRB Office at 301-405-4212 or irb@umd.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Maryland College Park (UMCP) IRB's records.

Appendix 6: Program Competencies

Competencies Addressed
Specify multiple targets and levels of intervention for social and behavioral science programs and/or policies
Identify basic theories, concepts and models from a range of social and behavioral disciplines that are used in public health research
Identify the causes of social and behavioral factors that affect health of individuals and populations
Describe the merits of social and behavioral science interventions and policies
Describe the roles of history, power, privilege, and structural inequality in producing health disparities

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