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Predictors of Sexual Relationship Power, Communication and Sexual Decision Making among Latino Couples

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Predictors of Sexual Relationship Power, Communication and Sexual Decision Making among Latino Couples

A dissertation submitted in partial fulfillment of the requirements

for the degree of Doctor of Philosophy at Virginia Commonwealth University

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Abstract

PREDICTORS OF SEXUAL RELATIONSHIP POWER, COMMUNICATION AND SEXUAL DECISION MAKING AMONG LATINO COUPLES

By Yui Matsuda, RN, BSN

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

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Unintended pregnancy (UP) is increasing among Latinos in the United States. Unintended pregnancy contributes to many negative consequences for infants, mothers and families. Concurrently, various factors affect Latino couples' sexual relationship power, communication and decision making about family planning, including sexual relationship power, relationship commitment, dyadic adjustment, individual background, and cultural characteristics. Previous research has not focused on understanding the factors that affect Latino couples' sexual relationship power, communication and sexual decision making from each partner's perspective. The purpose of this study was to examine the association between sexual relationship power, communication, and sexual decision making from each partner's perspective in relationship to family planning. In a cross-sectional design, recruited were a convenience sample of 40 Latino couples whose female partners in their second/third trimester from prenatal care clinics. Almost half of the participants were Mexican (males: 48%; females: 43%). The mean ages were 28 years

(males, SD:5.67) and 26.5 years old (females, SD 4.81). Sample characteristics and partner responses were compared and contrasted. Machismo, perceived relationship commitment, relationship satisfaction and perceived decision making significantly contributed to the variance in sexual relationship power among women ($F(8,26) = 6.776$, $p < 0.001$). Increasing sexual relationship power through Latina empowerment and mutual decision making has the potential to build sustainable relationships. Relationship commitment, relationship satisfactions as well as cultural values (machismo and marianismo) were also the significant predictors for most of the study key variables. Decision making conversations among couples should optimally begin before the initiation of sexual activity and continue throughout the couples' active sexual relationship. Couples communication facilitates making known each other's will and thoughts and helps to promote healthy reproductive and sexual lives. Findings will contribute to developing targeted interventions to decrease UP while increasing quality of life for Latino families.

Chapter 1

Introduction and Overview of the Dissertation

Unintended pregnancy (UP) is increasing among Latinos in the United States. Unintended pregnancy contributes to many negative consequences for infants, mothers and families. Concurrently, various factors affect Latino couples' communication and decision making about family planning, including sexual relationship power, relationship commitment, dyadic adjustment, individual background, and cultural characteristics. Moreover, the lack of negotiation power is a key factor in unsafe sexual behaviors in couples. The Sexual Relationship Power Scale (SRPS) was developed to measure this important concept. Even though this concept and scale has been deemed important and has been used in various studies, there has not been a review done that integrates what has been published in the literature. The purpose of this integrative review is to examine the reliability and validity of the scale across published studies as well as to integrate the results and suggest implications for future research and clinical practice with a focus on improving the health of women and couples. Web of Science, Pubmed, CINAHL and PsychINFO were systematically searched using the authors' names and keywords; 13 studies met inclusion criteria. Critical analysis of study results suggests that the scale is valid and reliable, and useful in examining gender power within relationships.

Given the importance of examining sexual relationship power as one of the predictors for sexual decision making and communication, the purpose of the dissertation study was to examine the association between sexual relationship power, communication, and sexual decision making from each partner's perspective. In a cross-sectional design, a convenience sample of 40 Latino couples whose female partners were in their second/third trimester was recruited from prenatal

care clinics. Almost half of the participants were Mexican (males: 48%; females: 43%). The mean ages were 28 years (males, SD:5.67) and 26.5 years old (females, SD 4.81). Sample characteristics and partner responses were compared and contrasted. Machismo, perceived relationship commitment, relationship satisfaction and perceived decision making significantly contributed to the variance in sexual relationship power among women (F [8,26] = 6.776, $p <$ 0.001). Increasing sexual relationship power through Latina empowerment and mutual decision making has the potential to build sustainable relationships. Relationship commitment, relationship satisfaction as well as machismo and marianismo were predictors for most of the communication variables as well as decision making among both women and men.

Decision making conversations among couples should optimally begin before the initiation of sexual activity and continue throughout the couples' active sexual relationship. Couples communication facilitates making known each other's will and thoughts and helps to promote healthy reproductive and sexual lives. Findings will contribute to developing targeted interventions to decrease UP while increasing quality of life for Latino families.

Chapter 2

Use of the Sexual Relationship Power Scale in Research: An Integrative Review

The following manuscript was prepared in partial fulfillment of the requirements for a manuscript-format dissertation.

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Abstract

The lack of negotiation power is a key factor in unsafe sexual behaviors in couples. Pulerwitz, Gortmaker and DeJong (2000) developed the Sexual Relationship Power Scale (SRPS) in English and Spanish to measure this important concept. The purpose of this integrative review is to examine the reliability and validity of the scale across published studies as well as to integrate the results and suggest implications for future research and clinical practice with a focus on improving the health of women and couples. Web of Science, Pubmed, CINAHL and PsychINFO were systematically searched using the authors' names and keywords; 13 studies met inclusion criteria. Critical analysis of study results suggests that the scale is valid and reliable, and useful in examining gender power within relationships.

Keywords: power, sexual relationship power, gender dynamics, male & female, integrative review

Resumen

La falta de poder para negociar es un factor clave en el sexo sin protección en parejas. Pulerwitz,Gortmaker and DeJong (2000) crearon La Escala de Poder Sexual entre Pareja en Ingles e Español para medir este concepto importante. El propósito de este análisis integrativo es para examinar la confianza y validez de la escala en estudios publicados, así como integrar los resultados y sugerir implicaciones para futuros estudios y para el tratamiento clínico con el propósito de mejorar la salud de la mujer y de parejas. Web of Science, Pubmed, CINAHL and PsycINFO fueron examinados sistemáticamente usando los nombres de los autores y palabras claves; trece estudios cumplieron el criterio para ser incluidos. Análisis crítico del los resultados del estudio indicaron que la escala es confiable, valida, e útil en examinar la relación de poder entre géneros.

Use of the Sexual Relationship Power Scale in Research: An Integrative Review

Over time, both practitioners and researchers have begun to emphasize the importance of embracing reproductive health with both members of a couple rather than with women alone (Becker, 1996; Grady, Klepinger, Billy, & Cubbins, 2010). These recommendations are based in the fact that sexual behavior is dyadic in nature and both members contribute to the outcomes of the relationship. Approaching both men and women together and separately is desirable to achieving optimum reproductive health outcomes and to prevent sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) (Billy, Grady, & Sill, 2009; Harvey, Henderson, & Branch, 2004; Kraft, 2007; Kraft et al.) . Although evidence has shown that bringing couples together for education and counseling is an effective intervention in preventing STIs and HIV, such approaches remain underrepresented in research related to other areas of reproductive health such as controlling unintended pregnancies and promoting family planning communication between couples (Grady et al., 2010).

Further, when examining the dyadic behavior within a couple, gender and the power dynamic between partners play an essential role in choosing to engage in protective or risky behaviors. Gender is socially constructed and embedded in social context, defining self-concepts, beliefs, and expectations for behavior (Deaux & Major, 1987; Potuchek, 1992). Studies have shown that gender inequalities often places women in difficult situations when negotiating safe sex behaviors (Marin & Gamba, 1996; Wood & Price, 1997). Particularly, minority women have been shown to have increasing vulnerability in relationship to sensitive sex-related outcomes. Unintended pregnancy rate of Latinas were more than twice higher than that of Whites, and unintended pregnancy rate of African American women were almost three times higher that of Whites (Finer & Henshaw, 2006). Moreover, the rate of HIV infection among Latina women was

nearly four times that of white women in 2006 (14.4/100,000 vs. 3.8/100,000) (Centers for Disease Control and Prevention [CDC], 2010b), and the rate of new HIV infection among African American women was nearly 15 times as high as that of white women (CDC, 2010a).

Moreover, traditional Latino cultural concepts impede Latina women in communication about all sex behaviors including safe sex. The concept of "machismo" is one of the most prominent Latino characteristics. "Machismo" is a predominant social behavioral pattern of the Latino male in which he demonstrates a dominating attitude to those inferior to him and demands their sub-ordinance. Given this characteristic, males are often more dominant in decision making in the areas of reproductive health as well as household matters (Amaro, 1988). In the area of reproductive health, studies have shown that women demonstrated limited assertiveness about sexual practices and condom use (Wood and Price, 1997; Gomez & Marin, 1996). Traditionally Latina women will not speak to men about sexual matters and communicating preferences about sexual preferences may be seen as promiscuous behavior (Amaro, 1988). Women are expected to demonstrate "marianismo", which means being like Mary (the mother of Christ) by performing as dutiful mothers and wives (Wood and Price, 1997). Such traditional views of male and female roles remain apparent in the Latino population (Chavira-Prado, 1992). Thus, women are in a difficult position to actively participate in or initiate family planning decision making (Gomez & Marin, 1996).

Therefore, it is important to consider how gender inequalities and power between partners of different genders play into the dynamics of safe sex negotiation and to reach out to minority women and couples in HIV and unintended pregnancy prevention. One definition of relationship power is the ability or skill to influence or control another person's actions (Ragsdale, Gore-Felton, Koopman, & Seal, 2009). Even though relationship power has been

considered as an important component in women's condom negotiation (Pulerwitz, Gortmaker, & DeJong, 2000), this concept has not been empirically tested due to the lack of valid instruments. Therefore, to provide empirical evidence about relationship power and its influences in women's sexual decision making, the Sexual Relationship Power Scale (SRPS) was developed by Pulerwitz, Gortmaker, and DeJong (2000). The SRPS was originally developed for use only with women; however, since its development other authors have now used it for men.

The SRPS originated from two theoretical frameworks: The Theory of Gender and Power, and The Social Exchange Theory. The Theory of Gender and Power explains gender inequality in relation to societal gender roles (Cornnell, 1987). There are three overlapping but distinct structures that have been found to create power differences in heterosexual relationships: sexual division of labor; sexual division of power; and structure of cathexis (Wingood & DiClemente, 1998). First, sexual division of labor is related to the fact that women tend to perform household work or child care, which are unpaid. Thus, their educational opportunities are limited. Furthermore, women with low income tend to engage in higher risk sex behavior rather than prioritizing healthy sex behavior, because they are afraid that the partner will abandon her if she expresses what he (who is often the source of income) may not want (i.e. wearing condom) (Wingood & DiClemente, 1998). Second, sexual division of power is demonstrated when the over exaggerated power of men (particularly in physical force) results in partner abuse. Abused women or women with a history of abuse lack a sense of power, and thus tend to be more vulnerable and are more likely to participate in risky sexual behaviors (Wingood & DiClemente, 1998). Third, the structure of cathexis or the social norms about acceptable women's sexual behaviors may also be at work influencing how the women behave. For example, if society views women who carry condoms as "loose," women will not be as likely to

do so to protect themselves from HIV or other STIs (Wingood & DiClemente, 1998). In summary according to the Theory of Gender and Power, societal norms place women in a more difficult position with regard to protecting themselves from risky sexual behavior.

The Social Exchange Theory provides an interpersonal definition of relationship power (Emerson, 1981). Relationship power is expressed through decision making dominance: how much one partner can make decisions against the other's wishes or how much one partner controls the other. Relationship power increases with one partner's dependency on the other, quantity of resources available to the relationship and existence of alternatives in the relationship. The SRPS was developed by using the frameworks of these two theories and existing literature about relationship power. In addition, the input of the target population (minority women) was utilized to increase face and construct validity (Pulerwitz et al., 2000).

The final model of the SRPS consists of 23 items divided between two subscales (overall Cronbach's $\alpha = 0.84$ [English version] and $\alpha=0.88$ [Spanish version]): the Relationship Control Subscale (RCS) (fifteen items, $\alpha=0.85$[English version] and $\alpha=0.89$ [Spanish version])and the Decision Making Dominance Subscale (DMDS) (eight items, $\alpha= 0.63$ [English version] and $\alpha=0.60$ [Spanish version]), with good to fair internal consistency for both subscales (Pulerwitz et al., 2000). The RCS uses a four point-Likert scale (1=strongly agree to 4=strongly disagree) and asks questions about the woman's perception about the partner's behavior towards condom use and how much the partner controls what the woman does. The DMDS asks who has more weight in decision making on each given topic in their daily lives and has the participant select between your partner, both of you equally, or you (Pulerwitz et al., 2000). Pulerwitz et al. (2000) states that the two subscales can be administered separately or together, depending on the aim of the research. In addition, the modified sexual relationship power scale (SRPS-M) was created which

does not contain condom use related questions (4 items). The SRPS-M still maintains a good internal consistency (α=0.85). The subscales also have internal consistency reliability similar to the original scale (modified RCS: α=0.84; modified DMDS: α=0.6). Furthermore, it was tested and shown that the SRPS-M is associated with consistent condom use (Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Pulerwitz et al., 2000). Thus, when researchers want to more closely examine consistent condom use and relationship power, the SRPS-M can be used to ensure that the association between the two is not particularly related to the inclusion of direct questions about condom use found in the questionnaire (Pulerwitz et al., 2000).

The SRPS is the only tool consistently used to examine relationship power in research with couples. It has been translated into at least eleven languages and used with diverse populations of women and men around the globe (modified for use with men). We did not find a previous integrative review of studies using the SPRS in the literature. Therefore, the purpose of this review is to examine the reliability and validity of the scale across published studies as well as to integrate the results and suggest implications for use of the scale in clinical setting and in future research. First, the characteristics of the research studies that used the SRPS are presented including the scales' validity and reliability, and study findings. Then, studies where the SRPS was administered to men are discussed. Third, the research implications with various modified versions of the SRPS are presented. We believe that by examining the current literature systematically, the importance of sexual relationship power in research interventions and clinical practices settings will be revealed.

Method

A systematic literature search was conducted in the following databases; Web of Science, PubMed, CINAHL, and PsychINFO. Web of Science was used mainly due to its unique function of completing a cited reference search. The cited reference search allows the user to enter a researcher and find his/her publications. In addition, each publication is accompanied by a list of publications that cites the current publication. *Pulerwitz J,* the first author of the SRPS original research study was entered so that whoever cited this study would be captured in the search results. Since "*sexual relationship power/sexual relationship power scale"* is not a MeSH term (pubmed), CINAHL headings or Psychological Index Term (PsychINFO), these databases were used to discover if there were any additional research studies that the Web of Science did not capture. The selected range of years for the search was from 2000 to 2011, since the original publication of the SRPS was in 2000.

Results

Please refer to Figure 1, the flow chart of the articles included/excluded for this review. 178 articles were found. After removing duplicate studies (28), 150 studies were screened. The following categories of publications are excluded (12): dissertations (if peer-reviewed and published, they are included in the searched results, five articles); books (4); studies published other than English language (1 in Spanish and 1 in Portuguese); and one study unavailable (notified as the source exhausted). 138 research studies were examined for its eligibility. Upon further examination, 23 studies were found that did not cite the Pulerwitz et al. study, but may have been included in the results because of their reference to gender power. These were excluded. Studies that cited the Pulerwitz et al. (2000) article but did not use the SRPS as the study instrument were excluded (68). The SRPS was originally created to measure women's

relationship power in a context of heterosexual relationship and as such one study with homosexual relationships was excluded.

We also excluded 32 more studies with major modifications of the SPRS; 8 studies modified the RCS, 7 modified the DMDS, 5 were an African version of the SRPS (Dunkle et al., 2004), and 11 modified more than half of the scale, or it was not clear how the scale was modified. Three studies used the RCS alone as a measure of sexual relationship power. Six studies administered the scale to men even though the SRPS was only originally validated for women. For the present integrative review, we chose to include a separate discussion of these 6 studies since there appears to be a need to consider how men might be studied in relationship to power within relationships. Including these studies in this integrative review provides a way for researchers and practitioners to gain insights about how to approach men in regards to the relationship power and health issues and involve both partners within the couple in interventions and research. After a full examination of the literature, a total of 11 studies were found and included in this review (9 used the SRPS, 4 used SRPS-M, 2 studies used both (Pulerwitz et al., 2002; Pulerwitz et al., 2000). The reporting method of this article is based on the PRISMA Guidelines (Preferred Reporting Items for Systematic reviews and Meta-Analysis) (Moher, Liberati, Tetzlaff, & Altman, 2009).

The summary of the 11 studies included in the review are included in Table 1. (Please insert table here).The table is categorized by use of the two different scales (SRPS and SRPS-M). First, 9 studies that included SRPS are discussed. Of these 9, seven studies employed cross sectional data collection method, one study was from the data obtained after two week use of simulated microbicide product (Mosack, Weeks, Sylla, & Abbott, 2005), and one study was longitudinal in nature examining mediating effects of pregnancy intention between risk factors

and pregnancy (two years, four data points) (Rocca, Doherty, Padian, Hubbard, & Minnis, 2010). The sample size of the studies range from 95 to 492 (N=95[(Mosack et al., 2005)]; N=492[Powwattana, 2009]). Three studies had questionnaires administered in both English and Spanish. Seventy percent of the participants completed the questionnaires in Spanish for the two studies by Pulerwitz et al. (2000) and Pulerwitz et al. (2002). Rocca et al. (2010) stated that one of the study inclusion criteria was to speak English or Spanish. However, they did not report what language was used by participants to complete the questionnaires. Powwattana (2009) studied sexual behaviors, thought process, sexual self-efficacy and relationship power on young Thai women in slum neighborhoods in Thailand. She does not state whether the questionnaires were administered in Thai or if there was any translation process for the questionnaires.

All but one study was completed with the population deemed as high risk for STIs. Studies were completed with minority girls and women: only Latinas (one study [Rocca et al., 2010]); only African Americans (one study [Bralock & Koniak-Griffin, 2007]); and mainly Latinas and African Americans (four studies [Mosack et al., 2005; Pulerwitz, et al., 2002; Pulerwitz, et al., 2000; Roye, Krauss, & Silverman, 2010]). Of those, two studies were with high risk adolescents (Bralock & Koniak-Griffin, 2007; Rocca et al., 2010). Knudsen et al. (2008) studied incarcerated women offenders who have higher risks for acquiring HIV because of their prior illegal drug use increasing the likelihood of engaging in risky sexual behaviors. (Knudsen et al., 2008). Powwattana (2009) conducted a study with young Thai women who have increased HIV prevalence due to risky sexual behaviors. Most recently, Filson, Ulloa, Runfola, & Hokoda (2010) conducted a study with college students and stated that their study population is a non-high risk group in their limitation section.

Pulerwitz et al. (2000) in the original research provided data about the validity of the scale. Pulerwitz et al. tested the construct validity and found that the scale had positive associations with higher education ($p<0.001$), satisfaction with relationship ($p<0.01$) and consistent condom use ($p<0.01$). Pulerwitz et al. (2002) also found that the sexual relationship power is associated with consistent condom use. On the other hand, the scale had negative associations with physical violence ($p<0.01$) and relationship history of forced sex ($p<0.001$). Then, a factor analysis was conducted to refine and examine domains within the SRPS. Finally, content and face validity was ensured through constructs based on theories and focus group findings from the target population (Pulerwitz et al., 2000).

Findings from other studies include: (a) a positive associations between high relationship power and less risky sexual behavior (OR; 0.37, 95% confidence interval [CI]: 0.16, 0.85; (Knudsen et al., 2008); (b) relationship power was a partial mediator between intimate partner violence and depression (Filson, Ulloa, Runfola, & Hokoda, 2010); (c) low relationship power was associated with pregnancy among Latina adolescents (Rocca et al., 2010); (d) and low RCS generally correlates with increased anal intercourse (Roye et al., 2010). These findings demonstrate the scale's construct validity where it is expected that high SRPS scores correlates with low involvement in risky sexual behaviors and its precipitating factors.

For some studies, relationship power has been found to be negatively associated with certain variables. There was no association between consistent condom use and relationship power in studies with African American adolescents (Bralock & Koniak-Griffin, 2007). In this study, teenage girls tended to score high on relationship power yet, even though they believed they had power, they did not demonstrate it with consistent condom use. Rather, it was found that behavioral intentions to use condom predicted consistent condom use (Bralock & Koniak-

Griffin, 2007). Mosack (2005) found a negative association between simulated microbicide use and relationship power. However, microbicide use was also associated with sexual assertiveness (Mosack, 2005). On the other hand, Powwattana (2009) found that an increase in DMDS significantly predicted a decrease in risky sexual behaviors. Other validity testing such as predictive validity, concurrent validity and face validity were not found in the literature.

All but two studies reported the internal consistency of the SRPS. In addition, the Expected A-Priori/plausible value (EAP/PV) reliability (similar to Cronbach's alpha) of the scales was reported by Rocca et al. (2010) for the SRPS subscales (0.85 [RCS] and 0.56 [DMDS]). Similarly, they also reported the EAP/PV reliability for RCS and the DMDS when the two subscales were treated as two individual scales (0.86 [RCS] and 0.53 [DMDS], respectively, C. Rocca, personal communication, August 5, 2011). In the Pulerwitz et al., (2002) the researchers reported the Cronbach's alphas of the original study. Of the 7 other studies, three reported the Cronbach's alpha for the total scale ranged from 0.84 to 0.93 (Knudsen et al., 2008; Mosack et al., 2010; Pulerwitz et al., 2000). Six out of seven studies reported the Cronbach's alphas of the RCS (0.74 to 0.92). Five out of seven studies reported the Cronbach's alphas of the DMDS (0.61 to 0.83). EAP/PV reliability by Rocca et al. (2010) was 0.53 (C. Rocca, personal communication, August 5, 2011). Other reliability measures include temporal stability (test-retest reliability) and stability of factor structure. Temporal stability was not discussed in any of the studies. Stability of factor structure was discussed in Pulerwitz et al. (2000) and Roye et al. (2010). In Pulerwitz et al. (2000), factor analysis was used to select the best questions for the SRPS and ensure an adequate factor structure. No loading factors or how many factors were loaded were reported, however the authors state that factor structure was adequate to move forward with the selected questions. Roye et al. (2010) conducted a factor analysis of each

subscale and found that the RCS had a better stability than the DMDS. The items loaded on a single factor for the RCS (Kaiser-Meyer-Olin [KMO]=0.87; with Eigenvalue=6.8; loadings ranged from *r*=0.53 to *r*=0.77). However for the DMDS items were found to barely reach the threshold for data appropriate for factor analysis (KMO=0.56), and the scale was not used for analysis (Roye et al., 2010).

There are four studies that used SRPS-M. Pulerwitz et al. (2000) and Pulerwitz et al. (2002) showed an association between consistent condom use and higher relationship power. Similarly, (Harris, Gant, Pitter, & Brodie, 2009) found that women with low sexual relationship power were less likely to ask their partner to use a condom due to partners' reactions such as anger, violence or abandonment. On the other hand, Campbell et al. (2009) found that high DMDS was associated with less unprotected sex. They also stated that high DMDS scores were associated with less unprotected sex and recommended that use of the DMDS would be a better mechanism to identify and help reduce risky sexual behaviors (Campbell et al., 2009).

Six studies were identified that used the SRPS with men or with men and women. Please refer to Table 2 for the details of the studies. (Please insert table 2 here). The six studies have been completed in different locations (South Africa [three studies], Thailand, Canada (with South Asian immigrants), and Spain [one study each]); all examined risky sexual behaviors and prevention of HIV/STIs. The author of the study who worked with young adults in Thailand wrote back and shared the copy of her questionnaires (A. Rasamimari, personal communication, April 11, 2011).Two of the South African studies used the same version of the modified scale. However, these reports lacked detail about how the scale was modified. Otherwise, we were unable to determine if others have used the same version of the scale, or how the scales have been modified.

Discussion

Overall, the six studies using the SRPS have demonstrated or yielded good construct validity for the scale. When the SRPS was not associated with the variables used in the study, the population or construct had unique characteristics such that the lack of association was explainable. However, face validity is only addressed in the scale development study by Pulerwitz et al. (2000), and concurrent validity was not in the scope of their study. On one hand, it is understandable that not much information is shared about validity and reliability of the scale in a manuscript where the SRPS is only one of many scales used in the study. On the other hand, if the scale is selected and used for a reason it is more helpful to readers to know that the scale is valid and reliable in the population of interest and in the context of the research. For the SRPS-M, the same trend of lack of validity and reliability reporting exists. Studies using the SRPS-M demonstrated the intended modification by showing the associations between consistent condom use and sexual relationship power. Thus, good construct validity was obtained. Since the creation of the SRPS (Pulerwitz et al., 2000), the internal consistency of the DMDS was lower than the one for the RCS. In the studies reviewed, we did not find an association between the sample size or design of the study and internal consistency.

Some studies did not use the DMDS, some researchers criticized this subscale as being not stable enough to include in their study (Roye et al., 2010) or concluded that the DMDS pulled the study results towards the null (Knudsen et al., 2008). Interestingly, the DMDS which was designed to be used with minority women was concluded by some researchers as particularly useful among different populations. For example, the Campbell et al sample was over half Caucasian (Campbell et al., 2009). Knudson et al., (2009) used the instrument with a sample that was almost seventy percent white, and Powattana (2009) studied used the

instruments with Thai teenagers. These findings confirm that women of different culture demonstrate different characteristics in presenting their sexual relationship power, and research needs to continue to find ways for the vulnerable minority women to be an increased risk for HIV and unintended pregnancy rate by promoting family planning communication between couples. Both increase in women's sexual relationship power and equalizing couples' sexual relationship power can be possible approaches. Thus, it is important to remember that the SRPS was initially designed to measure sexual relationship power for minority women so when it is used with different samples of women from different cultures the association within the instrument factors may be different. Moreover, Pulerwitz et al. (2000) intended the subscales to be used both separately and together depending on the kind of study researchers were conducting. However, both relationship control and decision making dominance are determined to be critical component women's safe sex negotiation, and that is why they are both part of the SRPS. Several studies reported good construct validity and the internal consistency of the SRPS as in 0.80's (Knudsen et al., 2008; Mosack et al., 2005; Pulerwitz et al., 2000), which is a range of acceptable number.

Several studies dealing with sexual decision making and contraceptive use for couples have similar findings. Grady, Klepinger, Billy and Cubbins studied relationship power and contraceptive use using the National Couples Survey (2010). They found association between relationship power and method of contraception choice. The trend was different between married/cohabitating couples versus dating couples in that the former group demonstrated more power in relationship to contraception choice while the latter had greater power in relationship with the degree of commitment. Moreover, the existence of alternative relationships also increased the women's sense of power within her relationships (Grady et al., 2010). Harvey et al.

(2006) tested a conceptual model for women's condom use intentions. The degree of influence, on condom use decision making has been shown to directly affect their condom use intention. Harvey et al. (2006) state that condom use decision making measured a specific domain of relationship power. The SRPS includes the above mentioned, components of power through the theory of gender and power, and the scale has been validated by Pulerwitz et al. (2000). These findings in the literature supports why the SRPS is an important scale to be used and increasingly validated by many more researchers.

A frequent limitation mentioned in the studies included the nature of the cross-sectional research, in which the investigators could only report the associations but not establish causation between the variables of interest. However, at the same time, the trend seems to be that researchers are examining sexual relationship power as a variable of concern, but not a variable for intervention. As the state of the science increases in relationship to what we understand about sexual relationship power for women or how to best mediate it for couples, interventions can be designed. Thus, for sexual relationship power, established causation is not applicable at this time. More research is needed so that sexual relationship power can be mediated by evidence-based interventions. In addition, most measures were obtained by self-report and/or from convenient sample, thus information bias as well as selection bias exists in the presented research.

Use of the SRPS with men is reported in this review. However, it was not feasible to compare and contrast the results as each study uses different versions of the SRPS and reports different valuables for validity and reliability. Authors were contacted to provide further details about how the scale was modified as well as the scale's validity and reliability with men. However, few researchers responded so a discussion was not supported. Uniformity of the scale and lack of information from the researchers made the review unfeasible. Despite these

challenges, a critical discussion of the male version of the SRPS remains important. Even though the SRPS was originally created for women due to their vulnerability in negotiating safer sex, many researchers have administered the scale to men deeming its importance in improving safer sex behaviors within couples. Intervening with couples has been proved effective in regards to reproductive health matters in general (El-Bassel et al., 2003; Harvey et al., 2009; Kraft, 2007). As the literature emphasizes the importance of couples' involvement in promoting safe sex, other empirical measures to learn more about the men's relationship power characteristics would be useful in further understanding and finding ways to intervene with couples. In addition, results with men and women can be compared to gain a greater understanding of the similarities and differences. Future studies are needed to ensure validity and reliability of the SRPS in men. Continuing to promote the man's involvement in the relationship with determining power differences is a critical piece to couples encouraging safe sexual behaviors and a healthy relationship.

In summary, many of the studies found during the integrative review process from 2007 or more recent. Thus, this review reflects current sexual attitudes and behaviors. However, one major concern with this scale is that too many different versions of the modified SRPS exist in the literature without any details of modifications made for the current study. It appears that the items used in each version are different, and it is not clear from the descriptions, which items make up each version. In addition, validity/reliability information was not included for any of the newly modified SRPS. Thus, future researchers are unable to make good decisions about which version of the scale they should be using for their own work. This creation of several modified scales is a difficult problem in terms of building science. Researchers would ideally be able to pull information about previous studies, understand and be able to use the modified scale with

appropriate rationale given the application to their own research question and population of interest. Again, considering that the SRPS was one of the many variables measured in the reviewed studies, the researchers may not have had enough space to add the details. However, such practice or limitation on the manuscript made this integrative review difficult and less complete in its results and analysis as well as limiting our ability to make recommendations for future use of the scale in research.

Recommendation for research

The authors recommend that the researchers use the SRPS as one scale rather than separating the subscales and using it separately. Depending on the variables of interest, appropriate modification may be necessary. However, it is best to use the scale as it was created so that comparisons can be made from one study to the next. We also recommend including in publication information about validity and reliability, as such information helps other researchers to build the overall science. Although it is sometimes difficult to include such information when there are page limits for the manuscript, we suggest publishing the psychometrics of the scales used as separate publications with reference to these publications in reports of the overall results. Researchers must work together to logically build science; making sure to get these kinds of results into the literature is a worthwhile time investment.

Although this critical review was not able to synthesize the SRPS use in men due to scale modification and lack of information, modifying appropriately and establish validity and reliability of the SRPS men's version is also recommended for future research. We also found an association between the behaviors of interest and the SRPS. However, we noted that no one has examined resilience factors, characteristics that increase a woman's sexual relationship power.

We wonder if there are ways to help women learn early in life how to build a healthy sexual relationship power. Thinking about these issues may help researchers brainstorm and develop interventions that increase the balance of relationship power within a couple. Thus, interventions can be created and tested to promote not only couples' safe sexual behaviors but also their overall quality of the relationship. Lastly, future studies might include interventions and programs that integrate relationship power as well as promoting family planning communication between couples, decreasing unintended pregnancy, as well as with HIV prevention (Pulerwitz et al., 2002).

Implication for practice

The SRPS has been used in a variety of settings to examine the relationship between sexual relationship power, protective/risky sexual behaviors and related concepts. No reports of use of the scale in clinical settings were found. However, it has the potential to be used as a screening tool. For example, routinely administering the SRPS in the family planning and/or Obstetrics and Gynecology (OBGYN) clinic and use of the score as an assessment parameter could guide clinicians in discussions of healthy sexual behaviors and strategies to achieve them with their patients. Clinicians could emphasize consistent condom use and lead discussions about safe practices with anal intercourse to those who scored low on the SRPS, since this integrative review showed the associations between those risky sexual behaviors and low SRPS scores.

Conclusion

With the available information, the SRPS is a valid and reliable tool that has been used in various populations in the context of examining risky sex practice and its associated variables. Of the two subscales, the RCS generally has higher internal consistency than the DMDS.

However, overall internal consistency of the SRPS is good, and it is recommended that the subscales be used together to preserve the important elements of the total scale. Generally, the DMDS was also found useful among both Caucasian and with international populations. Such differences in results are noted related to race and ethnicity which reinforce the need for researchers to understand and create culturally-appropriate interventions to decrease HIV and unintended pregnancy rate and promote couples' family planning communication targeting toward increasing sexual relationship power among women or equalizing sexual relationship power within couples. In the process of examining studies for this integrative review, the authors found many studies with modified scale without reporting the modification, validity and reliability information. This is an issue in building science, and researchers need to include more details as well as including both validity and reliability information so that others can see the modifications and build science from there. Relationship power is a key factor that is associated with self-protective behaviors that lead to healthy sexual behaviors. Balancing relationship power facilitates respect and concern for each partner's opinion and builds a healthy relationship.

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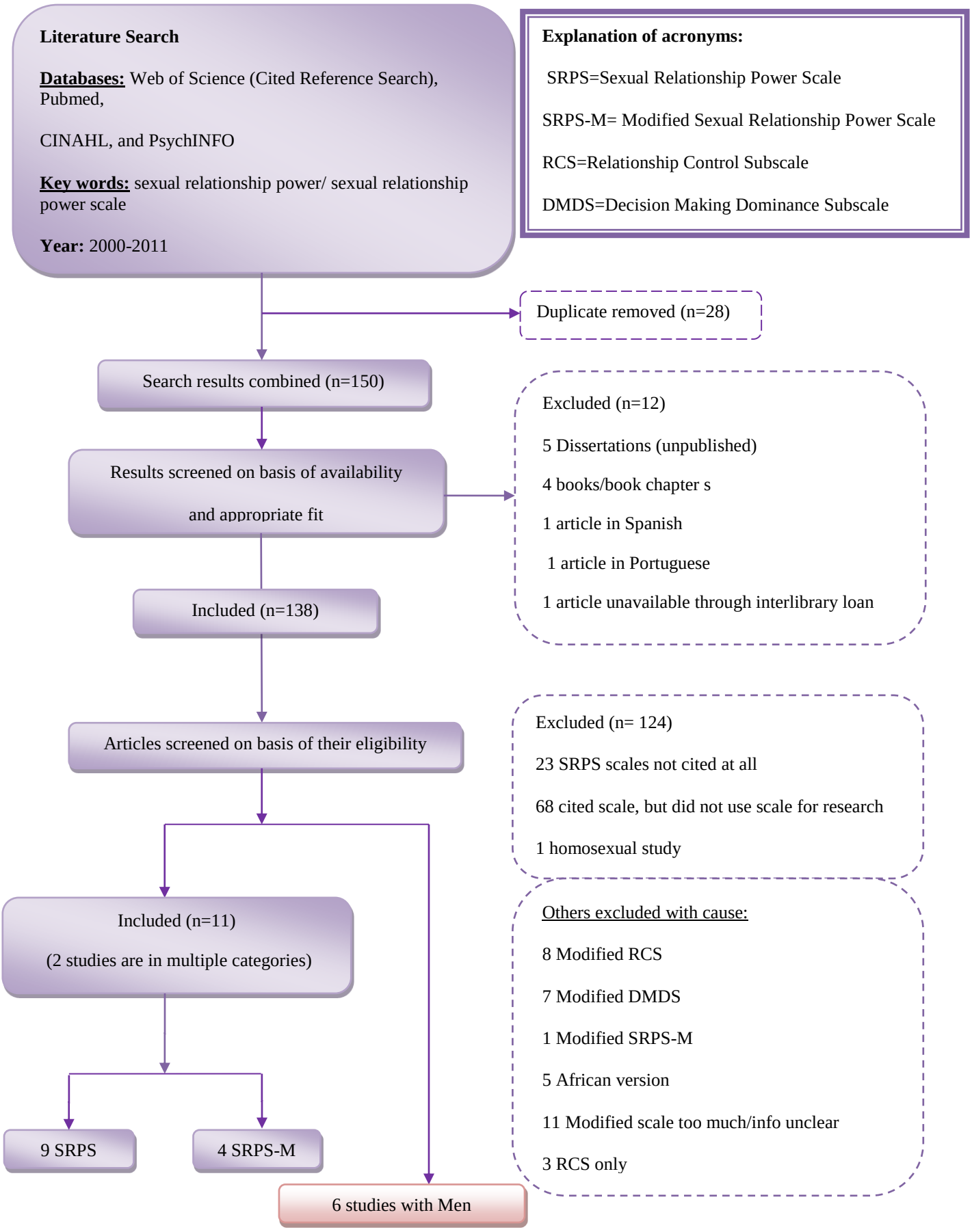
Figure 1. Flow Chart of Review Inclusion and Exclusion Criteria



Acronyms in the table

AA=African American
y.o.=years old
SRP=sexual relationship power
HIV=Human Immunodeficiency Virus
STI=Sexually Transmitted Infection

Table 1. Studies that used the Sexual Relationship Power Scale (SRPS) and Modified SRPS (SRPS-M)

SRPS: Sexual Relationship Power Scale (Consist of Relationship Control Subscale[RCS] and Decision Making Dominance Subscale [DMDS])

Source	Purpose	Sample	Methods	Reliability/Validity	Results/Conclusions
Pulerwitz, Gortmaker, & DeJong (2000)	Designed and evaluated the Spanish & Englishlanguage version of SRPS	Study1: Scale generation N=56, Ages:16-44 y.o. 57% Latina, 30% AA Study 2: Scale Evaluation, N=380, Mean age: 27 y.o. 89% Latina & 9% AA	Study 1: focus groups & panel discussion. Study 2: Descriptive, questionnaires	Study 2: SRPS Cronbach's α=0.84(English) &α=0.88(Spanish) RCS α=0.86, DMDS α=0.62 Construct validity; positive association satisfaction with relationship (p<0.01) & consistent condom use (p<0.01)	Study 1: 50 items were selected after focus groups. Study 2: 23items are remained in the scale.
Pulerwitz, Amaro, DeJong, Gortmaker & Rudd (2002)	Explored the influence of SRP in women's safersex negotiations	N=369 Mean age:27 y.o. 88%Latina	Descriptive, survey	No values given for current study. Referred to the internal consistency from Pulerwitz et al., (2000)	Relationship power has a strong association with consistent condom use (=decrease in HIV/STI risk).
Mosack, Weeks, Sylla & Abbott (2005)	Examined women's experiences using simulated microbicides	N=95, Mean age 36 y.o. AA 52.6%, Hispanic 29.5%, Caucasian 15.8%	Descriptive, survey after simulated microbicide trial	SRPS Cronbach's α=0.88	Women who used micribicides had lower relationship power. However, higher sexual assertiveness predicted microbicide use.
Bralock & Koniak-Griffin (2007)	Examined self-efficacy, intentions, SRP & sexual risk-taking behavior	N=130 AA adolescent, ages 14-20	Descriptive, cross sectional survey	RCS: Cronbach's α=0.89 DMDS: Cronbach's α=0.63	Condom use was not associated with sexual relationship power. 65.9% of adolescents had high level of perceived power.
Knudsen et al. (2008)	Examined relationship between SPRS items and risky sexual behaviors among women offenders	N=304 offenders, >age 18, substance use & incarceration, 68%white	Descriptive, interview questionnaires	SRPS Cronbach's α=0.93 (RCS=0.92, DMDS=0.83)	Higher relationship power is associated with less risky sexual behaviors, thus protective in HIV prevention
Powwattana (2009)	Test a model includes self-discrepancies, negative emotions, cognitive strategies, SRP, & sexual self-efficacy	N=492 young Thai (mean age:19.7 years)	Descriptive, questionnaires	RCS: Cronbach's α=0.74 DMDS: Cronbach's α=0.68	Thai women who were most likely to engage in risky sexual had lower DMD, and were likely to have less ability to say no to unprotected sex. Less SRP increases the chance of risky sexual behaviors.

Filson, Ulloa, Runfola & Hokoda (2010)	Test if SRP could act as a mediator of the relationship between IPV and depression	N=327 single Undergraduates Mean age:19.64 y.o. (SD=2.63),51.7% White & 18% Hispanics	Descriptive-survey	RCS-15 items: Cronbach's α=0.87 DMDS-8 items: Cronbach's α=0.61	Women who felt powerless had higher rates of intimate violence victimization and higher level of depression; mediation analysis revealed that SRP mediated the relationship between IPV &depression.
Rocca, Doherty, Padian, Hubbard &Minnis (2010)	To find out the extent of pregnancy intentions' mediation effects of individual, familial & cultural characteristics & teen pregnancy	N=213 Latina adolescents	Descriptive (prospective cohort) study, Questionnaire, four time points	23 item SRPS EAP/PV reliability 0.85(RCS) and 0.56 (DMDS). EAP/PV reliability when treated as two individual scales: 0.86 (RCS) and 0.53 (DMDS)	Pregnancy intentions were found to be an independent risk factors rather than mediator. Wantedness of pregnancy or actual pregnancy did not relate to favorable attitudes towards potential pregnancy among girls with high family norms.
Roye, Krauss, & Silverman (2010)	Examine the prevalence of heterosexual anal intercourse (HAI) & its relationship with SRPS in the minority urban female adolescents	N=101, Ages:15-22 years, African American (45%) or Latina/Hispanic (55%) in New York City	Descriptive, Questionnaire	Factor analysis on RCS: loaded on a single factor *r*=0.53 to 0.77 Item total correlations *r*=0.43 to 0.73 Cronbach's α= 0.9, Factor analysis on DMDS: not meeting threshold; not used in analysis	Young women with low RCS scores were more likely to engage in AI than those with middle-range or high RCS scores. However, the relationship between RCS and AI was not linear (due to small sample size).

SRPS-M:Use of the Modified SRPS

Source	Purpose	Sample	Methods	Reliability/Validity	Results/Conclusions
Pulerwitz, Gortmaker, & DeJong (2000)	Designed and evaluated Spanish & English language version of SRPS-M	Study 2: Scale Evaluation N=38,Mean age: 27 y.o. 89% Latina, 9% AA	Study 2: Descriptive, questionnaires	Study 2: SRPS-M, RCS-M&DMDS-M Reliabilities: α=0.86, 0.85 & 0.57 (English) & α= 0.82, 0.81 & 0.62 (Spanish)]	The SRPS-M is associated with consistent condom use.
Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd (2002)	Explored the influence of SRP in women's safer sex negotiations	N=369, Mean age:27 y.o. 88%Latina	Descriptive, survey	values referred from Pulerwitz et al., 2000 article	Relationship power has a strong association with consistent condom use (=decrease in HIV/STI risk).
Campbell, Tross, Dworkin, Hu, Manuel, Pavlicova, & Nunes(2009)	Examined the association between SRP and unprotected vaginal or anal sex	N=396, who had unprotected vaginal or anal sex with a male partner, Mean age: 38.6, 56.8 % Caucasian	Descriptive, survey	Used SRPS-M version RCS: Cronbach's α=0.9, DMDS:Cronbach's α=0.78	Increased decision making dominance was associated with decreased unprotected sex. Severity in substance abuse & lack of condom use intention were risk factors for women even with higher relationship control score.
Harris, Gant, Pitter and Brodie (2009)	Examined the relationship between SRP, unmitigated communication and risk for HIV infection	N=217, AA between 18-45 years old	Descriptive, survey	SRPS: Cronbach's α= 0.89 Factor Analysis RCS:0.87 DMDS:0.88	SRP has significant relationship with HIV risk behavior. Women with low SRP are less likely to suggest their partners to use condom due to fear of his negative reactions (violence,anger& abandonment).

HIV=Human Immunodeficiency Virus STI=Sexually Transmitted Infection

SRP=Sexual Relationship Power RCS=Relationship Control Scale

DMDS: Decision Making Dominance Scale Cronbach's = α

y.o.= years old

Acronyms in the table

Table 2. Studies that administered the Sexual Relationship Power Scale (SRPS) with Men

Source	Purpose	Sample	Methods	Reliability/Validity	Results/Conclusions
Jewkes,et al. (2006)	Described factors associated with HIV infection in Men aged 15-26 years	N=1277 sexually experienced males in South Africa Mean age: 19.2 y.o.	Mixed method, Cross-sectional, questionnaire	Modified 13 item SRPS (& items on attitudes towards women) combined α=0.69	HIV positivity is associated with age, having made a woman pregnant, having been circumcised, and having had sex with a man.
Dunkle, et al. (2007)	Explored prevalence and predictors of transactional sex	N=1288 men who live in the rural South Africa Ages: 15-26 years	Descriptive	13 item modified SRPS and scale to assess gender norms beliefs (combined α=0.69).	Transactional sexual relationships are strongly correlated with increased perpetration of gender-based violence by young men.
Rasa-mimari, et al. (2007)	Identified correlates of sexual behavior	N=405 Thai young adults (both men & women) M = 19.23 y.o. (SD1.11)	Descriptive, cross sectional survey	RCS: 15items DMDS:8 items Reliability not noted	Geographic residence & negotiation for safer sex (SRPS) were related to subjects' gender & sexual experience. HIV knowledge & safe sex negotiation were related to number of sexual partner.
Kaufman, et al. (2008)	Examined how gender attitudes & beliefs are related to HIV risk behavior	N=309 men in Cape Town, South Africa ages:18-45 years	Descriptive, questionnaire	10 items RCS α=0.889 6 items DMDS α=0.908	Endorsement of traditional male gender roles was inversely related to RC but positively related to DMD in one's relationship. SRP did not significantly mediate gender attitudes and HIV risk behavior.
Gagnon, et al (2010)	Examined differences in gender & knowledge, attitudes of HIV & STIs	N=122 women (81)& men (41) from South Asian immigrants who reside in Montreal	Descriptive, survey	None noted	Knowledge gaps regarding HIV exist; Knowledge about STI was lower than HIV. Women with high power were more likely to have heard about STIs and to feel that they could ask their partner to use a condom.
Bermudez, et al. (2010)	Examined cultural & gender differences for SRP in couples and risks for STI/HIV	N=689 adolescents; n=406 native Spaniards, n=286 Latin American immigrants	Descriptive questionnaire	RCS: native Spaniards α=0.88, immigrants α=0.90, DMDS: native Spaniards α=0.7 Immigrants α=0.88	The predictors of higher STI/HIV risk exist with older immigrant with higher score on double standard and those with less decision-making control. Males and females differences were noted.

Chapter 3

Science on Predictors of Sexual Relationship Power, Communication and Family Planning Decision Making among Latino Couples

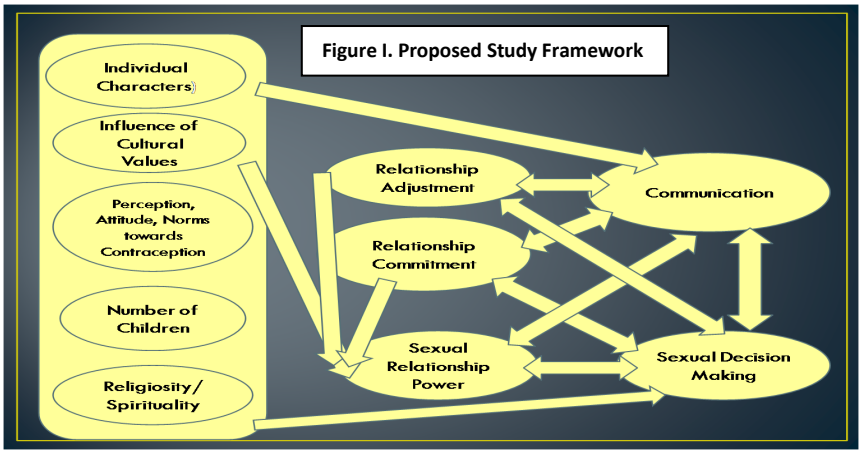
Dissertation Proposal

Latinos are currently the largest minority group in the United States (U.S.) (16% of the population) (U.S. Census Bureau, 2010) and are estimated to grow to 29% of the total U.S. population by 2050 (Pew Hispanic Center, 2008). The Latino population accounts for over half of the population increase between 2000- 2010 in the U.S. (15.2 million vs. 27.3 million) (Pew Hispanic Center, 2008). Latinos in the U.S. have the highest birth rate among all races and ethnicities and the rate is expected to continue to rise (U.S. Census Bureau, 2011). Moreover, Latinos are experiencing an increase in the rate of unintended pregnancies (Finer and Henshaw, 2006). Unintended pregnancy (UP) is defined as a pregnancy that is considered either mistimed or unwanted at the time of conception (Brown and Eisenburg, 1995). In general, UP negatively affects various aspects of health for both women and their infants. In general, women with UP are more likely to delay prenatal care (Cheng, Schwarz, Douglas, & Horon, 2009) and as a result, pregnancy-induced conditions may not be adequately managed (Ever, de Valk, & Visser, 2004). Moreover, UP disrupts optimum birth spacing; both overly short and overly long birth intervals have been shown to negatively affect mother and infant health outcomes.(Conde-Agudelo, Rosas-Bermudez, & Kafury-Goeta, 2007; Fuentes-Afflick & Hessol, 2000) Some of the negative consequences of UP include low birth weight and long-term developmental concerns (Bhutta, Cleves, Casey, Cradock, & Anand, 2002). Therefore, preventing UP might contribute to overall reduced physical and emotional burdens on families.

According to the World Health Organization (WHO), family planning (FP) refers to the ability of individuals and couples, through their own intent, to determine their desired number of children and the spacing and timing of their births (World Health Organization, 2011). There are several challenges associated with achieving optimal FP promotion such as facilitating the involvement of couples and making FP resources accessible for couples (Becker & Robinson, 1998). Despite the WHO definition of FP as a couples' process, FP interventions have traditionally been directed at women and this delivery method has been shown to be unsuccessful.(Becker, 1996; Kerns, Westhoff, Morroni, & Murphy, 2003) However, sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) prevention intervention initiatives have focused on bringing couples together to discuss these issues and these efforts have been shown to be effective.(Harvey et al., 2009; Kraft et al., 2007) Considered in tandem, these findings suggest that FP interventions might benefit from focusing on couples' communication skills rather than targeting only women.

Couples' communication and decision making is affected by gender norms which are socially constructed and make up the social context, self-concepts, beliefs, and expectations for behavior (Potuchek, 1992). Several studies have shown that open communication between partners about FP decision making increases contraceptive use (Becker, 1995; Harvey & Henderson, 2006; Harvey et al., 2006; Beckman, Harvey, Thorburn, Maher, & Burns, 2006). Although the "Latina paradox" is a known phenomenon among first generation Latinas (i.e. first generation immigrant Latinas tend to have better birth outcomes compared to second and third generation Latinas) (McGlade, Saha, & Dahlstrom, 2004), this finding does not preclude the importance of improving FP communication in all Latino couples . Ambiguous FP communication, lack of FP decision making and irregular contraceptive usage could increase the

risk of unintended pregnancies, which could lead to inadequate birth spacing and parenting difficulties (El-Kamary et al., 2004). Latina women are 1.35 times more likely to have unintended pregnancy compared to Whites (Finer and Henshaw, 2006). FP decision making conversations among couples should optimally begin before the initiation of sexual activity and continue throughout the couples' active sexual relationship. FP discussions facilitate couples' open communication regarding their thoughts and feelings about this important issue, thus helping to promote healthy reproductive and sexual lives for the couples. Furthermore, couples' FP discussions have the potential to promote a sound family dynamic, since parents teach their children by example. As such, couples who engage in FP communication become role models for healthy relationships for their children. Synchronizing the pieces applicable in Latino couples' family planning communication and decision- making, the proposed study framework was designed using Fishbein's Integrative model (which has been created by using components of the Theory of Reasoned Action, Social Cognitive Theory and Health Belief Model) (Fishbein, 2000) and Harvey's structural model of condom use intention (2006) as well as the current literature, the framework for the current study is shown in Figure 1.The proposed study will test the associations of listed variables and ultimately build a model to best illuminate interrelationships of the identified variables.



Individual personal factors, as well as the couple's relationship dynamic affect their FP communication and decision making in a complex manner. Individuals bring their own set of values to the relationship. Each couple creates its own relationship dynamics that affects their FP communication style and decision making. Yet, sexual relationship power (SRP), defined as the ability or skill to influence or control another person's actions in regards to sexual matters (Ragsdale, Gore-Felton, Koopman, & Seal, 2009) has the potential to change the dynamics in relationships. SRP may be affected by many factors, including: (a) the cultural values of male dominance (Wood & Price, 1997) (the quality, state or degree of being masculine (Marriam-Webster Dictionary, 2011) and fatalism, which refers to the degree to which people feel their destinies are beyond their control (Cuéllar, Arnold, & Gonzales, 1995); (b) attitudes and perceptions towards contraception (Harvey et al., 2006); (c) religiosity/spirituality; (d) length of relationship; and (e) number of shared children; and, (f) number of children from previous relationships. Other factors that can influence couples communication and FP decision making are relationship commitment (Harvey et al., 2006) and dyadic adjustment, which refers to how much one adjusts for the other in a romantic relationship (Spanier, 1976). From this list of factors, it appears that UP prevention is a complex issue, involving multiple social and cultural elements. To date, there has been limited research investigating factors related to FP decision making and communication among Latino couples, despite the consequences.

Specific Aims

The following three aims of this study will be examined independently among men, women and couples (Olson & McCubbin, 1983). Analyses of the couples' model will include both group differences and paired (couples) differences. Data analysis details will be discussed in

greater depth in the Data Analysis section of the proposal. Hypotheses were developed based on a critical review of the existing literature. The specific aims of the study are:

1. The first study aim is to determine predictors of sexual relationship power. Potential predictors include the cultural values of masculinity and fatalism), attitudes and perceptions towards contraception, religion/spirituality, demographic, personal and couple factors (i.e. age, education, length of relationship, relationship status, and number of children the couples have together and separately), relationship adjustment and relationship commitment.
    a. Hypothesis 1: Higher scores on the masculinity scale predict lower sexual relationship power.
    b. Hypothesis 2: Number of completed years of education predicts sexual relationship power as follows:
        i. Greater number of completed years of education by the male partner predicts equal sexual relationship power.
        ii. Lesser number of completed years of education completed by the male partner predicts higher sexual relationship power for males.
        iii. Greater number of years of education completed by the female partner predicts higher sexual relationship power for females.
    c. Hypothesis 3: The greater the number of children couples have together predicts increases in women's sexual relationship power.
2. The second aim of this study is to explore which demographic/personal factors and relationship variables predict communication. Potential predictors are demographic/personal factors (i.e. age, education completed, number of children

together, women's number of children, length of relationship, marital status); degree of dyadic adjustment and relationship commitment; and sexual relationship power.

   a. Hypothesis 4: There is a positive and significant relation between the degree of dyadic adjustment and communication.
   b. Hypothesis 5: After controlling for or eliminating significant demographic/personal factors, the degree of dyadic adjustment or relationship commitment, sexual relationship power still predicts communication.

3. The final study aim is to examine which demographic/personal factors and relationship variable/s predict sexual decision making. Potential predictors are demographic/personal factors (i.e. age, education completed, number of children together, women's number of children, length of relationship, relationship status), degree of dyadic adjustment and relationship commitment communication and sexual relationship power.

   a. Hypothesis 6: Greater number of completed years of education by the male partner predicts higher decision making scores.
   b. Hypothesis 7: An increase in the number of children couples have together predicts an increase in decision making score in women.
   c. Hypothesis 8: After controlling for or eliminating significant demographic/personal factors, degree of dyadic adjustment and relationship commitment, sexual relationship power still predicts sexual decision making.

Background and Significance

Unintended Pregnancy and Family Planning Approach for Latinos

Importance of Unintended Pregnancy Prevention.

Latinos in the U.S. have both high fertility and high unintended pregnancy rates.(U.S. Census Beureau, 2011; Finer & Henshaw, 2006) Unintended pregnancy is defined as a pregnancy that women consider either mistimed or unwanted at the time of conception (Brown & Eisenburg, 1995). Unintended pregnancy has various deleterious effects on the lives of mothers, infants, and families. Women with unintended pregnancies tend to delay prenatal care which, in turn, delays their receiving support and education for any pregnancy-induced conditions, including diabetes, hypertension and hyperphenylalanemia (Conde-Agudelo et al., 2007; Fuentes-Afflick & Hessol, 2000; Evers et al., 2004; Cheng et al., 2009). Moreover, women with unintended pregnancies are less likely to engage in appropriate behavior modifications such as smoking cessation and withdrawal from alcohol, illegal drugs or other medications.(Cheng et al., 2009) Additionally, women experiencing unintended pregnancies may have failed to obtain HIV testing prior to their pregnancies. Failure to recognize HIV status may be detrimental to the fetus if appropriate HIV treatment is delayed. Women with unintended pregnancies may also be under- immunized, especially against rubella, placing their infants at further risk.

The Latina paradox has been observed in Latinas who are less acculturated. Acculturation is defined as cultural modification that occurs by adapting to another culture (Marriam-Webster Dictionary, 2011). Latina paradox is defined as follows: Latinas who are less acculturated have been reported to have more favorable birth outcomes than the general American population with the same economic status and little or no prenatal care (McGlade et al., 2004). Even though Latina paradox is observed among less acculturated Latinas, instead of leaving them alone, the health care providers should take advantage of their entries to medical care during prenatal period and use them as opportunities to reach the population. Regardless of their legal status, Latinas tend to seek out pregnancy-related health care services, even though they may forego

regular medical services or other public programs (Geltman & Meyers, 1999). Less acculturated persons typically do not have medical insurance, primary care providers, and preventative health care (Pearson, Ahluwalia, Ford, & Mokdad, 2008). Thus, Latino couples are likely to not seek out preventative services such as family planning, where they could learn ways to promote communication and sexual decision making. However, reaching less acculturated Latino couples in communication and FP decision making assists in increasing quality of life as a family. It can prevent inadequate birth spacing and repeat rapid unintended pregnancies, thus parenting difficulties that may arise sooner or later in their family lives (El-Kamary et al., 2004). Fuentes-Afflick and Hessol (2000) found that birth intervals between 18-59 months are associated with the lowest risk of prematurity, while Zhu and Le (2003) found that inter-pregnancy intervals between 18-23 months result in the lowest risk of low birth weight infants. Inadequate birth intervals have also been correlated with uterine rupture during vaginal delivery after a previous cesarean section (Fuentes-Afflick and Hessol, 2000). An overly long birth interval increases the risk of preeclampsia and labor dystocia (Conde-Agudelo et al., 2007). Both overly-short and overly-long birth intervals are associated with risk of low birth weight (LBW), which has been shown to contribute to the risk of higher infant morbidity and mortality (Fuentes-Afflick and Hessol, 2000).

Ideally, every childbearing woman should receive preconception care. In 2005 the National Summit of Preconception Care (a collaboration of the Centers for Disease Control and Prevention [CDC] and 35 partner organizations) defined preconception care as "a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management (Johnson et al., 2006)." However, even though preconception care considers various aspects of women's lives,

research related to Latino preconception care has primarily focused on folic acid intake (Yang et al., 2007; Kannan, Menotti, Schere, Dickinson, & Larson, 2007; Perlow, 2001). While this emphasis is important given that Latino infants are 1.5 to 3 times more likely to be born with neural tube defects than other ethnic groups in the US (Hendricks, Simpson, & Larsen, 1999), other aspects of care have not received as much attention. In particular, the prevention of unintended pregnancy and family planning decision making have received little attention. According to the WHO (2011), family planning "implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births." Family planning not only includes the use of conventional contraceptive methods to control unintended pregnancies, but also is aimed at promotion of couples' discussion regarding this matter, introduction of the couple to available pharmacological and non-pharmacological methods to prevent pregnancy (including ovulation method, withdrawal, abstinence or surgical sterilization), and guidance to couples about how to choose and use methods of their choice.

Latino family planning intervention - past, present and future.

Family planning services have traditionally been delivered to women only. Yet, the women-only approach has not been shown to be successful.(Becker, 1996; Kerns et al., 2003) Moreover, it is difficult for Latina women to be proactive and assertive with men about reproductive choices because 'machismo' is a traditional cultural norm. In 1994, conference leaders at the International Conference on Population (ICPD), recommended "gender equality in all sphere's of life, including family and community life, and encouraged men to take responsibility for their sexual and reproductive behavior and their social and family roles (ICPD, 1994)." Since these recommendations, research efforts have increasingly focused on the importance of men's involvement in reproductive health matters.(Becker, 1996; Becker &

Robinson, 1998; Kang-Kim et al., 2008) Studies have shown the importance of couple communication in the area of contraceptive compliance. Kerns et al. (2003) conducted a study in which Latina women took oral contraceptives without disclosing usage to their partners and found that the probability of discontinuing oral contraceptives was significantly higher when they were taken without their partners' awareness. Another study showed that the biggest barrier to Latina teenagers' oral contraceptive compliance was partner disapproval (Romo, Berenson, & Segars, 2004). Teenage Latina mothers also experience social pressure to continue having children even if the young women do not desire more. Partners use children as a way to control the teenage mothers' ability to engage in other activities, such as returning to school (Erickson, 1994). In another study, men perceived women's use of modern contraceptive methods as a way to be flirtatious (Sable, Campbell, Schwarz, Brandt, & Dannerbeck, 2006). Only a few heterosexual couples' intervention exist for HIV/STI prevention purposes. Some research has shown that bringing couples together to discuss ways to prevent HIV/STI has positive effects on consistent condom use and the effective use of other contraception methods.(Harvey et al., 2009; Kraft et al., 2007) Other research study tested the efficacy of a HIV prevention intervention on a control group (women-only) vs. a couples intervention group. There was no difference in the self-protective behavior improvement among the women-only group (control) and couple intervention group (both group showed improvement) (El-Bassel et al., 2003). However, the authors believed that women-only group improved as well as the couples' group because their sessions focused greatly on couples' communication and emphasized how to apply what they learned in class during their interactions with their partners (El-Bassel et al., 2003). Thus, it appears that involving couples together to promote communication about reproductive behaviors would be a promising strategy for couples' family planning. Kraft et al.'s and Harvey et al.'s

control group had HIV/STI as well as unintended pregnancy prevention content during the lesson. Their intervention group was heavily focused on improving couples' communication skills. The intervention by El-Bassel et al. focused soley on HIV prevention, however, the women-only and couples' lesson contents were heavily focused on improving relationship communication, negotiation and problem-solving skills. Both of their study populations were 50% Hispanics. Due to the fact that communication was emphasized in these interventions, there are some overlapping focal points that can easily be applied to family planning communication. However, there are also contraception methods that can be initiated only by a woman, if she decides not to disclose such information to her partner. This covert use of contraception is not commonly presented with HIV prevention efforts since common methods for HIV prevention do not allow for covert use. While there have been only a few couples interventions examined, there has not been a study identifying key factors of Latino couples' FP communication. Examining the predictors of FP communication and decision making may reveal possibilities for approaching this sensitive topic in an innovative way, and inform effective interventions to reduce unintended pregnancies in Latino couples.

Sexual Decision Making and Communication

Couple decision making and the importance of gender.

Decision making between couples cannot be explained without describing the influence of gender. Gender is socially constructed and embedded in social context, defining self-concepts, beliefs, and expectations for behavior.(Deaux & Major, 1987; Potuchek, 1992) Therefore, gender perspective builds on how individuals perceive what is appropriate and inappropriate in their interaction with others (Zvonkovic, Greaves, Schmiege, & Hall, 1996). Duaux and Major's

model of social interaction for gender-related behavior illustrates how the perceiver receives a message and interprets based on her gender belief. Then, she acts according to her gender related beliefs. Moreover, the action is modified depending on the perceiver's social desirability, certainty of influence towards the person with whom she interacts, and the context of the situation (Deaux & Major, 1987). This model explains how gender-related beliefs influence everyday actions. Zvonkovic et al. (1996) conducted a study on married couples' job and family decision making and observed that males often dominated the decision making process. Moreover, even though some couples were said to have equal power in decision making, the actual measures of influence leaned towards the husbands' preference. Zvonkovic et al. (1996) concluded that gender power in marriage is consistent with the traditional cultural value of male dominance. Yet, the influence of gender in marriage is not always clearly recognized within couples. Mbweza, Norr, & McElmurry (2008) examined decision making processes among Malawian married couples. They found two core categories of decision making processes: (a) final decision making approach (husband-dominated, wife-dominated and shared); and (b) decision making rationale (gender-based and non gender-based cultural script). Gender-based cultural scripts emphasize sources of power over one partner whereas non-gender-based cultural scripts focus on more equal power and shared decision making. Even though couples were recruited from two distinct tribes with patrilineal and matrilineal traditions, more than 66% of the sample couples used all three final decision making approaches depending on the situation and goals (Mbweza et al., 2008). It is apparent that gender-related beliefs have deeply affected how couples interact, sometimes rather unconsciously, because gender is an ingrained societal norm to which the members of the society are exposed to from birth.

Couple communication and contraceptive/FP method use.

While the strong influence of gender in couples' interaction exists, open communication within couples is encouraged to promote shared decision making (Zvonkovic et al., 1996; Mbweza et al., 2008; Blanc, 2001). In fact, among different cultures, health protective communication between partners has been shown to be associated with contraceptive use.(Harvey et al., 2009; Salway, 1994) However, Blanc (2001) notes that couples' conversations regarding reproductive health are infrequent due to gender-based power inequality, particularly among couples from developing countries,. This is a notable finding given our interest in understanding the predictors of communication and decision making in relation to relationship power (ability to influence another person's actions) (Ragsdale et al., 2009) within Latino couples. There are also community interventions that positively promote men's communication about reproductive health matters (Lundgren, Gribble, Greene, Emrick, & Monroy, 2005). Such initiatives to involve men in the reproductive health arena have been tested on a small scale mostly in developing countries.(Becker, 1996; Sternberg & Hubley, 2004) However, men's involvement in family planning and other reproductive health matters still requires improvement to become a mainstream approach. Rather, women are generally provided with contraceptive methods without meaningful discussions about sexual matters. If her partner is present the woman may be unwilling to ask questions because doing so may be perceived by her partner as suggesting that she might be considering promiscuous behavior (Wood & Price, 1997). Ironically, having frequent family planning discussions are a significant predictor of contraceptive use (Kerns et al., 2003). Studies have shown that intervening with couples is an effective way to promote participation in contraceptive decision-making (Becker, 1996; El-Bassel et al., 2003; Harvey et al., 2009; Kraft et al., 2007).

Existing theories and concerns in counseling and working with couples.

An emphasis on equal participation of women and men in reproductive health was the focus at the 1994 International Conference on Population and Development (ICPD). Reproductive health includes family planning, prevention of STI including HIV, and unintended pregnancy. The conference program of action stressed the importance of improving communication between men and women in reproductive health with a focus on joint responsibilities (ICPD, 1994). In 1996, Becker, in a critical review of reproductive health studies, acknowledged few experimental studies in the area of couples' interventions even though the studies reviewed showed the effectiveness of "couples" intervention for family planning as well as HIV prevention (Becker, 1996). Studies included in the review demonstrated a significant difference in couples' rating of their partners' perceptions (less than 60-70% accuracy) (Becker, 1996). Additionally, several studies used wives' proxy reports of their husbands' perceptions, even though this approach is often inaccurate. Becker (1996) proposed the importance of developing a conceptual framework for individuals and couples' reproductive decision making and their reproductive health behaviors. His 1995 unpublished conceptual framework incorporates individuals' background, resources, attitudes, and couples' communication; and the outcome variable is couples' reproductive health behavior (Becker, 1995). Couples' communication about reproductive health behavior is a critical component of the framework. Only a few studies have focused on factors associated with effective contraceptive use in Latino populations. In those studies, the length of relationship (Harvey & Henderson, 2006; Harvey et al., 2006; Beckman et al., 2006), decision-making involvement on contraceptive use (Harvey & Henderson, 2006; Harvey et al., 2006), and partner discussions about contraception were all found to be significant variables (Beckman et al., 2006; Harvey et al., 2006). Harvey et al., in 2006, developed a model of women's condom use intentions based on Fishbein's Integrated

Behavior Change Model and Information-Motivation-Behavioral Skills (IMB) Model of HIV/AIDS Risk Reduction with interpersonal and relationship factors on contraceptive use (Harvey et al., 2006). As a result, three exogenous constructs (HIV information heuristics, commitment, and duration of relationship) and four as mediating factors (perceived vulnerability, attitudes, condom use decision making, and partner norms) were found (Harvey et al., 2006). This model addresses interpersonal factors regarding the intention for condom use from the perspective of young women and is useful in understanding perceptions of what affects the intention for condom use and perhaps other contraceptive methods. However, the model was developed from a woman's perspective and is not specific to communication between partners in contraceptive use. One other study used a health behavior change model-based HIV/STI prevention intervention and found that condom use increased at follow-up times in both intervention and control group by bringing couples together and providing contraception education (no difference was found between standard of care group versus. risk reduction intervention group) (Harvey et al., 2009).

Various other models and theories have been used to encourage healthy reproductive behavior choices. These include social cognitive theory and motivational interviewing. Agnew addresses a concern that these theories may not fit with couples' interpersonal behavior, since two people must be involved in the prevention of unintended pregnancy (Agnew, 1999). Again, contribution of both partners is essential to its prevention. Although research findings emphasize the importance of couple interventions, the factors that affect couples' communication have not been fully explored among Latino couples. This study will examine those factors that affect couples' communication and sexual decision making.

Important Factors in Communication and Sexual Decision Making

Sexual relationship power.

Sexual relationship power is defined as the ability to influence another person's actions related to sexual behavior (Ragsdale et al., 2009). The theory of gender and power and the social exchange theory both can help to illuminate the concept of sexual relationship power. The theory of gender and power explains how gender inequality results from gender norms that are socially constructed (Cornnell, 1987). The social exchange theory shows how relationship power depends on three variables: (a) the degree to which a person feels dependent on his or her partner; (b) the amount of resources available; and (c) any alternatives that exist outside of the relationship (Emerson, 1981). As explained in the previous sections, both gender and the partner power dynamic play a critical role in sexual decision making (Zvonkovic et al., 1996; Mbweza et al., 2008; Blanc, 2001). Greater sexual relationship power is associated with protective sexual behaviors, most notably, consistent condom use for HIV prevention and higher self-efficacy for partner condom negotiation (Cromwell & Olson, 1975; Salway, 1994). Due to the associations between sexual relationship power and sexual behaviors, sexual relationship power is also considered a key factor in other relationship- and sexual behavior-related variables, including couples' communication and sexual decision making.

Relationship commitment.

Rusbult (1983), who proposed the investment model of relationship commitment and stability, defines commitment as the tendency to maintain relationships and feel psychologically attached to them. According to Rusbult (1983), relationship commitment predictors include relationship satisfaction, quality of the alternatives that exist outside of the current relationship and investments in the relationship. This tested model has demonstrated that commitment

predicts relationship stability logituginally (Bui, Peplau, & Hill, 1996; Impett, Beals, & Peplau, 2001). In a related study, Harvey et al. (2006) tested a conceptual model for women's intention to use condom during intercourse with their male partners in relation to partner dynamics. It showed that women's relationship commitment is associated with increased participation in condom use decision making and higher perceived partner norms for using condom. The findings from these two studies support the idea that relationship commitment leads to a range of positive outcomes including, relationship stability and increased condom use decision making.

Dyadic adjustment.

Spanier (1976) states that dyadic adjustment is the best indicator for marital quality and how well a marriage is functioning. Dyadic adjustment is a widely studied concept because of the wide range of topics it covers and the possibility it provides for both understanding and improving relationships. The relationship between communication style (when discussing relationship problem) and dyadic adjustment has been examined, and there are evidence showing that the association between communication and dyadic adjustment is stronger for women than for men (Gordon, Baucom, Epstein, Burnett, Rankin, 1999; Litzinger & Gordon, 2005). This may be due to women being more sensitive towards dyadic adjustment and communication. Or it may be because women prefer and feel fulfilled by talking more than men. These studies were not specific to the Latino population. Li and Caldwell (1987) found that sex-role attitudes influence dyadic adjustment as follows: husbands' egalitarian views towards their wives was associated with higher dyadic adjustment, while non-egalitarian views were associated with lower dyadic adjustment. The study population was mostly Caucasian (>90%) and highly educated (>70% graduated from college) (Li & Caldwell, 1987). Associations between dyadic adjustment and sexual relationship power, communication, and sexual decision making have not

been examined in the literature to date. Other factors that may affect communication and decision making in Latino couples include: 1) individual factors, such as education completed, socioeconomic status (SES) and residence; and, 2) influential Latino cultural concepts such as machismo and fatalismo. Each component is discussed below in relation to Latino couples' unintended pregnancy prevention, sexual decision making, and communication.

Individual characteristics and Latino's cultural concepts.

Cultural characteristics and ethnic background have influence on gender dominance, family dynamics and ultimately, sexual decision making. Cromwell and Olson (1975) state that power is composed of three elements: (1) the bases of power, which are comprised of various resources including, money, employment and physical attractiveness; (2) the processes of power, which refers to types of interactions such as persuasion, assertiveness and problem solving: and (3) the outcomes of power, including whose decision becomes the final one, and who makes the important decisions. Based on the individual's resources, partners use power within discussions to negotiate and make decisions. However, there is research suggesting that husbands who are more educated and formally employed tend to encourage shared decision making (Mbweza et al., 2008). Conversely, male partners were found to dominate decision making when they had less than a secondary school education, were in a lower SES, and/or were from a rural area (Forrest & Frost, 1996; Mbweza et al., 2008; Speizer, Whittle, & Carter, 2005). This behavior can be explained by the concept of "machismo" (masculinity). The concept of "machismo" is one of the most prominent Latino male characteristics. "Machismo" is a social behavioral pattern found in Latino males in which they demonstrate a dominating attitude to those inferior to them and demand subordinance. Latino men tend to express stronger "machismo" (masculinity) when they grow up with limited resources. In contrast, it has been found that Latinas feel more powerful

when they supply valuable resources for the family (Pearson et al., 2008) experience some economic independence (Becker et al., 2006) have completed a higher level of education, and/or were physically more attractive (Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002). Given these culturally influenced gender characteristics, males are often more dominant in decision making in the areas of reproductive health as well as household matters (Amaro, 1988). In the area of reproductive health, studies have shown that women demonstrated limited assertiveness about sexual practices and condom use (Gómez & Marín, 1996; Wood & Price, 1997). Tradition dictates that Latinas should not speak to men about sexual matters and preferences because these behaviors may be seen as promiscuous (Chavira-Prado, 1992). Culturally, women are expected to demonstrate "marianismo", which means being like Mary (the mother of Christ) by performing as dutiful mothers and wives (Wood and Price, 1997). These traditional views of male and female roles are strongly held in the Latino population (Chavira-Prado, 1992). Thus, women find it difficult to actively participate in or initiate family planning decision making (Gómez & Marin, 1996). However, it has been found that generally, Latina women actually become less supportive of male-centered decision making as the number of children in the household rises, which may be due to their increased interactions in the healthcare environment as a result of multiple pregnancies as well as their increased responsibilities in the home (Agnew, 1999).

"Fatalismo", or fatalism, is another cultural concept among Latinos. It refers to how much people feel that their destinies are beyond their control (Cuéllar et al., 1995). Fatalism, also referred to as powerlessness, is linked with Latinos' negative health outcomes and their ability to change their lifestyles to adopt healthy behaviors (Torres & Cernada, 2003). Attitudes and initiative towards taking an active role in family planning may run counter to this belief. Most

Latinos are traditionally influenced by Catholic Christianity in their home countries. The influence of religion and spirituality on health among Latinas has been studied in the context of acculturation. Religiosity/spirituality has a significant negative association with acculturated young women of their prenatal and postpartum stress (Mann, Mannan, Quinones, Palmer, & Torres, 2010). Other research has examined the relationships between religiosity, contraceptive use and individual factors and found that religiosity and years of education are associated with family size. However, they are not associated with contraceptive use (Romo et al., 2004). On the other hand, religiosity of Latinos may contribute positively to health. The degree to which religion and spirituality may affect Latinos' daily lives and couples' communication and sexual relationship power has not yet been explored. Hill et al. (2000) distinguish between religiosity and spirituality as follows: spirituality refers to the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred, whereas religiosity is (a) the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred, AND/OR (b) a search for non-sacred goals, such as identity, belongingness, meaning, health, wellness in a context that has as its primary goal the facilitation of (a), AND (c) the means and methods (e.g. rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people. From these definitions, spirituality seems as if it is a narrower concept, while religiosity is combination of the three factors mentioned above. Furthermore, religiosity identifies spirituality in combination with people's actions. And it tends to be more focused on specific activities people do to reflect their spirituality (Campesino & Schwartz, 2006). As such, religiosity may be a better reflection of what should be captured as an understanding of relationship between religiosity, couple communication, and sexual decision making.

Summary

Unintended pregnancy contributes to many negative consequences for families and, as such, should be kept to a minimum. However, various factors affect Latino couples' communication and decision making about family planning, including relationship power, relationship commitment, dyadic adjustment, individual background, and cultural characteristics. Little is known about how those factors interact to affect communication and decision making among Latino couples to better approach this sensitive issue. Therefore, there is a need to investigate the predictors of communication and sexual decision making so that we can understand how those factors relate to each other. In this way, we can design interventions to decrease unintended pregnancies and increase the quality of family lives within the Latino community. Decision making conversations among couples should optimally begin before the initiation of sexual activity and continue throughout the couples' active sexual relationship. Couples' communication facilitates making each other's will and thoughts known and helps to promote healthy reproductive and sexual lives. The proposed study will focus on Latino couples by having both partners complete questionnaires exploring these topics. Partner responses will be compared and contrasted as a beginning step in this much needed trajectory of research.

Preliminary Progress/Data Report

The researcher is conducting a pilot study titled "LATINAS' CONTRACEPTION EXPERIENCE AND PLANNING (LCEP)" at the proposed recruitment site (Richmond City Health District [RCHD]). The purpose of this pilot study is to obtain information from Latinas in their third trimester about contraception perception, experience and planning process and learn about the characteristics of the pregnant Latina population in the RCHD. Twenty participants are anticipated. Each woman will be asked demographic information (age, country of origin, length of relationship, number of pregnancy and birth, intention to continue relationship with current

partner [father of the baby for this pregnancy after delivery]) and to fill out the bidimensional acculturation scale and sexual relationship power scale. In addition, interviews will be conducted with participants to inquire about their previous experiences with contraception, their readiness for contraception planning after delivery, and communication about contraception with their partners. Interviews are conducted in Spanish or English, depending on the preference of the participant. All the interviews thus far have been conducted in Spanish. Descriptive statistics will be obtained from the demographic information as well as from the two questionnaires. This study helps us learn the characteristics of the population in the clinic. The interviews are recorded, transcribed and analyzed using the content analysis technique. The researcher has been learning about the logistics of the recruitment at the RCHD from this pilot study. The analysis is still in progress.

Research Method and Design

Proposed is a descriptive study of 40 heterosexual Latino couples whose female members are in the second or third trimester of their pregnancies, when postpartum contraception are beginning to be discussed at the prenatal care visits (Day, Raker, & Boardman, 2008). Recruitment will take place from maternity clinics at the Virginia Department of Health (VDH), Richmond City Health District (RCHD), the CrossOver Ministry Clinics (please see appendix A: Letters of Support) and by word of mouth with pregnancy verification. The researcher will conduct a chart review to identify potential female participants. She will briefly describe the project to potential participants. Screening questions will be posed in a private location to determine eligibility. At this initial meeting, the researcher will explain the project in detail, answer questions, and obtain consent for participation, if both partners of the couple are present in the clinic. If only female partners are in the clinic, the researcher will ask the women if they

would be willing to speak to their spouses about the study. They will be followed up by telephone or at their next prenatal care visits. Flyer will be given to aid in informing male partners about the study (please see Appendix B). The study team (doctoral student [bilingual] and a bilingual Latino male research assistant) will visit the potential couples (with their permission) at their preferred location to explain the study further and obtain consent for participation (please refer to Appendix C: Informed Consent Form). Self-report measures will be obtained at the time of data collection. Paper forms will be used. These forms are written in English and Spanish, as are the consent documents. Some measures are available both in Spanish and English. However, those that are not available in Spanish as well as informed consent form are translated and back translated using American Academy of Orthopaedic Surgeons' Institute for Work & Health Guideline (Beaton, Bombardier, Francis, & Bosi, 2002). Two bilingual people whose native language is Spanish translate the English documents into Spanish. A bilingual moderator whose native language is also Spanish compares translations done by two people and synthesizes the documents into one. If questions arise, she contacts the original translators. Then, two bilingual people whose native language is English back-translate the synthesized document into English. Another moderator whose native language is English compares the back-translated documents to the original document to make sure that the contents are accurately translated. Again, if questions arise, she returns to the back-translators for clarification. At the end, the translated documents are administered to the population very similar to the target population of the study. After explaining about the consents and administering the measures, each individual is interviewed to probe what they think the questions mean to ensure their equivalence for use with the target population of this study. When completing the study measures at the data collection visits, assistance by the study team will be available if a

participant prefers the questions be read to them or if they require clarifications about the questionnaires. The researcher also may review the medical chart for data to determine the history of the female's pregnancies and current gestational age. Participants will be provided a $20.00 incentive per couple for their time and effort. Total time required for participation by each participant within the couple will be approximately 1 hour.

Questionnaires

Once informed consent is obtained, several measures will be obtained during a routine prenatal visit or at other locations convenient for the couples. Paper and pencil measures will be given to each member of the couple individually. Please refer to Table 1 for the list and details and study measures in Appendix D.

Personal Factor/ Demographic Information: Descriptive information will be collected on a demographic information form including such items as length of stay in the U.S., length of relationship, the number of pregnancies and birth (with and without current partner), income, job status, education completed, religious preference and if provider has spoken to the participants about postpartum contraception. At the end of all the questionnaires, a question is asked about their intention for postpartum contraception use and method they prefer.

Screening questions will address current gestation of this pregnancy, potential participants' age, country of origin, preferred language, partner status, intention to stay together after baby's birth and staying sexually active, and reporting sterilization procedure. Instruments are slightly different for female and male participants.

Sexual Relationship Power Scale (SRPS): This scale was created by Pulerwitz, Gortmaker and Dejong, because of the need to quantify sexual relationship power that was deemed to be an important factor in HIV prevention (condom negotiation) and other sexual health protective

behaviors for women (Pulerwitz et al., 2000). The SRPS consists of two subscales; relationship control subscale (RCS) (fifteen items), and decision making dominance subscale (DMDS) (eight items). The present study only uses the RCS subscale due to an overlapping concept between the decision making dominance subscale and the sexual decision making scale. The RCS uses a 4-point rating scale of 1=*strongly agree* to 4=*strongly disagree* and asks questions of how her partner reacts to various daily and sex-related behaviors (Pulerwitz et al., 2000). The higher scores represent higher sexual relationship power. The possible minimum score of the RCS is 15, and the maximum score is 60. The scale was first tested for its validity and reliability with Latina women and other minority women. The RCS has good internal consistency (alpha= 0.85 and 0.89 for English and Spanish, respectively) (Pulerwitz et al., 2000). Construct validity was tested and showed an expected correlation between the score and each background characteristics and condom use. The SRPS has been used with variety of populations in a broad range of topics such as sexual risky behavior, HIV, STI, and family planning as well as intimate partner violence and sexual dysfunction. (Lau et al., 2006; Pulerwitz et al., 2002; Ragsdale et al., 2009; Teitelman, Ratcliffe, Morales-Aleman, & Sullivan, 2008) In addition, the scale has been investigated in various parts of the world from the U.S.A., Spain, South Africa, Thailand to China (Ragsdale et al., 2009; Dunkle et al., 2007; Rasamimari, Dancy, Talashek, & Park, 2007; Bermudez, Castro, Gude, & Buela-Casal, 2010). Even though the scale was originally developed for women, there have been studies that administered the SRPS to men after appropriate modifications. For this study, wording will be appropriately changed, and the scale will be administered to both male and female partners.

Machismo Scale: This scale measures "machismo", male dominance, one of the important cultural concepts among Latinos (Cuéllar et al., 1995). Cuellar et al. developed the scale along

with other cultural value scales (e.g.fatalism) to study cultural constructs of Mexican Americans (Cuéllar et al., 1995). The original Machismo scale employs 17 items and consists of True/False answer format. A higher machismo score represents a stronger belief of machismo. The original internal consistency was an alpha of 0.78 (Cuéllar et al., 1995). Harvey modified the scale to 5-point Likert scale from 1=*do not agree at all* to 5=*completely agree*. The internal consistency of her data was an alpha of 0.89 (men and women combined; men, alpha=0.89; women, alpha=0.86) (Harvey et al., 2011). The scale has been widely used and found to have evidence for estimated internal consistency in mental health areas (i.e. from Depression in Latino adolescents [alpha=0.82]) (Cespedes & Huey, 2008) to legitimacy in hate crime [alpha=0.75]) (Dunbar & Molina, 2004).

Marianismo Beliefs Scale: This scale is a 24-item scale that consist of five factors (family pillar, virtuous and chaste, subordinate to others, silencing self to maintain harmony, and spiritual pillar) per exploratory factor analysis with Eigenvalues greater than 1.00 (Castillo, Perez, Castillo, & Ghosheh, 2010). Confirmatory factor analysis showed a adequate fit for 5-factor model. Internal consistency of each of the five factor is 0.77, 0.79, 0.76, 0.78 and 0.85 (Castillo et al., 2010). The instrument employs 4-point rating scale, and exists both in English and in Spanish.

Fatalism scale: This is an 8-item scale to measure the cultural concept of "fatalismo", fatalism. This scale was also created by Cuellar et al. as a part of the multiphasic assessment of cultural constructs (Cuéllar et al., 1995). Fatalism is about how much people feel that their destinies are beyond their control (Cuéllar et al., 1995). Respondents answer each statement with true or false, higher scores indicate higher belief in fatalism. The original article (scale development) states that the internal consistency of the fatalism scale was an alpha of .63 (Cuéllar et al., 1995).

Fatalism has been studied among Latino population with fair internal consistencies from cancer screening (alpha, not reported) (Randolph, Freeman, & Freeman, 2002), and mental health disorders (alpha=0.75) (Greenwell & Cosden, 2009) to academic attitudes and achievement (alpha=0.63) (Guzman, Santiago-Rivera, & Hasse, 2005) because of its psychological effects on those behaviors. Fatalism is not associated always with the outcomes detailed in previous studies (i.e. fatalism did not have significant effect on pap smear use among older women). However, it has not been studied in the context of pregnancy and family planning. For this study, we will be using 5-point rating scale to be consistent with the other scale (machismo scale).

Dyadic Adjustment Scale-7 items short form (DAS-7): DAS was created by Spanier due to lack of a precise measurement for marriage quality (1976). It has been used widely in research to measure couples' quality in terms of their relationship in various contexts, such as when a partner has chronic illness (Zhou et al., 2010), or couples have children that are ill (Benzies, Harrison, & Magil-Evans, 2004). The original scale consisted of 32 items, however a 7-item DAS has been created and validated because of the need to identify quickly dyadic adjustment scores. The 7-item DAS has alpha of 0.76, and the means correlate with the relationship status of couples (happily married vs. divorced) (Sharpley & Rogers, 1984). Hunsley, Pinsent, Lefebvre, James-Tunner, & Vito (1995) also showed that the 7-item DAS has good reliability (female alpha=0.84, male alpha=0.79, and overall alpha=0.82) and similar correlations when compared with the DAS vs. other marital measures and DAS-7 vs. other marital measures (Hunsley et al., 1995). Therefore in the present study the researcher will use the 7-item scale to minimize the burden of the participants, while not compromising the quality of the measures obtained. DAS-7 asks about agreements on values and time spent between couples, as well as overall satisfaction with the relationship with the partner. The possible score is 0 to 36, and

higher scores indicate higher relationship quality. Youngblut, Brooten, and Menzies have tested the Spanish translation of the DAS (*C*ronbach alpha 0.67 to 0.93; Paired *t*-tests showed that the similarity was high between the English and the Spanish versions of DAS [0.79 to .87]), however the study was done with the 32-item, not the 7-item version (Youngblut et al., 2006). No studies have reported validity and reliability of the Spanish version of DAS-7. Spanish version of the scale has been obtained from Youngblut et al.

Communication with partner scale: This measure captures the general communication among members of a couple on daily basis. It is comprised 13 of items, and respondents answer what they do and how they perceive communication with their partners from "*almost always*" to "*almost never*". The higher score indicates better communication between couples. This scale is a part of the Couples Pre-Counseling Inventory (CPCI) created by Stuart in 1973 and revised in 1983 (Stuart & Jacobson, 1987). CPCI consists of 13 sections. The CPCI has been used in clinical settings to identify therapy goals as well as being employed in research settings (Mostamandy, 2003). Validity and reliability of a subsection of the CPCI are not available. However, overall alpha of the inventory is 0.91 (Mostamandy, 2003).

Dyadic Sexual Communication Scale: This scale measures quality of sexual communication and consist of 13 items. This scale asks more specific questions about communication related to sexual matter rather than communication style (mentioned above). Both scales are used for this study. It uses 6-point Likert scale of 1=*disagree strongly* to 6=*agree strongly*. This scale has been used in high risk STI/HIV population (i.e. minority, young people and men have sex with men) (Catania, 1998).

Sexual Decision making: This is a 12-item scale that measures the participation/involvement of sexual decision making with the partner. Participants respond to the degree of involvement with

a 5-point Likert scale from 1=*not at all* to 5=*a great deal*. The minimum score is 12 and the maximum is 60. The scale was developed by Harvey's research team (2009), and the internal consistency was 0.82 (men and women combined; men, alpha=0.84; women, alpha=0.78) (Harvey et al., 2011). She and her team examine HIV/STI prevention for immigrant Latino population. The team has given us permission to use the tool. It is available both in English and Spanish.

Relationship Commitment: This 16-item scale also has been developed by Harvey's research team (Harvey et al., 2009) who does HIV/STI prevention for immigrant Latino population. The scale measures how much each person is committed to the existing relationship with the current partner. Respondents answer the degree of agreement from 0=*do not agree at all* to 8=*agree completely*. The score ranges from 0 to 128. The alpha of the scale was 0.77. The team has given us permission to use the tool. It is available both in English and Spanish.

Contraception attitudes and perception scale: A 21-item scale to measure different aspects of contraception: denial/knowledge/ambivalence; norms; partner; side effects; hassle; and cost. Participants indicate the degree of agreement from 1=*do not agree at all* to 5=*completely agree*. The score range is 21 to 105. This tool also was developed by Harvey's research team (2009), and we have gained permission to use it. The internal consistencies of the scale was alphas of 0.76, 0.79, and 0.74 (men and women, men only and women only (Harvey et al., 2011).

Religiousness Commitment Inventory (RCI-10): This scale was developed by Worthington et al. (2003) and measures religious commitment, which is defined as the degree to which a person adheres to his religious values, beliefs, and practices and the extent that he or she uses them in daily living. The scale was reduced from 17 items to 10 items and has been validated with a variety of sample population (Christian married couples, college students, Buddhists, Muslims,

Hindus). Respondents address various dimension of religiosity from 1=*not at all true to me* to 5=*totally true to me* (Worthington et al., 2003). The ranges of the scores are 10-50, and higher scores indicate more commitment to the religion in which one believes. It has not been translated into Spanish. However, it has good validity and reliability; coefficient alpha of the RCI-10 was 0.93, test-retest reliability was 0.87 (Worthington et al., 2003). In addition, construct, discriminant and criterion-related validity have been tested and resulted in significant results to establish validity.

Data analysis plan

Descriptive statistics will be obtained as well as numbers to describe the sample including calculating means, standard deviations, and ranges for the continuous variables, and counts with frequencies for the categorical variables. All three specific aims can be analyzed among men, women and couples (Olson & McCubbin, 1983). Furthermore, couples' analysis can be done as women versus men, as a group and being paired analysis per couple. Olson and McCubbin present several ways to analyze couples' score; couple mean scores, couple discrepancy score, and maximized couples score (Olson & McCubbin, 1983). Mean scores are useful and give an overview of where couples stand on the measures of interest. It is effectively used when couples' scores are relatively similar. However, if their scores differ, the differences are not captured. Therefore, this scoring system can be used depending on the similarities in the couples' score. Couple discrepancy scoring can look at the difference of couples' scores. Depending on how the scores compare, this scoring system is thought to be useful in this study, as couples with small versus large score differences may have different characteristics in FP decision making and communication. Maximized couple scores take into account the significant characteristics that one partner has but not the other. Again, this scoring system may not be used

frequently but may be useful when one partner has characteristics that are very different from his/her partner.

1. The first study aim is to examine the predictors of sexual relationship power. Potential predictors include the cultural values of male dominance, marianismo and fatalism, attitudes and perceptions towards contraception, religion/spirituality, demographics/personal and couple factors (i.e. age, education, length of relationship, relationship status, and number of children the couples have together and separately), relationship adjustment and relationship commitment. This analysis is completed with the male and female data separately, then again with the couples' data. The Mean is meaningful if the couples' scores are similar. A difference in the couples' scores is meaningful if the couples' scores are different. If there are larger differences between men and women's scores, sexual relationship power differences will be larger. If there are small differences between men and women's scores, sexual relationship power differences will be smaller.
    a. Hypothesis 1: Higher scores on the male dominance scale predict lower sexual relationship power.
    b. Hypothesis 2: Number of completed years of education predicts sexual relationship power as follows:
        i. Greater number of completed years of education by the male partner predicts equal sexual relationship power.
        ii. Lesser number of completed years of education completed by the male partner predicts higher sexual relationship power for males.

iii. Greater number of years of education completed by the female partner predicts higher sexual relationship power for females.

c. Hypothesis 3: The greater the number of children couples have together predicts increase in women's sexual relationship power.

2. The second aim of this study is to explore which demographics/personal factors and relationship variables predict communication. Potential predictors are demographic/personal factors (i.e. age, education completed, number of children together, women's number of children, length of relationship, marital status); degree of dyadic adjustment and relationship commitment; and sexual relationship power. In addition to testing each variable with communication through correlation analyses, regression analysis is used to examine predictors for communication.

Hypothesis 4: There is a significant relationship between the degree of dyadic adjustment and communication. Men's, women's and couples' models are explored. For the couple's model, couples' mean or difference scores will be used, depending on the distribution of the scores.

When couples' scores are similar, there are two possibilities how differences are distributed,

- The relationship adjustment scores are similar and moderate to high
- Both partners' scores are similar and lower

When couples' scores are different, there are two types of differences.

- men higher than women
- women higher than men,

Depending on the tendency in scores as noted above, communication may be predicted differently. Regression model is used for this analysis.

   a. Hypothesis 5: After controlling for or eliminating significant demographic/personal factors, degree of dyadic adjustment or relationship commitment, sexual relationship power still predicts communication. Regression model is used for this analysis.

3. The final study aim is to examine which demographic/personal factors and relationship variable/s predict sexual decision making. Potential predictors are demographic/personal factors (i.e. age, education completed, number of children together, women's number of children, length of relationship, relationship status), degree of dyadic adjustment, relationship commitment and sexual relationship power. Again, in addition to correlation analyses, regression analysis will be done to test the following hypothesis: After controlling for or eliminating significant demographic/personal factors, relationship variables (degree of dyadic adjustment and relationship commitment), sexual relationship power still predicts sexual decision making. Regression model is used for this analysis. After finding the main variables that affect sexual relationship power, communication and sexual decision-making, structural equation modeling (or multilevel modeling as appropriate for the data) will be performed to explorer the study model. Before finalizing the model, there will be testing of several alternative models against the hypothesized model to ensure there is no alternative that fits better than the developed model.

   a. Hypothesis 6: Greater number of completed years of education by the male partner predicts higher decision making scores(meaning active participation towards decision making and acknowledge the participation of his partners'

decision making). Men's, women's and couples' models are explored. For the couples' models, couples' mean or difference scores will be used depending on the distribution of the scores.

b. Hypothesis 7: An increase in the number of children couples have together predicts increase in the decision making score for women. This analysis is done using couples' scores. Mean scores will be used if the couples have the similar scores. Differences are used if couples' scores are different.
c. Hypothesis 8: After controlling for or eliminating significant demographic/personal factors, degree of dyadic adjustment and relationship commitment, sexual relationship power still predict sexual decision making. Regression model is used for this analysis.

When couples' scores are similar, there are two possibilities how differences are distributed,

1. The relationship adjustment, relationship commitment and sexual relationship power scores are similar and moderate to high
2. Both partners' scores are similar and lower

When couples' scores are different, there are two types of differences.

1. men higher than women
2. women higher than men.

Data safety and monitoring

The study, which does not test any intervention and is not a clinical trial, will be overseen by the PI. The protocol will undergo its initial review by the study team after 10% of the anticipated enrollment with follow-up review if necessary. We believe that the protocol is low risk and that this should be adequate as this is a cross sectional descriptive study rather than an intervention study. Adverse event reporting will occur as necessary. The PI and/or study team will be available 24 hours a day by cell phone whenever subjects are on project; this number will be provided to subjects.

The student will manage data under the PI's supervision. The data from the proposed study will come from the questionnaire collected by the study team. Questionnaires are transferred to electronic database. All data will be stored on secure locations (paper measures are stored at locked cabinet at the PI's office, and database is electronically locked). Data quality will be monitored for accuracy and validity under PI's supervision. Planned project involves minimal risk, no adverse events are expected to occur as a direct result of subject participation. However, should any event occur that might be related to project participation, the PI will assume responsibility for notification of the designated care providers and for any referral for recommended treatment, as well as notification to the VCU IRB. Adverse event reporting forms and procedures are available on-line at: http://www/orsp.vcu.edu/irb

Human subject instructions

A. Description

The study will involve a sample of 40 heterosexual first generation Latino couples whose female partners are in their second or third trimester. Participants must meet outlined study criteria and must be able to read and speak Spanish, or English and Spanish. The

potential female participants are identified through chart review and will be approached by the study team. Screening questions are asked prior to consent to ensure eligibility. Screenings are done in a private setting. Eligible participants and their partners will sign the consent and be asked to complete questionnaires. Both partners need to agree to participate in studies, since the study needs paired data. Participants will complete surveys. In addition, charts will be reviewed for medical information about the pregnancies. Total time required for participation will be approximately 1 hour.

B. Subject population

The sample will be comprised of 40 adult (18 or older) heterosexual Latino couples. Project inclusion criteria include

(a) Female partner in second or third trimester

(b) Both partners being born in any Latin American countries,

(c) Latinos who read and speak Spanish, or Spanish and English

(d) Couples who are in some form of close relationship (married or living together)

(e) Couples who have been and intend to be sexually active after delivery

(f) Both members of the couple want to participate in the study.

Exclusion criterions include men with sterilization procedure. NO the involvement of special cases of subjects, such as children, human fetuses, neonates, prisoners or others. Pregnant women will be in the research study. However, the risks are minimum.

C. Research material

Data will be collected from participants using the questionnaires displayed on Appendix D. All data will be obtained specifically for research purposes.

D. Recruitment plan

Chart review is conducted to determine the eligibility of the potential female participants at the recruitment sites. These women are approached during their routine clinic visits, when clinicians are not interacting with them. If their male partners are present, he would be approached to join the study. If their male partners are not present and female partners are interested, the student will ask if the female partners would be willing to speak about the study to them to see if they would be interested. The student will follow up with the female partners and if the male partners are interested, the student and her research team member (Hispanic male research assistant) will meet with the potential participants at the place of their convenience. Screening questions are administered in a private setting to ensure study eligibility. The participants will be all adults, and the survey will not harm their fetuses.

E. Privacy of participants

The data obtained from participants are not linked to their names, rather subject identification numbers so that privacy is ensured for this participant. Consent and questionnaires are stored in a locked office separately. All the study visits are conducted in a private room to ensure the participants' privacy.

F. Potential risks

Potential risks include mild distress from completing the questionnaire packet. There may be some unpleasant memories that may be brought back from filling out the surveys. The student will explain to the participants that they have a choice of not answering certain questions if they do not wish to do so. However, the likelihood of experiencing mild distress is minimal.

Breach of confidentiality and invasion of privacy is a potential risk. However, all systems and procedures are in place to avoid it from happening. The student will explain that their information is securely stored and has no link to government or police. She will also explain and ensure that the information will be de-identified and will not be in public or to her partner for any reason. If intimate partner violence is indicated, appropriate referral will be made to ensure the participants' safety.

G. Risk reduction

As part of the process involved in obtaining written informed consent, participants will be explained and given a copy of the informed consent form. Contact information for the PI and the student are provided on the consent form for the participants to ask questions freely. Confidentiality is assured before and throughout the study visit. When intimate partner violence is indicated, appropriate referral and assistance will be sought to ensure the participants' safety. If need for other resources arise, appropriate referral in each clinic will be made.

H. Additional safeguards for vulnerable participants

The risk to the pregnant women is not greater than minimal. Potential risks are described in the consent. At times, questions in the study may remind of past and current unpleasant experiences of the participants. However, the participants can stop answering questions in this case. If additional resources are needed, appropriate referral will be made.

I. Risk/benefit

There are no direct benefits to the subjects in this study as we are seeking information to understand factors that affects couples' communication such as sexual relationship power. It is possible that participants in this project will gain indirect benefits from the

knowledge that they are participating in a research project and become aware the importance of couples' communication about family planning. The risk is minimal and this information may benefit individuals, couples and their families in the future. In addition, the findings of the current study may have future benefits for other Latino couples.

J. Compensation plan

Participants as couples will receive a $20 incentive after both partners fill out the questionnaires.

K. 1. Consent process

The participants are asked to provide consent by the study team in their preferred language (English or Spanish) after both members of the couples agree and are willing to participate in the study. The research team members are frequent in English and Spanish. Thus, they are able to answer any questions that participants have in their preferred language. The potential participants are approached during their clinic visit. The consent is obtained at a private setting. Potential participants can take as much time as needed to read or discuss the consent with the principal investigator (PI), student, family or friends before making their decision. Furthermore, explanation of the study will be provided verbally and in writing. Patients will be allowed to ask questions or call the PI or student to discuss any concerns at any time. The student is not a clinic staff, and she will ensure to explain the potential participants that not participating the study would not affect their medical care they receive at the clinic.

2. Special consent provisions

Since it is anticipated that the majority of the participants prefer completing the questionnaires in Spanish, The consent form is prepared in English and Spanish. The participants are given choices of language (English or Spanish) for the consent form and the questionnaires. The consent form is translated and back-translated per American Academy of Orthopaedic Surgeons Institute for Work & Health Guildeline (Beaton et al., 2002) to ensure accuracy.

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Chapter 4

The following manuscript was prepared to describe the findings on this study.

The format used is consistent with requirements for a manuscript-format dissertation. The manuscript is prepared in the style of a selected journal that publishes nursing research.

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Abstract

Unintended pregnancy (UP) is increasing among Latinos in the United States. Individual and couples' relationship factors are likely to increase UP occurrence. Thus, the purpose of this study was to examine the association between sexual relationship power (SRP), communication, and sexual decision making from each partner's perspective. In a cross-sectional design, a convenience sample of 40 Latino couples was recruited. Female partners were pregnant. Sample characteristics and partner responses were compared and contrasted. Relationship satisfaction and commitment were found to be significantly associated with demographic factors. Increasing SRP through Latina empowerment and mutual decision making has the potential to build sustainable relationships. Findings will contribute to developing targeted interventions to decrease UP while increasing quality of life for Latino families.

Key words: Latinos, Hispanics, couples, family planning, decision making, pregnancy

One in six United States (U.S.) Americans are Latinos (U.S. Census Bureau, 2010); their growth rate accounts for over 50% of the U.S. population in the last 10 years (Pew Hispanic Center, 2008). Moreover, Latinos are estimated to be nearly 30% of the U.S. population by 2050 (U.S. Census Bureau, 2011). Concurrently, Latinos are experiencing an increase in unintended pregnancies (UP) (Finer and Henshaw, 2006). UP is defined as a pregnancy that is considered either mistimed or unwanted at the time of conception (Brown & Eisenburg, 1995). Women with UP are more likely to delay prenatal care (Cheng, Schwarz, Douglas, & Holon, 2009) and as a result, the pregnancy may be inadequately managed; predisposing both the mother and infant to poorer health outcomes (Evers, de Volk, & Visser, 2004). Moreover, UP disrupts optimum birth spacing; which may further predispose the mother and infant to long term negative effects (Fuentes-Afflick and Herrol, 2000; Conde-Agudelo, Rosas-Bermudez, & Kafury-Goeta, 2007; Bhutta, Cleves, Casey, Cradock, & Anando, 2002). In addition, parenting difficulties may arise sooner or later for these families (El-Kamary et al., 2004). Women with more UPs tend to use less effective method of contraception (Matsuda, Masho, & McGrath, 2012).

According to the World Health Organization (WHO) (2011), family planning (FP) refers to the ability of individuals and couples, through their own intent, to determine their desired number of children and the spacing and timing of their births. Despite the WHO definition of FP as a couples' process, FP interventions have traditionally been directed only at women and this delivery method has been shown to be unsuccessful (Becker, 1996; Becker & Robinson, 1998; Kerns, Westhoff, Morroni, & Murphy, 2003). However, sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) prevention intervention initiatives have successfully been implemented with couples (Kraft, 2007; Harvey et al., 2009; El-Bassel et al., 2003). Despite these related findings, there is little family planning research targeted at the decision making

between couples. Current findings and interventions focus primarily on providing contraceptives (Kirby, 2008) or building women's contraceptive negotiation skills (Choi, Wojcicki, & Valencia-Garcia, 2004). Considered these finding in tandem, FP interventions might benefit from focusing on couples' communication skills rather than targeting only women.

Aims and Hypotheses

The purpose of this study was to examine the predictors of sexual relationship power, communication (communication in general, and sexual communication) and sexual decision making. The first aim was to examine predictors of sexual relationship power. Potential factors include the cultural values of male dominance, female character ("marianismo") and fatalism, contraception barrier, religion commitment , demographic, personal and couple factors (i.e. age, education, length of relationship, relationship status, and number of children the couples have together and separately), relationship satisfaction and relationship commitment. From the existing literature, the following hypotheses were proposed: 1. Higher scores on the male dominance scale predict lower sexual relationship power for women; 2. Number of completed years of education predicts sexual relationship power for both women and men; the greater number of children the couple has together predicts an increase in the women's sexual relationship power. The second aim was to explore predictor of communication. The hypotheses were the following: There is a positive and significant relation between relationship satisfaction and communication (hypothesis 4), and after controlling for significant demographic/ personal factors, relationship satisfaction or relationship commitment, sexual relationship power still predicts communication (hypothesis 5). A third aim was to determine predictors of sexual decision making. The hypothesis were the following: greater number of completed years of education by the male partner predicts higher decision making scores (hypothesis 6); an increase

in the number of children couples have together predicts an increase in decision making in women (hypothesis 7); after controlling for or eliminating significant demographic/personal factors, degree of dyadic adjustment and relationship commitment, sexual relationship power still predicts sexual decision making (hypothesis 8).

Conceptual Framework

A couples' decision making is affected by gender norms which are socially constructed and make up the social context, self-concepts, beliefs, and expectations for behavior (Potuchek, 1992). In addition to the gender norms, male dominance in a culture greatly affects how and whether couples' decision making communication occurs or not. Open communication between partners about FP has been found to increases contraceptive use (Harvey et al., 2006; Harvey, Henderson, & Casillas, 2006; Beckman, Harvey, Thorburn, Maher, & Burns, 2006). Lack of FP communication and FP decision making and irregular contraceptive usage has the potential to increase the risk of UP, which could lead to poorer health outcomes, inadequate birth spacing and parenting difficulties (El-Kamary et al., 2004). FP decision making conversations amongst couples optimally begin before the initiation of sexual activity and continue throughout the couples' active sexual relationship. The proposed study framework was designed using Fishbein's Integrative model (which has been created by using components of the Theory of Reasoned Action, Social Cognitive Theory and Health Belief Model) (2000) and Harvey's structural model of condom use intention as well as the current literature, the framework for the current study is shown in Figure 1.

Method

Participants and Procedures

This was a cross-sectional descriptive study. A convenient sample of forty heterosexual immigrant Latino couples whose female partners were in their second or third trimester of their pregnancy were recruited for study participation. Recruitment occurred at prenatal care clinics and through personal referrals. The inclusion criteria included: (a) both partners 18 year or older; (b) both partners born in any Latin American countries; (c) Spanish speaking; (d) couples who are married or living together; (e) couples who have been and plan to be sexually active after delivery; and (f) both members of the couple willing to participate in the study. Exclusion criteria include: (a) sterilization of male partner; and (b) being single (not in a relationship). The potential female participants were identified through clinician referral and approached by the researcher. A male Latino research assistant joined in recruitment and data collection to increase male participants' comfort. Screening questions were asked in a private setting prior to consent to ensure eligibility, and the study visit appointments were made after both partners agreed to participate. Eligible participants and their partners signed the consent form and were asked to complete questionnaires independently and privately. Total time required for participation was approximately 1 hour. Prior to data collection, a power analysis was completed to obtain a medium effect size when comparing means (Dixon & Massey, 1983; O'Brien & Muller, 1983) and for regression analysis (Dupont & Plummer, 1998) (0.634, 0.635; respectfully) at 80% power for two-tailed test supports a minimum sample size of 40 participants per group (nQuery, 2008).

Measures: Once informed consent was obtained from each partner within the couple, paper and pencil measures were given to each member of the couple independently and completed in a separate space to protect the individual's confidentiality. The total number of the questions are 177 items (men) and 180 items (women). The following questionnaires were administered as a

packet to each partner (Packets were essentially the same for both partners except for the pregnancy information for women): Demographic/Personal Factors (14 items [men]; 17 items [women]), Religious Commitment Inventory (10 items), Sexual Relationship Power Scale (23 items), Communication with the Partner Scale (13 items), Dyadic Sexual Communication Scale (12 items), Sexual Decision Making Scale (12 items), Relationship Commitment Scale (16 items), Dyadic Adjustment Scale-Short Form (7), Contraception Barrier Scale (21 items), Machismo Scale (17 items), Marianismo Scale (21 items) and Fatalismo Scale (8 items). Please refer to table 1: Study Measures. Alphas of the scales range from 0.668 to 0.91(dyadic adjustment scale was the lowest, and relationship commitment scale and religious commitment scale were the highest). The cutoff of alpha is 0.6, therefore all the scales used for this study had adequate internal consistency.

Analysis

The statistical analysis was performed using SPSS software, version 19. Descriptive statistics were obtained including frequencies and percentages of the categorical/nominal variables, and means and standard deviations of the scales. Male and female data were compared with t-test to examine differences between genders. Then, correlation analyses were conducted to answer the proposed hypotheses. Then, hierarchical regression model was used to examine the following hypothesis; after controlling for or eliminating significant demographic/personal factors, significant relationship factor predicts sexual relationship power/communication/decision making.

Results

Heterosexual Latino couples (*N*=40) were enrolled after completing screening questions and having sought both partners' agreement to participation to the study. Demographic characteristics are shown in Table 2. All 40 couples (80 individuals) completed questionnaires in Spanish. Mean age of women was 26.5 years old (Standard Deviation [SD] =4.81), mean age of men was 28.2 years old (SD=5.67). Mean time since immigration to the U.S. was 6.7 years (SD=4.31) in women and 7.8 years (SD=4.95) in men. Mean gestational age for women was 28.5 weeks (SD=7.79). Many women and men have children from previous relationships, and the difference between mean number of pregnancy/delivery/children in life and with current partner reflected these numbers (i.e. Mean number of pregnancies in life: 2.7 [SD=1.22]; with current partner: 1.85 [SD=0.95]). For men, mean number of children fathered in life was 1.48 (SD=1.62), and mean number of children fathered with current partner was 0.85 (SD=0.86).

Almost half of the sample was of Mexican descent (women: *n*=19, 47.5%; men: *n* =17, 42.5%). Other participants were from various Central American countries. Most of the participants identified Spanish as their primary language (women: *n* =33, 82.5%; men: *n* =34, 85%). However, 8 women and 4 men reported their primary languages were either Spanish and their indigenous language (both women and men: *n* =4, 10%), or indigenous language alone (women: Mixteco: *n* =1, 2.5%; Chinanteco: *n* =1, 2.5%; men: *n* =0). The indigenous languages identified by study participants were Mixteco and Chinanteco, and both of these are spoken in Mexico. Two women who identified their indigenous languages as their primary languages understood and spoke enough Spanish to consent for participation and complete the questionnaires. For the completed years of education, most of the participants either fell in the categories of attended elementary school or attended high school (completed 1-6th grade: women: *n* =21, 52.5%; men: *n* =15, 37.5%; completed 7-8th grade: women: *n* =1, 2.5%; men: *n*

=4, 10%; completed 9-12th grade: women: *n* =17, 42.5%; men: *n* =15, 37.5%;). Two men (5%) did not have any formal education, and thus they did not read Spanish very well or not at all. Questionnaires were read to them by the male research assistant, and answer options were explained verbally to have them mark the most appropriate response to ensure privacy. One women (2.5%) and four men went on and/or completed college (completed 1-2 years of college: *n* =3, 7.5%; completed 3-4 years of college: *n* =1, 2.5%).

Most of the participants stated that they had a plan for postpartum contraception (women: *n* =38, 95%; men: *n* =36, 90%, see Table 3). Two women (5%) and four men (10%) said they had no contraceptive plan. The most prevalent plan for the postpartum contraception reported by women were the following: 13 women (32.5%) intended to use intrauterine devices (IUD); 11 women (27.5%) intended to use Depo-provera; and 5 women (12.5%) said they would like to use Implanon®. For men, 8 of them (20%) intended for women to use Depo-provera, 7 of the men (17.5%) reported a plan to use condoms, and the use of IUD and pill were chosen by 6 men respectively (15% per method) (other choices were in the minority, please refer to table 3).

As far as couples' characteristics, 28 couples (70%) were living together (see Table 4). They refer their relationship status as "acompañado" or "juntado." This is a phenomenon where a man and a woman decide to stay together and live together without commitment. This phenomenon is highly practiced among Latinos as the statistics of this study reflect. Twelve of the couples (30%) were either married through the judicial system or the church. Mean length of the current relationship was 4.83 years (SD=4.33) and ranged from 3 months to 20 years.

Independent *t*-test

Assuming independence between each participant's responses, independent t-tests were conducted to compare general difference in male and female responses. Please refer to Table 5 for the test results. Even though women had higher scores than men for sexual relationship power, there was no significant difference in the scores (measured and used the SRPS as a whole) for men (M [mean] =2.8, SD =0.42) and women (M=2.9, SD=0.34; $t(78)=-1.202$, $p=0.082$). There were significant difference in scores related to male dominance (men: M=51.36, SD=14.7, and women: M=42.95, SD=10.73; $t(76)=2.88$, $p=0.005$) and relationship commitment (men: M=60.5, SD=5.04, and women: M=56.38, SD=8.28; $t(78)=2.46$, $p=0.016$).

Paired *t*-test

Assuming interdependence between each participant's responses to his/her partner, paired t-tests were conducted to compare men and women's responses within a couple. Please refer to Table 6. Even though it is noted that women had higher scores than men, there was no significant difference in scores related to sexual relationship power (measured and used the SRPS as a whole) for men (M=2.8, SD=0.42) and women (M=2.9, SD=0.34; $t(39)=-1.285$, $p=0.206$) within couples. There were significant difference in scores of male dominance (men: M=51.26, SD=14.89, and women: M=43.39, SD=10.5; $t(37)=2.86$, $p=0.007$) and relationship commitment (men: M=60.39, SD=4.65, and women: M=54.66, SD=1.81; $t(37)=3.036$, $p=0.04$) within couples.

Correlation and Hierarchical Multiple Regression Analysis

Correlation and hierarchical multiple regression analyses were explored with women and men separately. Comparisons are made between findings for the two groups. Correlations

between key study variables (Table 7) as well as other demographic and cultural variables were examined in men and women separately (Table 8: women; Table 9: men).

Aim 1.

The first study aim was to determine predictors of sexual relationship power. Hypothesis 1 was that higher scores on the male dominance scale predicted lower sexual relationship power. Hypothesis 1 was only supported when examining the data from women participants. Stronger machismo belief was significantly and negatively correlated with sexual relationship power (r=-0.334, p=0.038, see Table 7). Thus, the higher the women's sexual relationship power, the less they held traditional cultural belief of male dominance. Hypothesis 2 was that number of completed years of education predicted sexual relationship power. For both women and men, number of completed years of education were not significantly correlated with high sexual relationship power (women: r=0.221, p=0.171, Table 8; men: r=0.268, p=0.093, Table 9). Therefore, the results did not support hypothesis 2. Hypothesis 3 was that the greater the number of children couples had together predicted increases in women's sexual relationship power. The hypothesis was not supported by the results (see Table 7).

To explore predictors of sexual relationship power, hierarchical multiple regression analysis was performed with sexual relationship power serving as the criterion variable. Multicollinearity and other assumptions were examined and all the variables were found to be appropriate to proceed to the hierarchical multiple regression analysis. Variables used in these analyses were first categorized by their characteristics in blocks. Blocks include demographics (age, religious commitment, length of stay in the U.S.), cultural factors (machismo, marianismo and fatalimo) .relationship related demographics (number of pregnancy/children with or not with

current partner, length of relationship), communication factors (communication and sexual communication scale), contraception barriers, relationship factors (relationship commitment, satisfaction and decision making) and sexual relationship power (for aim 2 and 3 only). Due the assumptions for multiple regressions, non-significant variables were removed. Eight variables per model were retained to compose the final model. The composition of the final model among women was the following: cultural factors of machismo were included in block 1; communication and sexual communication in block 2; following relationship factors in block 3 including relationship commitment, relationship satisfaction and decision making. The regression results are presented in Table 10 and Figure 2. The first block accounted for 11.1% of the variance, the second block accounted an additional 17.1% (change was significant, $p<0.05$), and the third block accounted an additional 39.3% (also significant change), $F(8,26) = 6.776$, $p < 0.001$. Machismo and perceived decision making ($\beta=-0.562$, $p=0.001$; $\beta=-0.398$, $p=0.041$) as well as perceived relationship commitment and relationship satisfaction ($\beta=0.59$, $p=0.004$; $\beta=0.422$, $p=0.007$) significantly contributed to the variance in sexual relationship power among women. For men, the women's final model was examined as a first step to understand what the differences between men and women might be. Machismo (the factor in the first block) accounted for only 3.7% of the variance, and communication factors in the second block accounted for an additional 20.6% (significant change), $p<0.05$). However, the final model with relationship factors in the third block did not demonstrate a significant model (accounted for only an additional 9.4%, $F[8,27] = 1.718$, $p = 0.14$, see Table 10 and Figure 3). Only sexual communication significantly contributed to the variance in sexual relationship power among men ($\beta=0.549$, $p=0.013$). Then a men's model was uniquely developed. Please refer to Table 11 and Figure 4 for the men's unique hierarchical regression model result. The composition of the final

model for men is the following: Demographic factors of age, years of education completed and time in U.S. were included in block 1 (accounted for 17.7% of the variance); machismo in block 2 (accounted an additional 0.4%); contraception barrier in block 3 (an additional 26.2%, significant change, $p<0.05$); sexual communication in block 4 (an additional 0.8%); following relationship factors in block 5 including relationship satisfaction and decision making (an additional 8.2%, $F[9,26] = 3.293$, $p < 0.008$). For this model, machismo and contraception barrier significantly contributed to the variance in sexual relationship power among men ($\beta=0.574$, $p =0.028$; $\beta=-0.672$, $p =0.01$).

Aim 2.

The second aim of this study was to explore predictors of communication. The study measured both couples' general communication and communication related to sexual matters. Hypothesis 4 was that there was a significant relationship between the degree of dyadic adjustment and communication. Both among men and women, there were significant positive correlations between relationship satisfaction and communication (men: $r=0.372$, $p=0.022$; women: $r=0.33$, $p=0.04$, see Table 7). Men and women who were satisfied with their relationships were significantly more likely to communicate than men and women who were not satisfied with their relationships. The results support hypothesis 4. For sexual communication, relationship satisfaction and sexual communication were significantly and positively correlated both among men and women (men: $r=0.318$, $p=0.048$; women: $r=0.33$, $p=0.038$, see Table 7). Therefore, couples who communicated about sexual matters and desires with less hesitancy and shame had higher satisfaction with their relationship. These results also support hypothesis 4. Then, to explore predictors of communication, hierarchical multiple regression analysis was performed with communication serving as the criterion variable. Time in U.S., was included in

block 1 (accounted for 4.2% of the variance), length of relationship was in block 2 (an additional 9%), machismo and marianismo were in block 3 (an additional 9.7%), relationship commitment, satisfaction and sexual decision making were in block 4 (an additional 33.4%, significant change, $p<0.05$) and sexual relationship power was in block 5 (an additional 2%, $F[8,28]=3.524$, $p=0.006$). The regression result for women is presented in Table 12 and Figure 5. Women's general communication model had four significant variables that contributed to the variance (time in U.S.: β=-0.465, p =0.008; machismo: β=0.69, p =0.001; marianismo: β=-0.855, p =0.003; and relationship satisfaction: β=0.484, p=0.021). Please refer to Table 12 and Figure 6 for the results; the same model was examined in men and found that only time in U.S. and relationship commitment were significant (F [8,27]=4.044, p=0.003). Then men's unique model was developed (Table 13 and Figure 7). Even though some of the variables were different (Years of education completed and length of stay in U.S. were included in block 1 [accounted for 15.2% of the variance], number of children was in block 2 [an additional 0.1%], relationship commitment, perceived relationship commitment, relationship satisfaction and decision making were in block 3 [an additional 38.8%, significant change, $p<0.05$], and sexual relationship power was in block 4 [an additional 0.6%], the same variables (time in U.S.: β=-0.384, p=0.015; and relationship commitment: β=0.379, p =0.029) were the only significant variables in the final model ($F[8,28]=4.229$, p=0.002).

Next, hierarchical multiple regression with sexual communication as the criterion variable was examined. The results are presented in Table 14, and Figure 8 and 9. Age and years of education were included in the first block (accounted for 0.6% of the variance), number of children in life and length of relationship were included in the second block (an additional 9.3%), contraception barrier was included in the third block (an additional 2.3%), relationship

commitment and relationship satisfaction were included in the fourth block (an additional 32.3%, significant change, $p<0.05$) and finally sexual relationship power was entered (an additional 1.9%, $F[8,29] = 3.136$, $p < 0.011$). Length of relationship (β=-0.438, p =0.006) and relationship commitment (β=0.484, p =0.021) significantly contributed to the variance in sexual communication among women. The same model was examined in men and found significant (F [8, 29]=4.058, p=0.002). However, only relationship commitment was found to be significant factor in the model. The men's unique model showed that contraception barrier and relationship commitment (β=-0.345, p =0.037; β=0.595, p =0.002) significantly contributed to the variance with sexual communication among men (F [8,28]=4.37, p=0.002). Please refer to Table 15 and Figure 10 for the results. Sexual relationship power was not a significant predictor in either of the communication model. Thus, hypothesis 5 was not supported.

Aim 3.

The third study aim was to examine predictors of sexual decision making. Hypothesis 6 was that greater number of completed years of education by the male partner predicted higher decision making scores. Number of completed years of education by male was not correlated with decision making scores (decision making: r=-0.109, p=0.509; perception of partners' decision making: r=-0.141, p=0.391, see Table 9). Therefore, the result did not support hypothesis 6. Hypothesis 7 was that an increase in the number of children couples had together predicted an increase in decision making score in women. Number of children couples conceived and delivered together was not correlated with decision making scores (decision making: r=-0.067, p=0.691; perception of partners' decision making: r=-0.172, p=0.31, see Table 9). Therefore, the result also did not support hypothesis 7. Finally, hierarchical multiple regression model was again examined with sexual decision making served as the criterion variable. Please refer to

Table 16, and Figure 11 and 12 for the results. For women, age, religious commitment and length of stay in the U.S. was in block 1 (accounting for 1% of the variance), marianismo was in block 2 (an additional 14.3% variance, significant change, $p<0.05$), communication, relationship commitment, and relationship satisfaction were in block 3 (an additional 57.7%, significant change, $p<0.05$) and sexual relationship power was in block 4 (an additional 2.1% variance accounted), (F [8,27]=10.167, p=0.000). Religious commitment, length of stay in the U.S., marianismo, relationship commitment and relationship satisfaction were significant in the final model (β=0.315, p =0.011; β=-0.432, p =0.001; β=-0.944, p =0.000; β=0.719, p =0.000; β=0.508, p =0.000). The same model was examined with men, however it was not significant (F [8,28]=2.000, p=0.084). Men's unique model was developed with the following blocks (please refer to Table 17 and Figure 13); age, years of education completed and religious commitment (block 1, 13.5% variance accounted for); number of children in life (block 2, an additional 7.1%); marianismo (block 3, an additional 16.9%, significant change, $p<0.05$), communication and relationship satisfaction (block 4, an additional 7.5%); and sexual relationship power (block 5, an additional 0.6%), (F [8,28]=2.932, p=0.016). Only number of children and marianismo were found to be significant (β=0.438, p =0.034; β=0.394, p =0.018). Hypothesis 8 was not supported.

Discussion

The present study explored predictors of sexual relationship power, communication and sexual decision making among heterosexual Latino couples to better describe the associations of these critical concepts. This is a unique study where data were collected from each member of an established couple. Most of the analyses were completed with women and men separately to gain perspectives from each gender. The first research aim was to examine the predictors of sexual

relationship power. Women's perceived relationship commitment and relationship satisfaction significantly predicted sexual relationship power. Zukoski, Harvey, Oakley, & Branch (2011) revealed from their qualitative study that there were two kinds of power that Latinos described, "power over the other" and "shared power." In regards to the first type of power, Grady, Klepinger, Billy, and Cubbins (2010) found that dating women who had more alternatives (in relationship) had higher decision making power. Even though decision making power and sexual relationship power are not exactly the same thing, when women feel that they are superior in their relationship, that reflects in having more power (Grady et al., 2010).When examining the second type of power, the association between sexual relationship power and relationship satisfaction can be explained. If women were satisfied with their relationship, they felt that they had power that were shared between partners, thus predicted higher sexual relationship power. Several studies reported that higher sexual relationship power was related to consistent condom use (Campbell et al., 2009; Powwattana, 2009; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002). Although these studies explored sexual relationship power from a perspective of HIV prevention, it is clear that condom use requires men's collaboration and corporation. Using a condom would seemingly appear to women that men take responsibility towards sexual matters (concept of decision making). Again, the second type of power, "shared power," seem to be exhibited by this result, and is consistent with the previous study findings (Zukoski et al., 2011).

In regards to cultural concepts, machismo may exhibit power perception among women and men differently. Machismo belief predicted women's sexual relationship power (negatively); however, machismo belief predicted men's sexual relationship power (positively). The result may be due to women seeing power as "shared power," and men seeing power as "power over the other." On the other hand, when examining sexual decision making (the third aim),

marianismo was a negative predictor for women and positive predictor for men. Marianismo is a view that Latina women should be like Virgin Mary, the mother of Christ, submissive and devoted to the family (Castillo et al., 2010). These results fit the traditional value that women should not initiate and take charge of sexual decision making but men should (Gómez and Marin, 1996).

Length of time in U.S. was a negative predictor for communication (the second aim) and sexual decision making among women. One of the acculturation measures is language use. This study had small sample of men and women who spoke both English and Spanish. Thus, analyzing the bilingual group separately was not possible. Even though there is a study that found that more acculturated couples convey direct expressions and more active participation in decision making regarding sexual matters than less acculturated couples (Flores, Tschann, VanOss Marin, & Pantoja, 2004), in the present study length of stay in U.S. negatively predicted sexual decision making and communication. Even though length of stay is not the only way to measure acculturation, it is a contributing factor. It is important to consider the effect of acculturation when examining immigrants in the U.S. including their perception of power that they may have acquired differently from their countries of origin.

Zukoski et al. also noted that only women perceived that relationship power was about communication and positive relationship qualities. In the present study, partially supported the findings of Zukoski et al. Communication was predicted by relationship satisfaction, and not by sexual relationship power. In the men's model, relationship satisfaction did not predict sexual relationship power ; rather, relationship commitment did. When men were more committed to their relationship, it might be speculated that they might make greater effort to communicate

with their partners. The partners may equate such effort of being listened and cared as satisfaction with the relationship.

Relationship commitment was also a predictor for sexual communication among both women and men. Harvey et al.'s (2006) conceptual model revealed that relationship commitment was associated with higher partner norms for using condoms and for decision making about whether to use condoms, and commitment led to the intention of using condoms with the primary partner. Although sexual communication was not measured in Harvey et al.'s (2006) study, those who had higher intention to use condom might have been more likely to communicate about intended condom use with their partners. Relationship commitment and satisfaction both predicted sexual decision making among women, and these findings are consistent with Harvey et al. (2006) as well. Given that the important factors affecting these concepts among men and women are different, further research can be done in measuring different types of power as well as finding ways to promote both men and women's relationship quality and mutual sexual decision making within a targeted intervention for the couple. Future studies could also examine the similarities and differences in couples' score. It would also be interesting to explore discrepancies between perceived relationship commitment of each other and the partner's own rating of their relationship commitment. The differences may be examined in terms of their associations with sexual relationship power and relationship satisfaction.

Nursing Implications

Predictors of the concepts examined in this study were different among men and women. For that reason, differences in how women and men regard these concepts need to be acknowledged and targeted uniquely to reach out to couples regarding postpartum contraception.

First of all, this study results showed that men's choice/use of contraception barriers predicted sexual relationship power and sexual communication negatively. Therefore, educating men about contraception is important to correct misunderstandings or myths. Healthcare providers (HCPs) should encourage women to bring their partners to the prenatal care visits. However, it may be difficult for some men to accompany their partners to the prenatal care visits, due to work or taking care of their older children. Therefore, if and when men can accompany their partners' to prenatal care visits, it is important to make the prenatal care environment more welcoming to men and to encourage them to be active participants in the pregnancy as fathers of the coming infant. Some men are hesitant to accompany their partner into the exam room because they may not feel welcome there. Even when invited, some may still hesitate. Yet, HCPs need to keep inviting and welcoming the presence of men. If we can increase the men's involvement in prenatal care, male partners might become more active participants in the postpartum contraception conversation as responsible partners in sexual decision making. Clinic policy changes to encourage partners' involvement should also be considered (Jooste & Amukugo, 2012). When couples are in the prenatal care visits, HCPs need to quickly assess the relationship dynamics to determine how best discussions about postpartum contraception can be facilitated. For example some couples need different approaches, when the male partner is more dominant in the relationship than the female partner may not speak when he is present and more encouragement or separate conversations may be need. When both partners are open to speaking about sexual matters and contraception discussions with the couple together can be encouraged. From our review of the literature, we know that most women are not happy with the contraceptive decision making process they currently have with their partners (Matsuda & McGrath, 2012). Thus, listening to fears or past failures of contraceptive methods as well as

discussing how couples' power dynamics affect contraception use is essential in women's effective use of contraception during the postpartum period and beyond. In addition, asking women about intendedness of the current pregnancy may remind them the importance of choosing right contraception. Finally, partner involvement can be emphasized in the Centering Pregnancy Program. Pregnant women periodically come back to the clinic for their prenatal care visits, and it is easier for providers to establish trust and rapport with the patients. Therefore, prenatal care period is the best time frame to approach women/couples about postpartum contraception. It may not seem imminent to deal with postpartum contraception while being pregnant. However, in a worst case, a pregnant woman may not come to see HCPs until she is pregnant again. If thinking this way, it would be important to address postpartum contraception to prevent recurrent unintended pregnancies. More efforts are needed to increase couples' involvement in contraception choices.

Limitations

Even though there are strengths in this study design, there are limitations that must be acknowledged. First, this is a not a randomized control study, but a descriptive study. Descriptive studies illustrate associations between variables and are useful in learning about the relationships of unstudied factors. However they do not establish causality. Therefore, this study was needed, and the findings will inform a research trajectory for developing randomized control studies for interventions related to family planning communication and decision making for couples. In addition, this study is cross-sectional study, not a longitudinal study. Following couples prenatally and postpartum may be explored to examine differences and similarities of contraception plan and practice in the future.

Second, this study included Latinos from variety of countries. However, Latinos from different countries of origin as well as Latinos with indigenous group origin may possess different characteristics. Therefore, more homogenous samples may be needed for future studies. In the same manner, there are Latinos with different levels of acculturations. This variable should be considered if looking at bigger pool of Latinos.

Third, there are other contextual factors regarding relationships that were not examined for this study. For example, this study was conducted at "new destination" areas, where Latino population is increasing, but bilingual resources are still limited. Therefore, lack of accessible resources may affect couples' relationship and willingness to be remain in the relationship.

Fourth, this study used a convenience sample. The study team approached potential participants or clinic staff introduced the team to the potential participants. There were those who did not want to participate in the study due to time constraints, partner not being available (working many hours), and presumed fear with getting involved with a project of a third-party (putting name on a sheet of paper that is not required as a part of clinic care may have connected to a fear of immigration for some potential participants). There may be other reasons that they refused participation which were not disclosed to the team. The people who refused may hold certain characteristics, may be in an abnormal relationship (i.e. intimate partner violence) or lack dyadic communication due to partner being occupied by work most of the time. In addition, most women who were excluded were due to being identified as single (without a partner). Although they did not have a partner when approached to be part of the study at the prenatal care clinics, most, if not all women had a partner to make the conception of the pregnancy possible. Because this was a study for couples, single women were simply excluded, and obtaining further information (i.e. reason for separation) was not part of the study. They may have had traumatic

reasons that caused separation and their power dynamics with their past partners (fathers of the babies) may be uniquely different. Moreover, their pregnancy and raising the child will be difficult due to lack of social and emotional support from the partners (Christensen, Stuart, Perry, & Le, 2011; Diaz, Le, Cooper, & Muñoz, 2007). Future study can focus on examining factors of single pregnant women to help with this presumably high risk population. Generalizability of the findings is limited because it was a convenience sample. Although there was barely enough power to detect the difference per power analysis with 40 couples, regression analyses require larger sample size. Due to limited sample size, variables in the final models had limited number of independent variables. Future studies need to be completed with larger sample sizes to include more variables in order to build more complex models and explain all the variable of interest.

Finally, it is important to remember that this study examined the women and men separately for correlation and hierarchical multiple regression analyses. Although study findings are unique and meaningful, couples' data could provide even more insight through dyad analyses. Future study can include secondary analyses of the data from this current study by examining this dyad data.

Conclusion

The current study revealed important findings regarding predictors of sexual relationship power, communication and sexual decision making among Latino couples. Since it appears that sexual relationship power can be predicted by relationship satisfaction, sexual relationship power is a variable that can be targeted when designing interventions to empower women for collaborative mutual sexual decision making with their partners, thus facilitating and promoting satisfying and healthy relationships for couples. For men, relationship commitment was found to

be the most influential factor predictive of active communication and sexual decision making. Finding ways to further examine relationship commitment (per relationship status or other contextual factors) needs to be considered.

The traditional cultural values in the Latino community can be barriers to mutual decision making; however, these same values can be positive factors in assuming responsibility for sexual matters within the couple. Perception of power may be different for individuals as well as among men and women. They also may have different perceptions about what makes them feel satisfied. Considering the differences for individuals within couples, working with couples rather than individually is critical to facilitating change within the couple; interventions which target this sensitive subject with couples must be developed and tested.

Latino immigrants in the United States are facing many difficulties with the transition to making a living and adjusting to an unfamiliar place. During this transition time reproductive matters may be secondary to them. However, it is a matter of concern that needs to be addressed since having children and raising them requires more adjustment and responsibility. Latinos also may face more difficulty raising children in the U.S. as they have to work harder with school systems and other organizations where language and/cultural differences may exist. The family is the smallest unit of human organization for children, and it begins with the couples desire to be together in support of growing children; therefore, efforts to promote couples' sexual decision making needs to be a priority in promoting healthy Latino families in the United States.

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Figure 1. Conceptual Framework

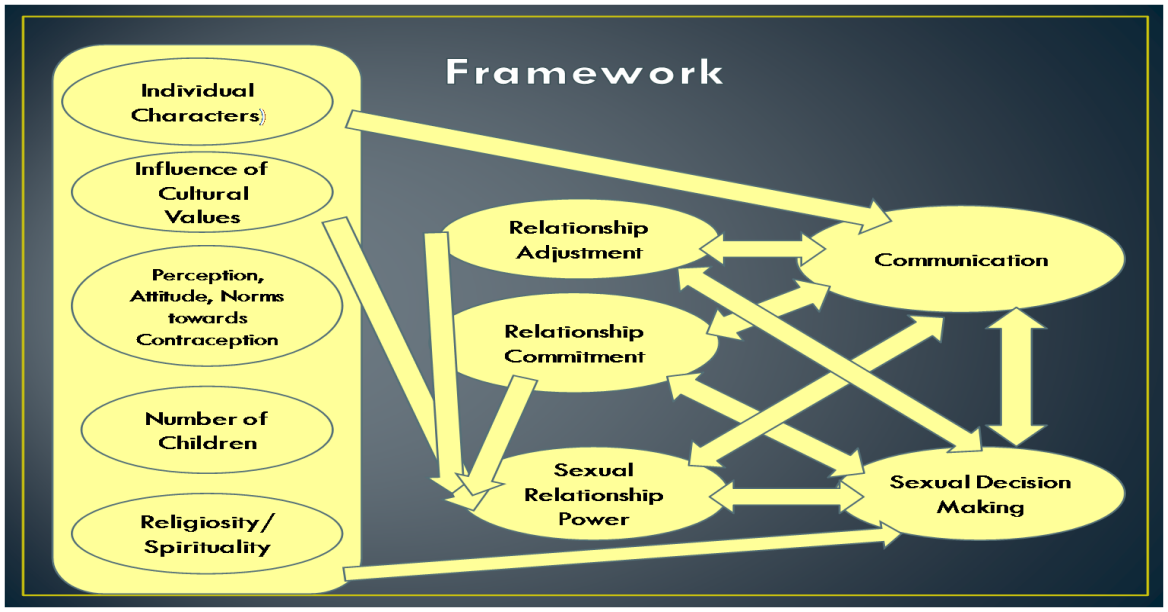


Figure 2. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Relationship Power in Women

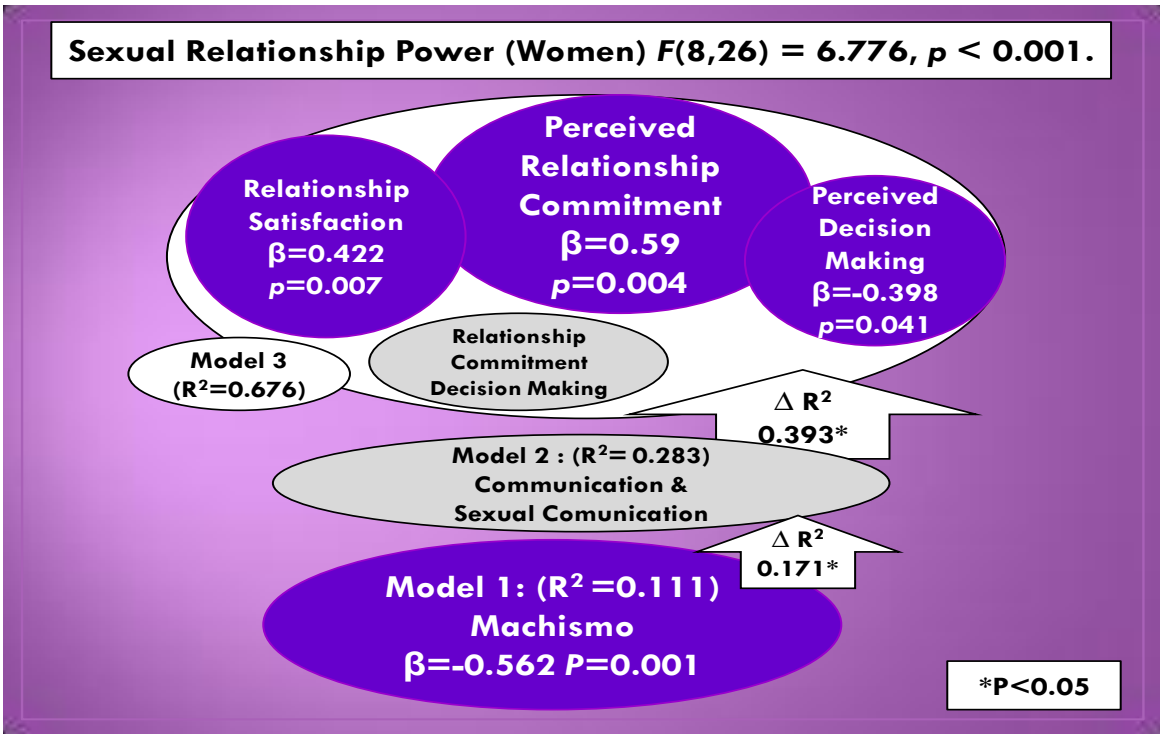


Figure 3. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Relationship Power in Men

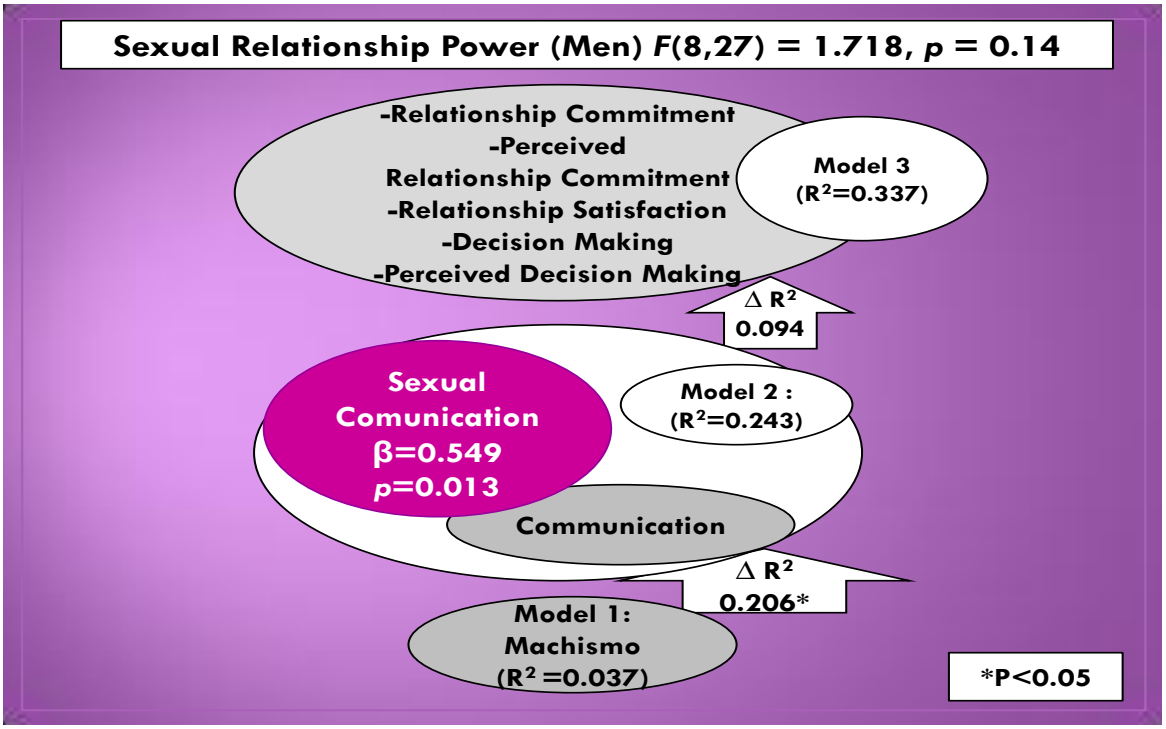


Figure 4. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Relationship Power in Men (unique model)

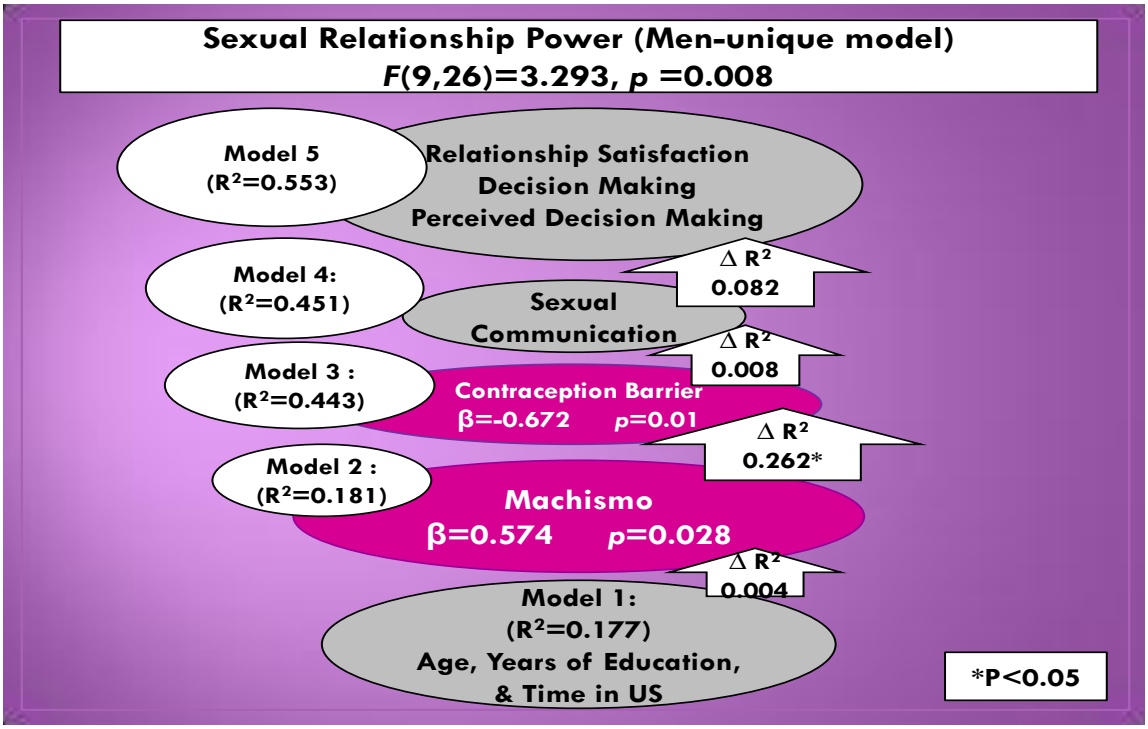


Figure 5. Hierarchical Regression Analysis Results Diagram for the Predictors of Communication in Women

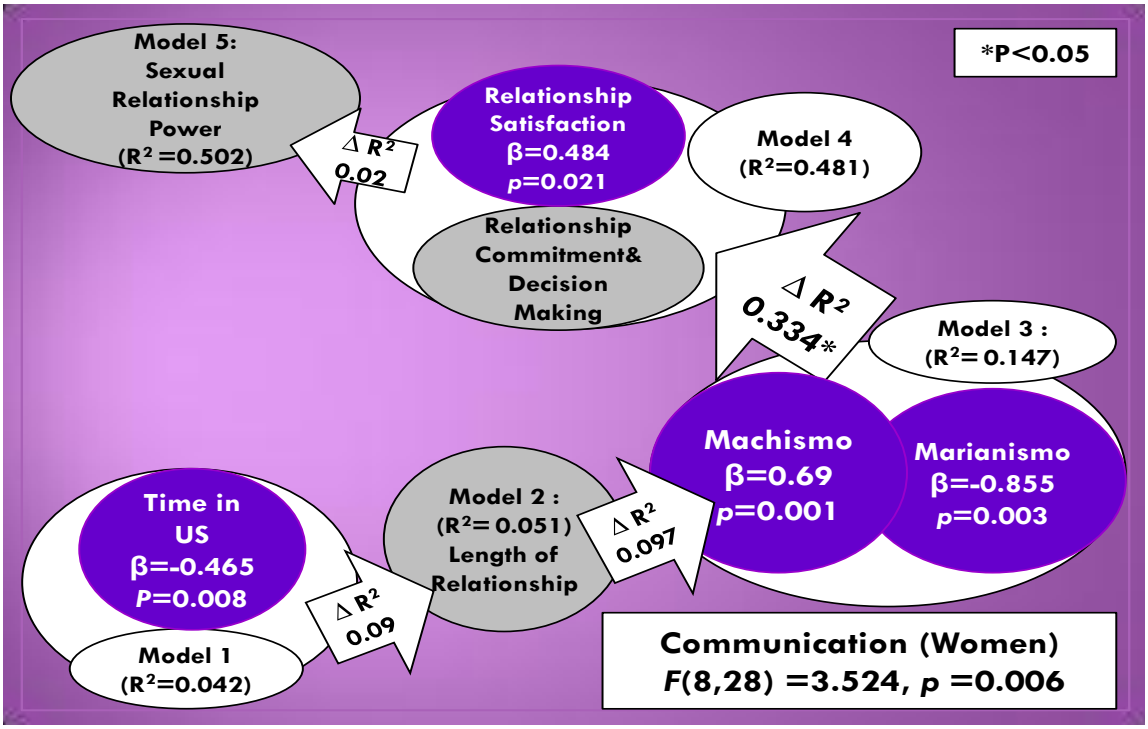
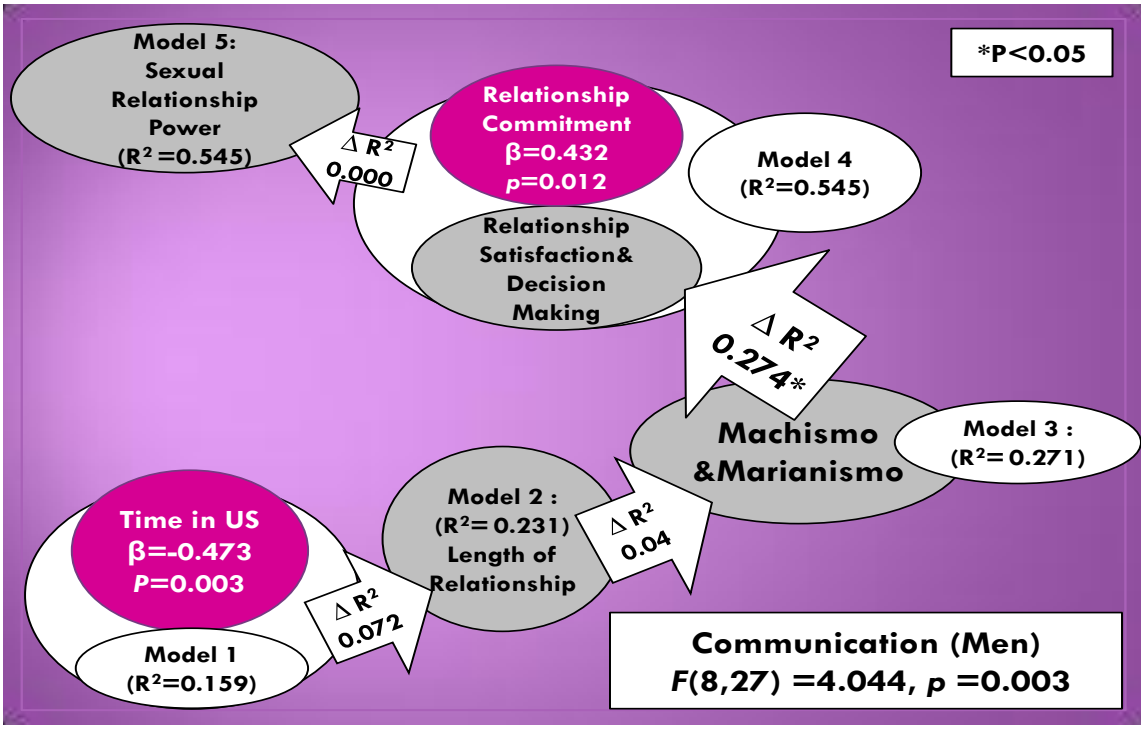


Figure 6. Hierarchical Regression Analysis Results Diagram for the Predictors of Communication in Men



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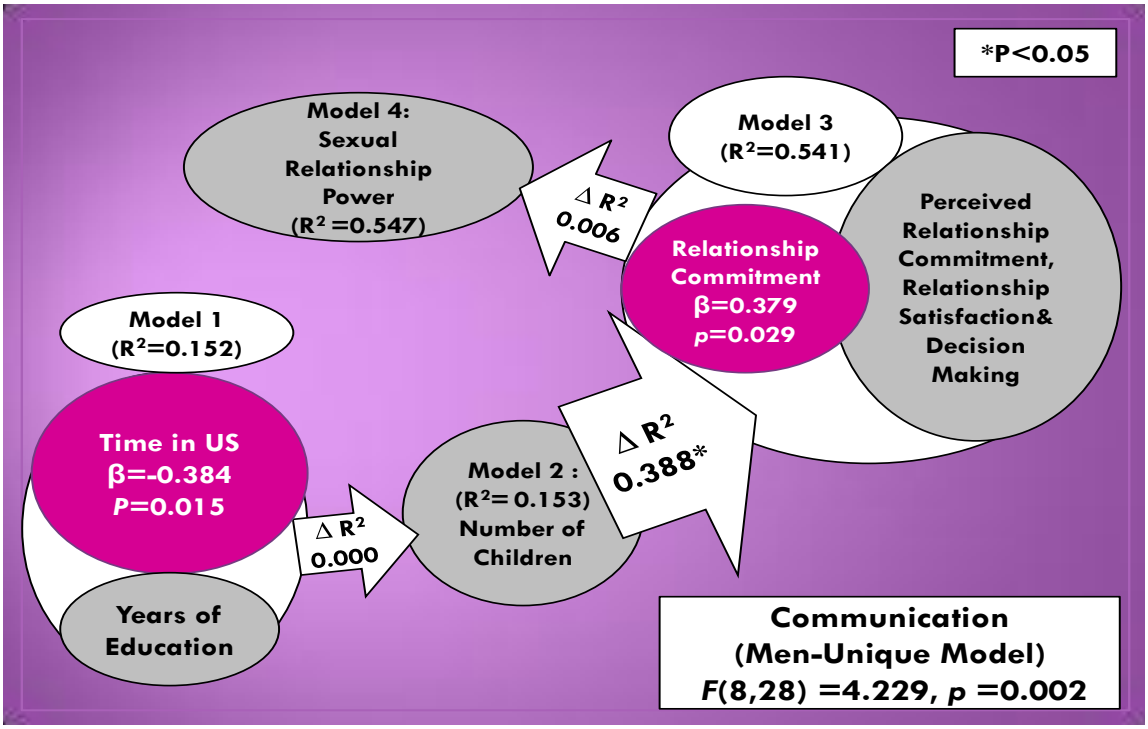


Figure 8. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Communication in Women

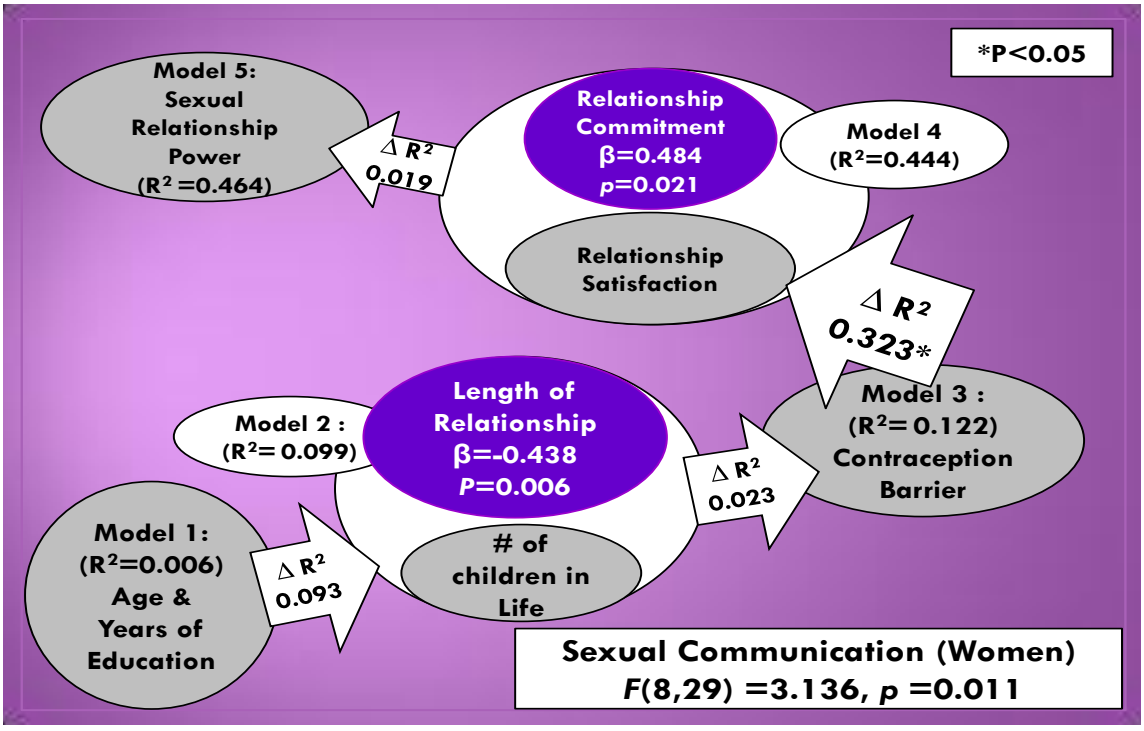


Figure 9. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Communication in Men

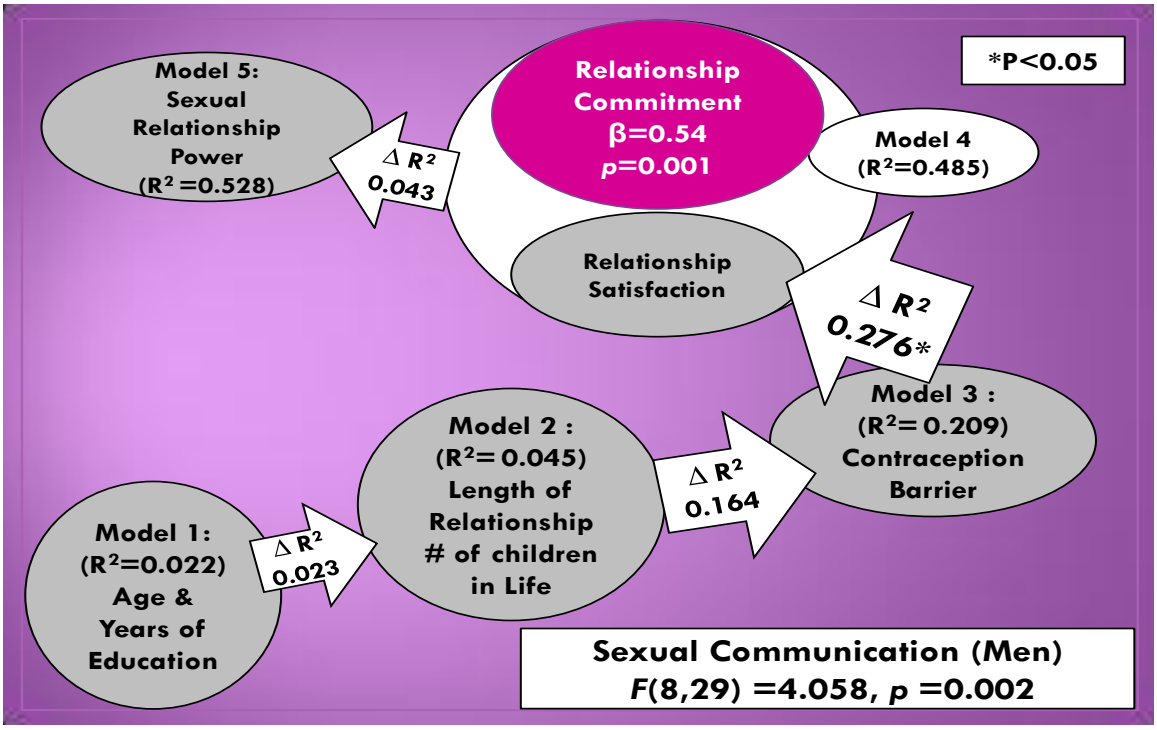


Figure 10. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Communication in Men (unique model)

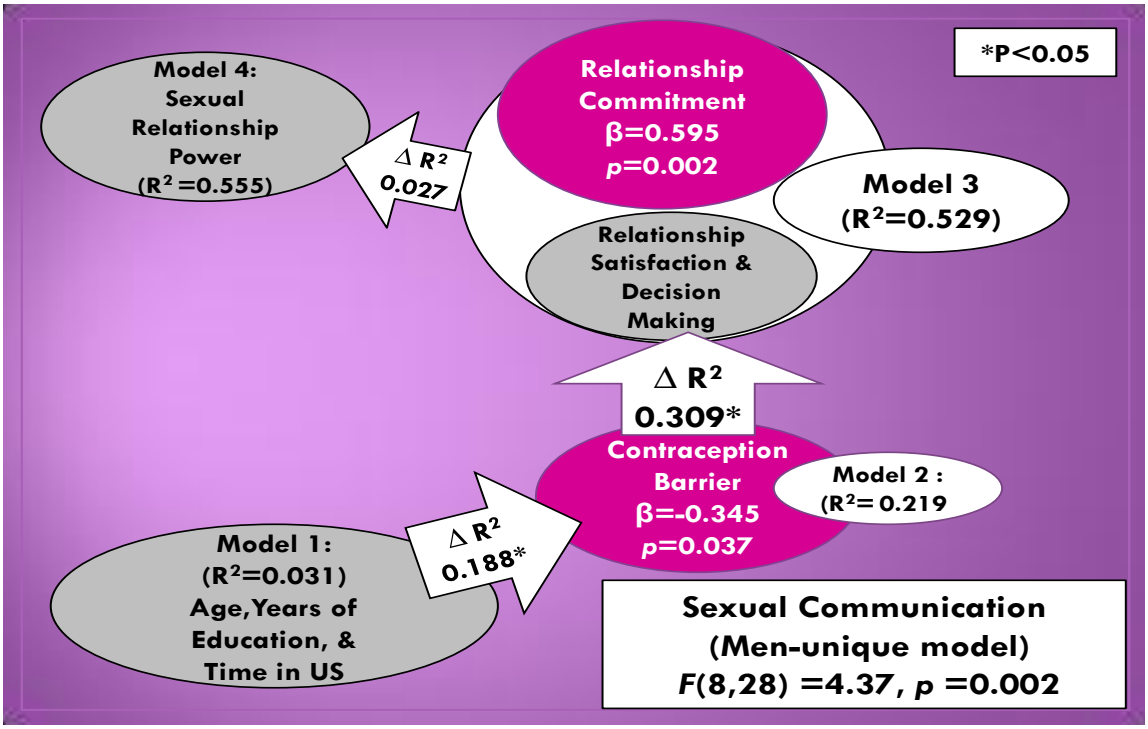


Figure 11. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Decision Making in Women

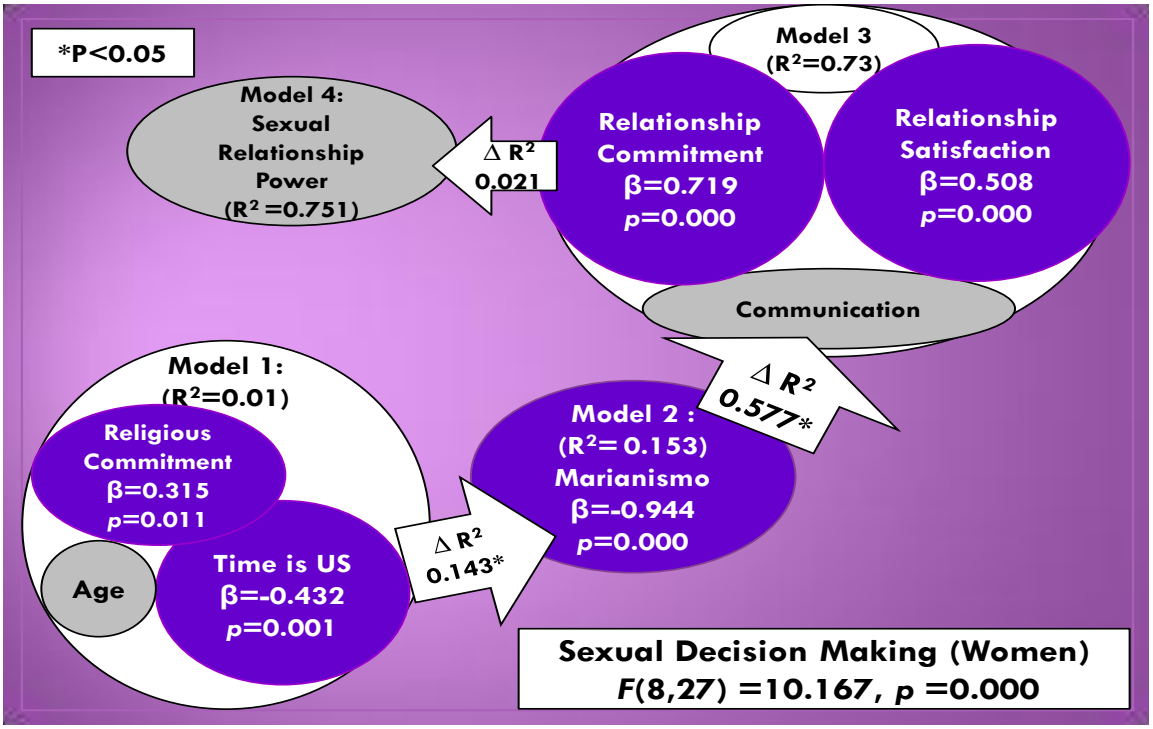


Figure 12. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Decision Making in Men

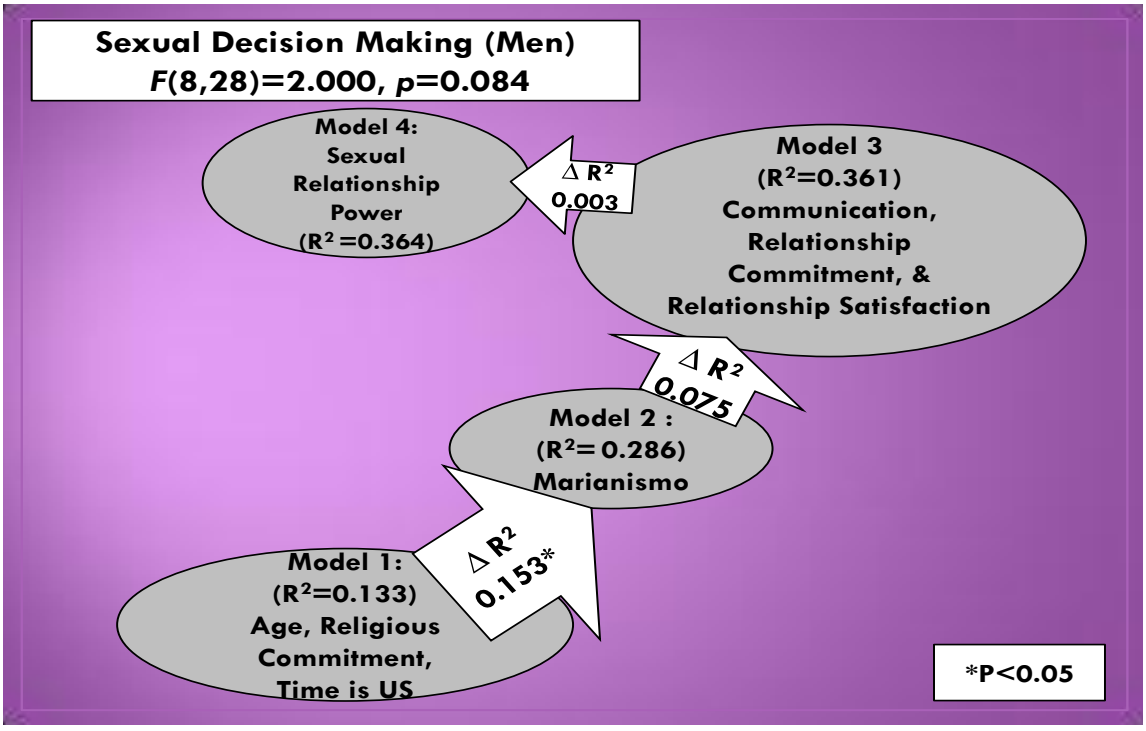


Figure 13. Hierarchical Regression Analysis Results Diagram for the Predictors of Sexual Decision Making in Men (unique model)

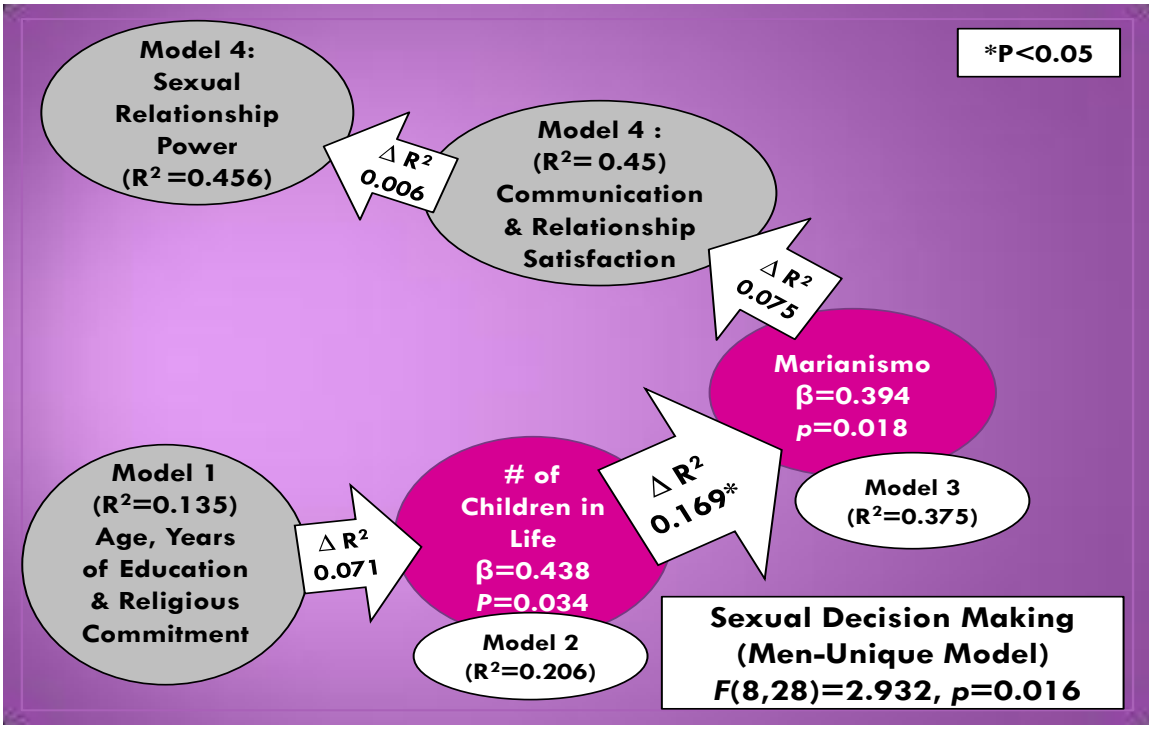


Table 1: Study Measures

Measures	Number of Items	Cronbach's α	Measuring Scale	Description
Demographic/Personal Factors language,	17 Women 14 men	N/A	Varies	Consist of age, sex, country of origin, primary education completed, income, job status, relationship status, length of relationship, religious preference, intention to stay sexually active, number of pregnancies and children with and not with the current partner. Also asked a plan for postpartum contraception and if health care providers have talked with participants about postpartum contraception.
Religious Commitment Inventory (RCI-10) (Worthington et al., 2003)	10	0.91	5-point Likert Scale	Measures degree of a person adheres to his religious values, beliefs, and practices and uses them in daily living. Higher scores represent more commitment to the one's religious belief.
Sexual Relationship Power Scale (SRPS) (Pulerwitz, Gortmaker, & DeJong, 2000)	23	0.801	4-point Likert Scale	Measures sexual relationship power. Consist of 2 subscales: Relationship Control Subscale (RCS) (15 items) & Decision Making Dominance

			(RPS) 3 answer Choices (DMDS)	Subscale (DMDS) (8 items).Validated with Latina women and other minority women. Has a good reliability on men's Cronbach's α with the current study sample (α=0.808, vs. women α=0.777).
Communication with the Partner Scale (CPS) (Stuart, 1987)	13	0.741	5-point Likert Scale	The scale is part of Couples pre-counseling inventory and measures how well couples communicate. Higher score represents better communication.
Dyadic Sexual Communication Scale (DSCS) (Catania, 1998)	12	0.689	6-point Likert Scale	This scale measures quality of sexual communication. Asks more specific questions about communication related to sexual matter. The scale has been used in high risk STI/HIV population.
Sexual Decision Making (SDM) (Harvey et al., 2009)	12	0.892 0.832 (DM) 0.817 (PDM)	5-point Likert Scale	Measures involvement of one's sexual decision making with the partner (DM) and one's perception of the partner's decision making (PDM).
Relationship Commitment (RC) (Harvey et al., 2009)	16	0.816 0.91(RC) 0.774 (PRC)	9-point Likert Scale	Measures how much one commits to the current relationship with partner (RC) and how much one perceives his/her partner's commitment is (PRC).
Dyadic Adjustment Scale-short form	7	0.668	6-point	Measures quality of dyadic relationship, thus

(DAS-7) (Spanier, 1976)			Likert Scale	relationship satisfaction. The original scale is consist of 32 items. The DAS 7 item short form has been validated to measure marital adjustment.
Contraception Barrier (Harvey et al., 2009)	21	0.814	5-point Likert Scale	Measures various aspects of contraception; denial/knowledge. ambivalence, norms, partner, side effects, hassle and cost. Higher score represents increased barriers to contraception.
Machismo (Cuellar, Arnold, & Gonzalez, 1995)	17	0.808	5-point Likert Scale	This scale measures "Machismo" which means male dominance in Spanish, and this is one of the important cultural concepts among Latinos. Higher score represents that one holds more traditional male dominance belief.
Marianismo (Castillo, Perez, Castillo, & Ghosheh, 2010)	24	0.862	4-point Likert Scale	This scale measures the belief of "marianismo", subordinate role of Latina. This is another traditional concepts within Latino culture. The scale consists of five factors (family pillar, virtuous and chaste, subordinate to others, silencing self to maintain harmony, and spiritual pillar).

Fatalismo (Cuellar, Arnold, & Gonzalez, 1995)	8	0.719	5-point Likert Scale	This scale measures another Latino cultural concept of "fatalismo", fatalism. Fatalism is about how much people feel that their destinies are beyond their control. Higher score represents stronger fatalism belief.

Table 2: Demographic Characteristics

	Women		Men	
	mean	SD	mean	SD
Age (years)	26.5	4.81	28.2	5.67
Time in US (years)	6.7	4.31	7.8	4.95
Gastational age (weeks)	28.5	7.79	N/A	
Number of pregnancy in life	2.7	1.22	N/A	
Number of pregnancy with current partner	1.85	0.95	N/A	
Number of delivery in life	1.55	1.2	N/A	
Number of delivery with current partner	0.8	0.84	N/A	
Number of children in life	N/A		1.48	1.62
Number of children with current partner	N/A		0.85	0.86
Country of origin:	N	%	N	%
Mexico	19	47.5	17	42.5
El Salvador	11	27.5	9	22.5
Honduras	5	12.5	7	17.5
Guatemala	5	12.5	6	15
Costa Rica	0		1	2.5
Primary language:				
Spanish	33	82.5	34	85
Spanish and Mixteco	4	10	4	10
Spanish and Chinanteco	2	5	2	5
Mixteco	1	2.5	0	
Chinanteco	1	2.5	0	
Work status:				
Full time	6	15	26	65
Part time	3	7.5	4	10
Work when there is a job	3	7.5	9	22.5
Take care of home/children	28	70	0	
Government assistance	0		1	2.5
Education:				
No schooling	0		2	5
1st-6th grade	21	52.5	15	37.5
7th-8th grade	1	2.5	4	10
9th-12th grade	17	42.5	15	37.5
1-2 years of college	1	2.5	3	7.5
3-4 years of college	0		1	2.5
Religious preference:				
Protestant	20	50	19	47.5
Catholic	18	45	19	47.5
Other	2	5	2	5

Table 3: Contraception Conversation and Plans

Contraception talk with a health care provider at the clinic	N	%	N	%
Yes with me	23	57.5	0	
Yes with me and my partner	6	15	14	35
No	11	27.5	26	65
Contraception plan after her delivery:				
Yes	38	95	36	90
No	2	5	4	10
Method of postpartum contraception choice				
Pill	3	7.5	6	15
Depo-provera	11	27.5	8	20
Implanon®	5	12.5	2	5
Patch	2	5	1	2.5
Intrauterine Device	13	32.5	6	15
Vaginal ring	0	0	1	2.5
Condom	1	2.5	7	17.5
Natural family planning	2	5	2	5
Tubal ligation	3	7.5	0	0
I don’t know	4	10	4	10
Missing	0	0	3	7.5
Marked more than one methods	3	7.5	0	0

Table 4: Characteristics Shared by Couples

	couple values	
	N	%
Relationship status:		
Married	12	30
Living together (acompanado, juntado)	28	70
	Mean	SD
Time together (years)	4.83	4.33
Household monthly income ($)	1540.63	856.61

Table 5

Comparison of means (independent sample t-tests)

	Men	Women	*df*	*t*	*p*
Sexual Relationship Power	2.80 (0.42)	2.90 (0.34)	78	-1.202	0.223
Communication	55.33 (5.37)	52.95 (7.97)	76	1.549	0.125
Sexual Dyadic Communication	55.65 (10.75)	56.25 (11.1)	78	-0.246	0.807
Dyadic Adjustment	28.31 (5.84)	26.6 (5.81)	77	1.303	0.196
Machismo	51.36 (14.7)	42.95 (10.73)	76	2.88*	0.005
Marianismo	2.73 (0.47)	2.58 (0.46)	78	1.46	0.149
Fatalismo	26.75 (6.02)	25.56 (5.90)	77	0.884	0.38
Contraception barriers	51.26 (18.87)	45 (11.34)	62.57	1.769	0.082
Decision making	45.64 (12.92)	47.39 (12.13)	73	-0.603	0.549
Perceived decision making	23.28 (7.1)	23.89 (6.42)	75	-0.397	0.693
Relationship Commitment	60.15 (5.04)	56.38 (8.28)	78	2.46*	0.016

Perception of the Partners' Relationship Commitment	57.78 (7.99)	54.66 (11.18)	76	1.42	0.159
Religious Commitment	33.4 (9.6)	33.21 (11.44)	77	0.082	0.935
Time is the U.S.	7.83 (5.01)	6.74 (4.31)	78	1.048	0.298

*=p_< 0.05, Parentheses are standard deviation.

Table 6

Comparison of means (paired t-test)

	Men	Women	*df*	*t*	*p*
Sexual Relationship	2.80	2.90	39	-1.285	0.206
Power	(0.42)	(0.34)			
Communication	55.39	53.63	37	1.268	0.213
	(5.43)	(6.82)			
Sexual Dyadic	55.65	56.25	39	-0.249	0.804
Communication	(10.75)	(11.1)			
Dyadic Adjustment	28.31	26.9	38	1.182	0.245
	(5.84)	(5.57)			
Machismo	51.26	43.39	37	2.86*	0.007
	(14.89)	(10.5)			
Marianismo	2.73	2.58	39	1.48	0.146
	(0.47)	(0.46)			
Fatalismo	26.56	25.56	38	0.772	0.475
	(5.99)	(5.9)			
Contraception barriers	49.97	44.95	36	1.677	0.102
	(17.11)	(11.49)			
Decision making	23.03	23.73	36	-0.518	0.734
	(7.19)	(6.43)			
Perceived	21.92	23.69	35	-0.995	0.327
Decision Making	(6.76)	(6.71)			
Relationship	60.39	54.66	37	3.036*	0.04
Commitment	(4.65)	(1.81)			

Perception of the Partners'	57.78	56.38	39	0.743	0.462
Relationship Commitment	(7.99)	(8.28)			
Religious Commitment	33.4	33.2	38	0.082	0.935
	(9.6)	(11.44)			
Time is U.S.	7.83	6.74	39	1.077	0.288
	(4.95)	(4.31)			

*=p_< 0.05, Parentheses are standard deviation.

Table 7: Correlation of the scale among men and women (men upper right side, women lower left side)

Variable	1	2	3	4	5	6	7	8	9
1. SRPS		-0.16	0.061	0.384*	-0.076	-0.238	0.089	0.091	0.065
		(0.331)	(0.712)	(0.01)	(0.645)	(0.145)	(0.584)	(0.575)	(0.694)
2. Machismo	-0.334*		0.297	-0.115	0.087	0	0.052	0.079	-0.003
	(0.038)		(0.07)	(0.486)	(0.602)	(0.999)	(0.753)	(0.632)	(0.986)
3. Communication	0.227	0.24		0.358*	0.376*	0.128	0.457*	0.343*	0.372*
	(0.164)	(0.146)		(0.025)	(0.02)	(0.443)	(0.003)	(0.032)	(0.022)
4. Sexual Communication	-0.226	0.1	0.492*		0.32*	0.176	0.588*	0.434*	0.318*
	(0.161)	(0.954)	(0.001)		(0.047)	(0.284)	(0.000)	(0.005)	(0.048)
5. Decision Making	0.282	-0.272	0.172	0.265		0.759*	0.519*	0.468*	0.339*
	(0.086)	(0.098)	(0.308)	(0.107)		(0.000)	(0.001)	(0.003)	(0.037)
6. Perceived Decision Making	0.171	-0.472*	-0.043	0.138	0.683*		0.297	0.283	0.322*
	(0.311)	(0.003)	(0.803)	(0.416)	(0.000)		(0.066)	(0.081)	(0.049)
7. Relationship Commitment	0.394*	0.186	0.237	0.454*	0.377*	0.064		0.575*	0.466*
	(0.012)	(0.258)	(0.146)	(0.003)	(0.02)	(0.707)		(0.000)	(0.003)
8. Perceived Relationship Commitment	0.503* (0.001)	0.291 (0.8)	0.388* (0.018)	0.451* (0.005)	0.226 (0.186)	0.119 (0.495)	0.714* (0.000)		0.397* (0.012)
9. Relationship satisfaction	0.605*	-0.182	0.33*	0.33*	0.503*	0.402*	0.351*	0.382*	
	(0.0)	(0.268)	(0.04)	(0.038)	(0.001)	(0.014)	(0.026)	(0.018)	

*p<0.05

Table 8: Correlation of the key relationship factors and demographic/cultural factors among women

Variable RS	SRPS	Machismo	Comm.	Sexual Comm.	DM	PDM	RC	PRC	
Age _	0.051 (0.757)	0.024 (0.885)	-0.155 (0.347)	0.02 (0.902)	-0.024 (0.888)	0.119 (0.483)	0.089 (0.585)	0.133 (0.426)	-0.102 (0.533)
Years of education _	0.221 (0.171)	0.413* (0.009)	-0.076 (0.646)	-0.086 (0.598)	0.417* (0.009)	0.414* (0.011)	0.04 (0.808)	-0.07 (0.677)	0.35* (0.027)
Time in the United States _	0.099 (0.541)	-0.093 (0.573)	-0.204 (0.213)	0.017 (0.919)	-0.034 (0.839)	0.01 (0.953)	0.159 (0.327)	0.149 (0.373)	-0.106 (0.514)
Length of relationship _	0.026 (0.874)	0.163 (0.32)	-0.037 (0.822)	-0.289 (0.07)	0.077 (0.647)	0.015 (0.928)	0.2 (0.217)	0.109 (0.513)	0.161 (0.32)
Number of pregnancy with current partner	-0.006 (0.972)	0.453* (0.004)	0.129 (0.433)	0.19 (0.24)	-0.067 (0.691)	-0.147 (0.386)	0.155 (0.341)	0.342* (0.036)	-0.085 (0.604)
Number of children with current partner	-0.2 (0.902)	0.459* (0.003)	0.113 (0.493)	0.14 (0.398)	-0.067 (0.691)	-0.172 (0.31)	0.124 (0.448)	0.275 (0.095)	-0.09 (0.58)
Number of children in life	0.096 (0.557)	-0.198 (0.227)	0.063 (0.705)	-0.046 (0.779)	-0.09 (0.593)	-0.152 (0.37)	0.095 (0.558)	0.108 (0.518)	0.002 (0.989)
Contraception barrier _	-0.07 (0.678)	0.403* (0.012)	0.458* (0.004)	0.171 (0.306)	-0.21 (0.213)	-0.141 (0.413)	0.007 (0.969)	0.3 (0.071)	-0.019 (0.91)
Marianismo	0.015 (0.952)	0.584* (0.000)	0.11 (0.942)	-0.003 (0.987)	-0.357* (0.028)	-0.385* (0.019)	0.386* (0.014)	0.359* (0.027)	0.108 (0.507)
Fatalismo _	0.13 (0.43)	0.037 (0.827)	-0.103 (0.538)	-0.065 (0.695)	0.144 (0.395)	0.052 (0.762)	0.381* (0.017)	0.287 (0.085)	0.132 (0.425)
Religious commitment _	-0.013 (0.939)	0.498* (0.001)	0.15 (0.367)	0.037 (0.822)	-0.097 (0.567)	-0.165 (0.338)	0.123 (0.454)	0.262 (0.117)	-0.018 (0.911)

Acronyms: Comm.=communication, DM=decision making, PDM=perceived partner's commitment, RC=relationship commitment, PRC=perceived relationship commitment, RS=relationship satisfaction, $p<0.05$*

Table 9: Correlation of the key relationship factors and demographic/cultural factors among men

Variable	SRPS	Machismo	Comm.	Sexual Comm.	DM	PDM	RC	PRC	RS
Age	0.315*	-0.313	-0.332*	0.105	0.053	0.149	0.224	0.165	0.094
_	(0.048)	(0.052)	(0.039)	(0.518)	(0.75)	(0.364)	(0.164)	(0.309)	(0.571)
Years of education	0.268	-0.479*	-0.108	0.039	-0.109	-0.141	-0.124	-0.106	-0.08
_	(0.093)	(0.002)	(0.512)	(0.81)	(0.509)	(0.391)	(0.447)	(0.514)	(0.628)
Time in the United States	0.058	-0.064	-0.353*	-0.027	0.024	0.12	0.197	0.183	-0.176
_	(0.723)	(0.7)	(0.027)	(0.87)	(0.887)	(0.466)	(0.223)	(0.258)	(0.285)
Length of relationship	0.041	0.167	0.085	0.108	0.072	-0.017	0.018	-0.014	0.056
_	(0.804)	(0.31)	(0.608)	(0.506)	(0.659)	(0.919)	(0.913)	(0.932)	(0.735)
Number of children with current partner	0.096 (0.556)	0.091 (0.583)	-0.402 (0.802)	0.16 (0.324)	0.215 (0.19)	0.2 (0.223)	0.38* (0.016)	0.268 (0.094)	0.154 (0.35)
Number of children in life	0.211 (0.19)	-0.15 (0.361)	-0.132 (0.423)	0.12 (0.459)	0.3 (0.064)	0.332* (0.039)	0.293 (0.067)	0.267 (0.096)	0.369 (0.021)
Contraception barrier	-0.469*	0.565*	0.19	-0.428*	-0.144	-0.013	-0.147	-0.015	-0.71
_	(0.003)	(0.000)	(0.254)	(0.007)	(0.389)	(0.94)	(0.372)	(0.927)	(0.673)
Marianismo	-0.234 (0.146)	0.49* (0.002)	0.257 (0.114)	-0.06 (0.712)	-0.447 (0.004)	0.306 (0.058)	0.228 (0.072)	0.421* (0.007)	0.158 (0.337)
Fatalismo	-0.184	0.39*	-0.002	-0.249	-0.174	-0.335*	-0.029	-0.049	-0.037
_	(0.255)	(0.014)	(0.988)	(0.122)	(0.289)	(0.037)	(0.858)	(0.766)	(0.823)
Religious commitment	0.041	0.113	0.237	0.332*	0.425*	0.381*	0.416*	0.358*	0.358*
_	(0.801)	(0.492)	(0.146)	(0.036)	(0.007)	(0.017)	(0.008)	(0.023)	(0.025)

Acronyms: Comm.=communication, DM=decision making, PDM=perceived partner's commitment, RC=relationship commitment, PRC=perceived relationship commitment, RS=relationship satisfaction, $p<0.05$*

Table 10: Hierarchical Regression Analysis Summary for the Predictors of Sexual Relationship Power

	WOMEN						MEN					
Variable	B	SEB	β	*p*	R^2	ΔR^2	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.111						0.037	
Machismo	-0.018	0.005	-0.562	0.001*			-0.04	0.005	-0.133	0.445		
Model 2					0.283	0.171*					0.243	0.206*
Communication	-0.003	0.006	-0.06	0.686			-0.015	0.016	-0.191	0.356		
Sexual Communication	0.003	0.004	0.098	0.502			0.022	0.008	0.549	0.013*		
Model 3					0.676	0.393*					0.337	0.094
Relationship Commitment	-0.004	0.008	-0.106	0.579			-0.012	0.021	-0.131	0.572		
Perceived Relationship Commitment	0.018	0.006	0.59	0.004*			-0.002	0.01	-0.031	0.875		
Relationship Satisfaction	0.024	0.008	0.422	0.007*			0.017	0.015	0.214	0.254		
Decision Making	0.004	0.01	0.08	0.673			0.016	0.017	0.239	0.372		
Perceived Decision Making	-0.02	0.009	-0.398	0.041*			-0.027	0.016	-0.4	0.102		

*P<0.05.

Table 11: Hierarchical Regression Analysis Summary for the Predictors of Sexual Relationship Power for Men

Variable	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.177	
Age	0.021	0.013	0.289	0.117		
Years of Education Completed	0.038	0.019	0.358	0.055		
Time in U.S.	-0.02	0.015	-0.236	0.199		
Model 2					0.181	0.004
Machismo	0.017	0.007	0.574	0.028*		
Model 3					0.443	0.262*
Contraception	-0.015	0.005	-0.672	0.01*		
Model 4					0.451	0.008
Sexual Communication	0.008	0.006	0.201	0.231		
Model 5					0.553	0.082
Relationship Satisfaction	-0.02	0.011	-0.022	0.889		
Decision Making	-0.012	0.015	-0.191	0.448		
Perceived Decision Making	-0.008	0.015	-0.127	0.61		

*P<0.05.

Table 12: Hierarchical Regression Analysis Summary for the Predictors of Communication

	WOMEN						MEN					
Variable	B	SEB	β	*p*	R^2	ΔR^2	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.042						0.159	
Time in US	-0.848	0.299	-0.465	0.008*			-0.499	0.151	-0.473	0.003*		
Model 2					0.051	0.09					0.231	0.072
Length of Relationship	-0.028	0.02	-0.21	0.162			0.023	0.014	0.228	0.104		
Model 3					0.147	0.097					0.271	0.04
Machismo	0.513	0.139	0.69	0.001*			0.028	0.062	0.073	0.659		
Marianismo	-14.49	4.404	-0.855	0.003*			-0.656	1.976	-0.057	0.743		
Model 4					0.481	0.334*					0.545	0.274*
Relationship Commitment	0.425	0.214	0.443	0.057			0.489	0.181	0.432	0.012*		
Relationship Satisfaction	0.702	0.287	0.484	0.021*			0.148	0.148	0.148	0.325		
Decision Making	-0.524	0.292	-0.415	0.083			0.091	0.125	0.111	0.475		
Model 5					0.502	0.02					0.545	0.000
Sexual Relationship Power	4.799	4.498	0.199	0.295			0.11	1.767	0.009	0.951		

*P<0.05.

Table 13: Hierarchical Regression Analysis Summary for the Predictors of Communication for Men

Variable	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.152	
Years of Education Completed	-0.154	0.185	-0.114	0.411		
Time in U.S.	-0.415	0.16	-0.384	0.015*		
Model 2					0.153	0.000
Number of Children	-0.916	0.551	-0.249	0.108		
Model 3					0.541	0.388*
Relationship Commitment	0.436	0.189	0.379	0.029*		
Perceived Relationship Commitment	0.094	0.111	0.138	0.404		
Relationship Satisfaction	0.179	0.158	0.175	0.268		
Decision Making	0.145	0.124	0.176	0.255		
Model 4					0.547	0.006
Sexual Relationship Power	1.125	1.815	0.088	0.54		

*P<0.05.

Table 14: Hierarchical Regression Analysis Summary for the Predictors of Sexual Communication

	WOMEN						MEN					
Variable	B	SEB	β	*p*	R^2	ΔR^2	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.006						0.022	
Age	-0.21	0.37	-0.084	0.575			-0.238	0.353	-0.133	0.507		
Years of Education	-0.307	0.476	-0.1	0.522			-0.078	0.39	-0.029	0.843		
Model 2					0.099	0.093					0.045	0.023
Number of Children in Life	-1.072	1.25	-0.119	0.398			-0.265	1.31	-0.04	0.841		
Length of Relationship	-0.079	0.027	-0.438	0.006*			0.008	0.024	0.046	0.729		
Model 3					0.122	0.023					0.209	0.164
Contraception Barrier	0.141	0.132	0.147	0.294			-0.159	0.088	-0.281	0.08		
Model 4					0.444	0.323*					0.485	0.276*
Relationship Commitment	0.574	0.2	0.444	0.008*			1.133	0.361	0.54	0.001*		
Relationship Satisfaction	0.278	0.345	0.148	0.426			0.109	0.286	0.059	0.705		
Model 5					0.464	0.019					0.528	0.043
Sexual Relationship Power	5.788	5.657	0.182	0.315			6.359	3.916	0.248	0.115		

*P<0.05.

Table 15: Hierarchical Regression Analysis Summary for the Predictors of Sexual Communication for Men

Variable	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.031	
Age	- 0.098	0.315	-0.053	0.757		
Years of Education Completed	-0.061	0.368	-0.022	0.869		
Time in U.S.	-0.499	0.371	-0.23	0.189		
Model 2					0.219	0.188*
Contraception Barrier	-0.197	0.09	-0.345	0.037*		
Model 3					0.529	0.309*
Relationship Commitment	1.253	0.357	0.595	0.002*		
Relationship Satisfaction	-0.042	0.283	-0.022	0.883		
Decision Making	-0.11	0.235	-0.07	0.962		
Model 4					0.555	0.027
Sexual Relationship Power	5.148	3.98	0.2	0.206		

*P<0.05.

Table 15: Hierarchical Regression Analysis Summary for the Predictors of Sexual Decision Making

	WOMEN						MEN					
Variable	B	SEB	β	*p*	R^2	Δ R^2	B	SEB	β	*p*	R^2	Δ R^2
Model 1					0.01						0.133	
Age	0.197	0.151	0.152	0.203			0.199	0.233	0.178	0.399		
Religious Commitment	0.172	0.063	0.315	0.011*			0.141	0.115	0.206	0.229		
Length of Stay in U.S.	-0.624	0.187	-0.432	0.002*			-0.029	0.276	-0.022	0.916		
Model 2					0.153	0.143*					0.286	0.153*
Marianismo	-12.599	1.796	-0.944	0.000*			4.4	2.324	0.321	0.069		
Model 3					0.73	0.577*					0.361	0.075
Communication	0.169	0.086	-0.217	0.06			0.289	0.261	0.238	0.276		
Relationship Commitment	0.539	0.095	0.719	0.000*			0.194	0.297	0.139	0.52		
Relationship Satisfaction	0.578	0.144	0.508	0.000*			-0.057	0.219	-0.046	0.795		
Model 4					0.751	0.021					0.364	0.003
Sexual Relationship Power	-5.487	2.316	-0.184	0.144			-0.91	2.692	-0.058	0.738		

*P<0.05.

Table 16: Hierarchical Regression Analysis Summary for the Predictors of Sexual Decision Making for Men

Variable	B	SEB	β	*p*	R^2	ΔR^2
Model 1					0.135	
Age	-0.059	0.222	-0.052	0.794		
Years of Education Completed	0.354	0.27	0.216	0.2		
Religious Commitment	0.179	0.104	0.261	0.096		
Model 2					0.206	0.071
Number of Children	1.952	0.877	0.438	0.034*		
Model 3					0.375	0.169*
Marianismo	5.395	2.157	0.394	0.018*		
Model 4					0.45	0.075
Communication	0.406	0.204	0.334	0.056		
Relationship Satisfaction	-0.224	0.213	-0.18	0.301		
Model 5					0.456	0.006
Sexual Relationship Power	-1.429	2.531	-0.092	0.577		

*P<0.05.

Appendix: A

Virginia Commonwealth University Institutional Review Board (VCU IRB) Research Plan

The following published research plan was submitted to and approved by the Virginia Commonwealth University Institutional Review Board.

Virginia Department of Health IRB Application

The following published research plan was submitted to and approved by the Virginia Department of Health Institutional Review Board.

IRB Approval Letters

VCU RESEARCH PLAN TEMPLATE

Use of this template is required to provide your VCU Research Plan to the IRB. Your responses should be written in terms for the non-scientist to understand. If a detailed research protocol (e.g., sponsor's protocol) exists, you may reference specific sections of that protocol. NOTE: **If that protocol does not address all of the issues outlined in each Section Heading, you must address the remaining issues in this Plan**. **It is NOT acceptable to reference a research funding proposal**.

ALL Sections of the Human Subjects Instructions must be completed with the exception of the Section entitled "Special Consent Provisions." Complete that Section if applicable. When other Sections are not applicable, list the Section Heading and indicate "N/A."

NOTE: The Research Plan is required with ALL Expedited and Full review submissions and MUST follow the template, and include version number or date, and page numbers.

DO NOT DELETE SECTION HEADINGS OR THE INSTRUCTIONS.

I. TITLE

Predictors of Communication and Sexual Decision Making among Latino Couples

II. RESEARCH PERSONNEL

A. PRINCIPAL INVESTIGATOR

List the name of the VCU Principal Investigator

Dr. Jacqueline M. McGrath

B. STUDY PERSONNEL

NOTE:

1. **Information pertaining to each project personnel, including their role, responsibilities, and qualifications, is to be submitted utilizing a *VCU IRB Study Personnel Information and Changes Form*. This form is available at http://www.research.vcu.edu/forms/vcuirb.htm.**
2. **A roster of all project personnel, including the principal investigator, medically responsible investigator, and non-VCU personnel, is to be maintained as a separate study document which is retained with the Research Plan, and is to be updated as necessary. This template document, entitled *VCU IRB Study Personnel Roster*, is available at http://www.research.vcu.edu/forms/vcuirb.htm.**

C. Describe the process that you will use to ensure that all persons assisting with the research are adequately informed about the protocol and their research-related duties and functions.

The PI will be closely working with the student and research assistant throughout the study. They will ensure to re
IRB plan, study forms, and other study documents thoroughly prior to initiation of study. In addition, the PI, the st
and the research assistant will go over the study procedure and conduct a trial run of the study prior to enrolling an
participants.

III. CONFLICT OF INTEREST

Describe how the principal investigator and sub/co-investigators might benefit from the subject's participation in this project or completion of the project in general. Do not describe (1) academic recognition such as publications or (2) grant or contract based support of VCU salary commensurate with the professional effort required for the conduct of the project

The researchers will not benefit from subjects participation or completion of this project.

IV. RESOURCES

Briefly describe the resources committed to this project including: (1) time available to conduct and complete the research, (2) facilities where you will conduct the research, (3) availability of medical or psychological resources that participants might require as a consequence of the research (if applicable), and (4) financial support.

The student is taking a dissertation credits under the PI's name (9 credits). This project is the student's dissertation. Facility to be utilized for recruitment and data collection include the Virginia Department of Health Richmond Healt District and CrossOver Ministry Clinic. Participants who seek additional contraception information will be given information about specific method by the study team, or referral will be given to the clinic staff, upon the completion the study. If intimate partner violence is indicated during the data collection, shelter, hotline, social worker referral a other necessary resources will be provided to the participants while ensuring his/her privacy.

V. HYPOTHESIS

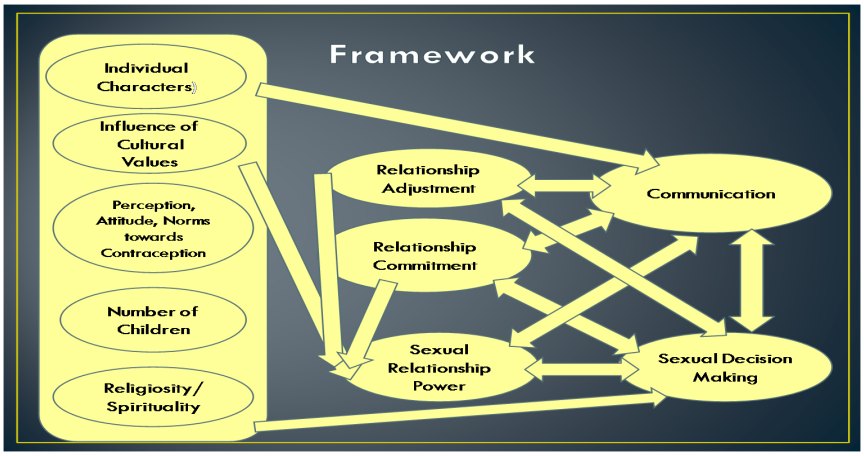
Briefly state the problem, background, importance of the research, and goals of the proposed project.

Latinos are currently the largest minority group in the United States (U.S.) (16% of the population){Burea #1} and are estimated to grow to 29% of the total U.S. population by 2050.{Center, 2008 #2} The Latino populati accounts for over half of the population increase between 2000- 2010 in the U.S. (15.2 million vs. 27.3 million).{C 2008 #2} Latinos in the U.S. have the highest birth rate among all races and ethnicities and the rate is expected to continue to rise.{Beureau, 2011 #3} Moreover, Latinos are experiencing an increase in the rate of unintended pregnancies.{Finer, 2006 #3} Unintended pregnancy (UP) is defined as a pregnancy that is considered either misti unwanted at the time of conception.{Brown, 1995 #4} UP negatively affect various aspects of health for both wom their infants. In general, women with UP are more likely to delay prenatal care{Cheng, 2009 #3} and as a result, pregnancy-induced conditions may not be adequately managed.{Evers, 2004 #3} Moreover, UP disrupts optimum spacing; both overly short and overly long birth intervals have been shown to negatively affect mother and infant h outcomes.(Conde-Agudelo et al., 2007; Fuentes-Afflick & Hessol, 2000) Some of the negative consequences of U include low birth weight and long-term developmental concerns (Bhutta et al., 2002). Therefore, preventing UP mi contribute to overall reduced physical and emotional burdens on families.

According to the World Health Organization(WHO), family planning (FP) refers to the ability of individua couples, through their own intent, to determine their desired number of children and the spacing and timing of thei (2011). There are several challenges associated with achieving optimal FP promotion such as facilitating the involv of couples and making FP resources accessible for couples.{Becker, 1998 #26} Despite the WHO definition of FP couples' process, FP interventions have traditionally been directed at women and this delivery method has been sh be unsuccessful (Becker, 1996; Kerns et al., 2003). However, sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) prevention intervention initiatives have focused on bringing couples together to dis these issues and these efforts have been shown to be effective (Harvey et al., 2009; Kraft et al., 2007). Considered tandem, these findings suggest that FP interventions might benefit from focusing on couples communication skills than targeting only women.

Couples' communication and decision making is affected by gender norms which are socially constructed make up the social context, self-concepts, beliefs, and expectations for behavior.{Potuchek, 1992 #29} Several s

have shown that open communication between partners about FP decision making increases contraceptive use.{Beck 1995 #30;Harvey, 2006 #8;Harvey, 2006 #31;Beckman, 2006 #95} Although the "Latina paradox" is a known phenomenon among first generation Latinas (i.e. first generation immigrant Latinas tend to have better birth outcome compared to second and third generation Latinas),{McGlade, 2004 #4} this finding does not preclude the importance improving FP communication in all Latino couples . Ambiguous FP communication, lack of FP decision making and irregular contraceptive usage could increase the risk of unintended pregnancies, which could lead to inadequate birth spacing and parenting difficulties.{El-Kamary, 2004 #2} Latina women are 1.35 times more likely to have unintende pregnancy compared to Whites.[{Finer, 2006 #5}] FP decision making conversations among couples should optimally begin before the initiation of sexual activity an continue throughout the couples' active s relationship. FP discussions facilitate cou open communication regarding their thou and feelings about this important issue, tl helping to promote healthy reproductive sexual lives for the couples. Furthermore couples' FP discussions have the potentia promote a sound family dynamic, since p teach their children by example. As such couples who engage in FP communicatio become role models for healthy relations for their children. Synchronizing the piec applicable in Latino couples' family plan communication and decision- making, the proposed study framework was designed using Fishbein's Integrative mod (which has been created by using components of the Theory of Reasoned Action, Social Cognitive Theory and Healt Belief Model){Fishbein, 2000 #12} and Harvey's structural model of condom use intention as well as the current literature, the framework for the current study is shown in Figure 1.The proposed study will test the associations of li variables and ultimately build a model to best illuminate interrelationships of the identified variables.



Individual personal factors, as well as the couple's relationship dynamic affect their FP communication and decision making in a complex manner. Individuals bring their own set of values to the relationship. Each couple creates its ow relationship dynamics that affects their FP communication style and decision making. Yet, sexual relationship power (SRP), defined as the ability or skill to influence or control another person's actions,[{Ragsdale, 2009 #74}] has the potential t change the dynamics in relationships. SRP may be affected by many factors, including: (a) the cultural values of mal dominance{Wood, 1997 #7} (the quality, state or degree of being masculine[{Dictionary, 2011 #6}]) and fatalism, which refe the degree to which people feel their destinies are beyond their control{Cuéllar, 1995 #1}); (b) attitudes and percepti towards contraception{Harvey, 2006 #9}; (c) religiosity/spirituality; (d) length of relationship; and (e) number of sha children; and, (f) number of children from previous relationships. Other factors that can influence couples communic and FP decision making are relationship commitment{Harvey, 2006 #9} and dyadic adjustment, which refers to how one adjusts for the other in a romantic relationship.{Spanier, 1976 #15} From this list of factors, it appears that UP prevention is a complex issue, involving multiple social and cultural elements. To date, there has been limited resear investigating factors related to FP decision making and communication among Latino couples, despite the consequer

VI. SPECIFIC AIMS

The following three aims of this study will be examined independently among men, women and couples.{Olson, 1 #32} Analyses of the couples' model will include both group differences and paired (couples) differences. Data an details will be discussed in greater depth in the Data Analysis section of the proposal. The specific aims of the stud

4. The first study aim is to determine predictors of sexual relationship power. Potential predictors include the cultural values of masculinity and fatalism), attitudes and perceptions towards contraception, religion/spiri demographic, personal and couple factors (i.e. age, education, length of relationship, relationship status, ar

number of children the couples have together and separately), relationship adjustment and relationship commitment.

a. Hypothesis 1: Higher scores on the masculinity scale predicts lower sexual relationship power.
b. Hypothesis 2: Number of completed years of education predicts sexual relationship power as follows
    i. Greater number of completed years of education by the male partner predicts equal se relationship power.
    ii. Lesser number of completed years of education completed by the male partner predict higher sexual relationship power for males.
    iii. Greater number of years of education completed by the female partner predicts higher sexual relationship power for females.
c. Hypothesis 3: The greater the number of children couples have together predicts increases in women sexual relationship power.

5. The second aim of this study is to explore which demographic/personal factors and relationship variables pre communication. Potential predictors are demographic/personal factors (i.e. age, education completed, numbe children together, women's number of children, length of relationship, marital status); degree of dyadic adju and relationship commitment; and sexual relationship power.
    a. Hypothesis 4: There is a significant relationship between the degree of dyadic adjustment and communication.
    b. Hypothesis 5: After controlling for or eliminating significant demographic/personal factors, the degr dyadic adjustment or relationship commitment, sexual relationship power still predicts communicati
6. The final study aim is to examine which demographic/personal factors and relationship variable/s predict sex decision making. Potential predictors are demographic/personal factors (i.e. age, education completed, numb children together, women's number of children, length of relationship, relationship status), degree of dyadic adjustment and relationship commitment and sexual relationship power.
    a. Hypothesis 6: Greater number of completed years of education by the male partner predicts higher decision making scores.
    . Hypothesis 7: An increase in the number of children couples have together predicts an increase in de making score in women.
    c. Hypothesis 8: After controlling for or eliminating significant demographic/personal factors, degree c dyadic adjustment and relationship commitment, sexual relationship power still predicts sexual decis making.

VII. BACKGROUND AND SIGNIFICANCE

Include information regarding pre-clinical and early human studies. Attach appropriate citations.

Unintended Pregnancy and Family planning approach for Latinos

Importance of Unintended Pregnancy Prevention.

Latinos in the U.S. have both high fertility and high unintended pregnancy rates.(U.S. Census Beureau, 20 Finer & Henshaw, 2006) Unintended pregnancy is defined as a pregnancy that women consider either mistimed or unwanted at the time of conception.{Brown, 1995 #4} Unintended pregnancy has various deleterious effects on th of mothers, infants, and families. Women with unintended pregnancies tend to delay prenatal care which, in turn, c their receiving support and education for any pregnancy-induced conditions, including diabetes, hypertension and hyperphenylalanemia.{Conde-Agudelo, 2007 #5;Fuentes-Afflick, 2000 #4;Evers, 2004 #3;Cheng, 2009 #3} More women with unintended pregnancies are less likely to engage in appropriate behavior modifications such as smoki cessation and withdrawal from alcohol, illegal drugs or other medications Additionally, women experiencing unint pregnancies may have failed to obtain HIV testing prior to their pregnancies. Failure to recognize HIV status may l detrimental to the fetus if appropriate HIV treatment is delayed. Women with unintended pregnancies may also be immunized, especially against rubella, placing their infants at further risk.

The Latina paradox has been observed in Latinas who are less acculturated. Acculturation is defined as cul modification that occurs by adapting to another culture.{Dictionary, 2011 #9} Latina paradox is defined as follow

Latinas who are less acculturated have been reported to have more favorable birth outcomes than the general Americ population with the same economic status and little or no prenatal care.{McGlade, 2004 #4} Even though Latina par is observed among less acculturated Latinas, instead of leaving them alone, the health care providers should take adv of their entries to medical care during prenatal period and use them as opportunities to reach the population. Regardl their legal status, Latinas tend to seek out pregnancy-related health care services, even though they may forego regul medical services or other public programs.{Geltman, 1999 #2} Less acculturated persons typically do not have medi insurance, primary care providers, and preventative health care.{Pearson, 2008 #5} Thus, Latino couples are likely t seek out preventative services such as family planning, where they could learn ways to promote communication and decision making. However, reaching less acculturated Latino couples in communication and FP decision making assi increasing quality of life as a family. It can prevent inadequate birth spacing and repeat rapid unintended pregnancies parenting difficulties that may arise sooner or later in their family lives.{El-Kamary, 2004 #2} Fuentes-Afflick and Hessol{Fuentes-Afflick, 2000 #4} found that birth intervals between 18-59 months are associated with the lowest ri prematurity, while Zhu and Le{Zhu, 2003 #9} found that inter-pregnancy intervals between 18-23 months result in t lowest risk of low birth weight infants. Inadequate birth intervals have also been correlated with uterine rupture durir vaginal delivery after a previous cesarean section.{Fuentes-Afflick, 2000 #4} An overly long birth interval increases risk of preeclampsia and labor dystocia.{Conde-Agudelo, 2007 #5} Both overly-short and overly-long birth intervals associated with risk of low birth weight (LBW), which has been shown to contribute to the risk of higher infant morb and mortality.{Fuentes-Afflick, 2000 #4}

Ideally, every childbearing woman should receive preconception care. In 2005 the National Summit of Preconception Care (a collaboration of the Center for Disease Control [CDC] and 35 partner organizations) defined preconception care as "a set of interventions that aim to identify and modify biomedical, behavioral, and social risks woman's health or pregnancy outcome through prevention and management."{Johnson, 2006 #11} However, even th preconception care considers various aspects of women's lives, research related to Latino preconception care has pri focused on folic acid intake.{Yang, 2007 #12;Kannan, 2007 #13;Perlow, 2001 #14} While this emphasis is importan given that Latino infants are 1.5 to 3 times more likely to be born with neural tube defects than other ethnic groups ir US,{Hendricks, 1999 #15} other aspects of care have not received as much attention. In particular, the prevention of unintended pregnancy and family planning decision making have received little attention. According to the WHO{Organization, 2011 #3}, family planning "implies the ability of individuals and couples to anticipate and attai desired number of children and the spacing and timing of their births." Family planning not only includes the use of conventional contraceptive methods to control unintended pregnancies, but also is aimed at promotion of couples' discussion regarding this matter, introduction of the couple to available pharmacological and non-pharmacological methods to prevent pregnancy (including ovulation method, withdrawal, abstinence or surgical sterilization), and gui to couples about how to choose and use methods of their choice.

Latino Family Planning Intervention - Past, Present and Future.

Family planning services have traditionally been delivered to women only. Yet, the women-only approach ha been shown to be successful.(Becker, 1996; Kerns et al., 2003) Moreover, it is difficult for Latina women to be proac and assertive with men about reproductive choices because 'machismo' is a traditional cultural norm. In 1994, confe leaders at the International Conference on Population (ICPD), recommended "gender equality in all sphere's of life, including family and community life, and encouraged men to take responsibility for their sexual and reproductive be and their social and family roles."{ICPD., 1994 #33} Since these recommendations, research efforts have increasingl focused on the importance of men's involvement in reproductive health matters.(Becker, 1996; Becker & Robinson, Kang-Kim et al., 2008) Studies have shown the importance of couple communication in the area of contraceptive compliance. Kerns et al. {Kerns, 2003 #28} conducted a study in which Latina women took oral contraceptives without disc usage to their partners and found that the probability of discontinuing oral contraceptives was significantly higher wh they were taken without their partners' awareness. Another study showed that the biggest barrier to Latina teenagers' contraceptive compliance was partner disapproval.{Romo, 2004 #35} Teenage Latina mothers also experience socia pressure to continue having children even if the young women do not desire more. Partners use children as a way to control the teenage mothers' ability to engage in other activities, such as returning to school.{Erickson, 1994 #16} In another study, men perceived women's use of modern contraceptive methods as a way to be flirtatious.{Sable, 2006 Only a few heterosexual couples' intervention exist for HIV/STI prevention purposes. Some research has shown that bringing couples together to discuss ways to prevent HIV/STI has positive effects on consistent condom use and the

effective use of other contraception methods.(Harvey et al., 2009; Kraft et al., 2007) Other research study tested the efficacy of a HIV prevention intervention on a control group (women-only) vs. a couples intervention group. There v difference in the self-protective behavior improvement among the women-only group (control) and couple interventi group (both group showed improvement).{El-Bassel, 2003 #24} However, the authors believed that women-only gro improved as well as the couples' group because their sessions focused greatly on couples communication and empha how to apply what they learned in class during their interactions with their partners.{El-Bassel, 2003 #24} Thus, it a that involving couples together to promote communication about reproductive behaviors would be a promising strate couples' family planning. Kraft et al.'s and Harvey et al.'s control group had HIV/STI as well as unintended pregnan prevention content during the lesson. Their intervention group was heavily focused on improving couples' communi skills. The intervention by El-Bassel et al. focused soley on HIV prevention, however, the women-only and couples' contents were heavily focused on improving relationship communication, negotiation and problem-solving skills. Bo their study populations were 50% Hispanics. Due to the fact that communication was emphasized in these interventi there are some overlapping focal points that can easily be applied to family planning communication. However, there also contraception methods that can be initiated only by woman, if she decides not to disclose such information to he partner. This covert use of contraception is not commonly presented with HIV prevention efforts since common meth for HIV prevention do not allow for covert use. While there have been only a few couples interventions examined, t has not been a study identifying key factors of Latino couples' FP communication. Examining the predictors of FP communication and decision making may reveal possibilities for approaching this sensitive topic in an innovative wa inform effective interventions to reduce unintended pregnancies in Latino couples.

Sexual Decision Making and Communication

Couple decision making and the importance of gender

Decision making between couples cannot be explained without describing the influence of gender. Gender is socially constructed and embedded in social context, defining self-concepts, beliefs, and expectations for behavior.(D & Major, 1987; Potuchek, 1992) Therefore, gender perspective builds on how individuals perceive what is appropria inappropriate in their interaction with others.{Zvonkovic, 1996 #40} Duaux and Major's model of social interaction gender-related behavior illustrates how the perceiver receives a message and interprets based on her gender belief. Th she acts according to her gender related beliefs. Moreover, the action is modified depending on the perceiver's socia desirability, certainty of influence towards the person with whom she interacts, and the context of the situation.{Dea 1987 #36} This model explains how gender-related beliefs influence everyday actions. Zvonkovic{Zvonkovic, 1996 conducted a study on married couples' job and family decision making and observed that males often dominated the decision making process. Moreover, even though some couples were said to have equal power in decision making, th actual measures of influence leaned towards the husbands' preference. Zvonkovic concluded that gender power in marriage is consistent with the traditional cultural value of male dominance. Yet, the influence of gender in marriage always clearly recognized within couples.{Zvonkovic, 1996 #40} Mbweza et al.{Mbweza, 2008 #3} examined decis making processes among Malawian married couples. They found two core categories of decision making processes: final decision making approach (husband-dominated, wife-dominated and shared); and (b) decision making rationale (gender-based and non gender-based cultural script). Gender-based cultural scripts emphasize sources of power over partner whereas non-gender-based cultural scripts focus on more equal power and shared decision making. Even thou couples were recruited from two distinct tribes with patrilineal and matrilineal traditions, more than 66% of the samp couples used all three final decision making approaches depending on the situation and goals.{Mbweza, 2008 #3} It apparent that gender-related beliefs have deeply affected how couples interact, sometimes rather unconsciously, beca gender is an ingrained societal norm to which the members of the society are exposed to from birth.

Couple communication and contraceptive/FP method use

While the strong influence of gender in couples' interaction exists, open communication within couples is encouraged to promote shared decision making.{Zvonkovic, 1996 #40;Mbweza, 2008 #3;Blanc, 2001 #41} In fact, a different cultures, health protective communication between partners has been shown to be associated with contracep use.(Harvey et al., 2009; Salway, 1994) However, Blanc{Blanc, 2001 #41} notes that couples' conversations regard reproductive health are infrequent due to gender-based power inequality, particularly among couples from developin countries,. This is a notable finding given our interest in understanding the predictors of communication and decision making in relation to relationship power (ability to influence another person's actions){Ragsdale, 2009 #74} within I

couples. There are also community interventions that positively promote men's communication about reproductive h matters (Lundgren, 2005). Such initiatives to involve men in the reproductive health arena have been tested on a sma scale mostly in developing countries.(Becker, 1996; Sternberg & Hubley, 2004) However, men's involvement in fam planning and other reproductive health matters still requires improvement to become a mainstream approach. Rather, women are generally provided with contraceptive methods without meaningful discussions about sexual matters. If h partner is present the woman may be unwilling to ask questions because doing so may be perceived by her partner as suggesting that she might be considering promiscuous behavior.{Wood, 1997 #7} Ironically, having frequent family planning discussions are a significant predictor of contraceptive use.[14] Studies have shown that intervening with coup an effective way to promote participation in contraceptive decision-making(Becker, 1996; El-Bassel et al., 2003; Har et al., 2009; Kraft et al., 2007)

Existing theories and concerns in counseling and working with couples

An emphasis on equal participation of women and men in reproductive health was the focus at the 1994 International Conference on Population and Development (ICPD). Reproductive health includes family planning, prevention of STI including HIV, and unintended pregnancy. The conference program of action stressed the importa improving communication between men and women in reproductive health with a focus on joint responsibilities.{IC 1994 #33} In 1996, Becker, in a critical review of reproductive health studies, acknowledged few experimental studi the area of couples' interventions even though the studies reviewed showed the effectiveness of "couples" interventi family planning as well as HIV prevention.{Becker, 1996 #27} Studies included in the review demonstrated a signifi difference in couples' rating of their partners' perceptions (less than 60-70% accuracy).{Becker, 1996 #27} Addition several studies used wives' proxy reports of their husbands' perceptions, even though this approach is often inaccura Becker{Becker, 1996 #27} proposed the importance of developing a conceptual framework for individuals and coup reproductive decision making and their reproductive health behaviors. His 1995 unpublished conceptual framework incorporates individuals' background, resources, attitudes, and couples' communication and places couples' reprodu health behavior as an outcome variable.{Becker, 1995 #30} Couples' communication about reproductive health beha is a critical component of the framework. Only a few studies have focused on factors associated with effective contraceptive use in Latino populations. In those studies, the length of relationship,{Harvey, 2006 #8;Harvey, 2006 #31;Beckman, 2006 #95} decision-making involvement on contraceptive use,(Harvey & Henderson, 2006; Harvey, 2006) and partner discussions about contraception were all found to be significant variables.(Beckman, et al., 2006; Harvey et al., 2006) Harvey et al. , in 2006, developed a model of women's condom use intentions based on Fishbein Integrated Behavior Change Model and Information-Motivation-Behavioral Skills (IMB) Model of HIV/AIDS Risk Reduction with interpersonal and relationship factors on contraceptive use.{Harvey, 2006 #9} As a result, three exog constructs (HIV information heuristics, commitment, and duration of relationship) and four as mediating factors (per vulnerability, attitudes, condom use decision making, and partner norms) were found.{Harvey, 2006 #9} This model addresses interpersonal factors regarding the intention for condom use from the perspective of young women and is u in understanding perceptions of what affects the intention for condom use and perhaps other contraceptive methods. However, the model was developed from a woman's perspective and is not specific to communication between partn contraceptive use. One other study used a health behavior change model-based HIV/STI prevention intervention and found that condom use increased at follow-up times in both intervention and control group by bringing couples toget and providing contraception education (no difference was found between standard of care group versus. risk reductio intervention group).{Harvey, 2009 #2}

Various other models and theories have been used to encourage healthy reproductive behavior choices. Thes include social cognitive theory and motivational interviewing. Agnew addresses a concern that these theories may no with couples' interpersonal behavior, since two people must be involved in the prevention of unintended pregnancy.{Agnew, 1999 #25} Again, contribution of both partners is essential to its prevention. Although research findings emphasize the importance of couple interventions, the factors that affect couples' communication has not be fully explored among Latino couples. This study will examine those factors that affect couples' communication and s decision making.

Important factors in communication and sexual decision making

Sexual Relationship Power

Sexual relationship power is defined as the ability to influence another person's actions related to sexual behavior.{Ragsdale, 2009 #74} The theory of gender and power and the social exchange theory both can help to illu the concept of sexual relationship power. The theory of gender and power explains how gender inequality results fro gender norms that are socially constructed.{Cornnell, 1987 #122} The social exchange theory shows how relationshi power depends on three variables: (a) the degree to which a person feels dependent on his or her partner; (b) the amo resources available; and (c) any alternatives that exist outside of the relationship.{Emerson, 1981 #123} As explaine the previous sections, both gender and the partner power dynamic play a critical role in sexual decision making.{Zvonkovic, 1996 #40;Mbweza, 2008 #3;Blanc, 2001 #41} Greater sexual relationship power is associated v protective sexual behaviors, most notably, consistent condom use for HIV prevention and higher self-efficacy for pa condom negotiation.(Cromwell & Olson, 1975; Salway, 1994) Due to the associations between sexual relationship p and sexual behaviors, sexual relationship power is also considered a key factor in other relationship- and sexual beha related variables, including couples' communication and sexual decision making.

Relationship Commitment

Rusbult{Rusbult, 1983 #14}, who proposed the investment model of relationship commitment and stability defines commitment as the tendency to maintain relationships and feel psychologically attached to them. According t Rusbult{Bui, 1996 #13}, relationship commitment predictors include relationship satisfaction, quality of the alternati that exist outside of the current relationship and investments in the relationship. This tested model has demonstrated commitment predicts relationship stability logituginally (Bui et al., 1996; Impett et al., 2001). In a related study, Har al.{Harvey, 2006 #9} tested a conceptual model for women's intention to use condom during intercoursewith their m partners in relation to partner dynamics. It showed that women's relationship commitment is associated with increase participation in condom use decision making and higher perceived partner norms for using condom. The findings fro these two studies support the idea that relationship commitment leads to a range of positive outcomes including, relationship stability and increased condom use decision making.

Dyadic adjustment

Spanier{Spanier, 1976 #15} states that dyadic adjustment is the best indicator for marital quality and how w marriage is functioning. Dyadic adjustment is a widely studied concept because of the wide range of topics it covers the possibility it provides for both understanding and improving relationships. The relationship between communicat style (when discussing relationship problem) and dyadic adjustment has been examined, and there is evidence showi the association between communication and dyadic adjustment is stronger for women than for men.{Gordon, 1999 #19}'{Litzinger, 2005 #11} This may be due to women being more sensitive towards dyadic adjustment and communication. Or it may be because women prefer and feel fulfilled by talking more than men. These studies were specific to a Latino population. Li and Caldwell{LI, 1987 #20} found that sex-role attitudes influence dyadic adjustn as follows: husbands' egalitarian views related to their wives was associated with higher dyadic adjustment, while n egalitarian views were associated with lower dyadic adjustment. The study population was mostly Caucasian (>90%) highly educated (>70% graduated from college).{LI, 1987 #20} Associations between dyadic adjustment and sexual relationship power, communication, and sexual decision making have not been examined in the literature to date. Oth factors that may affect communication and decision making in Latino couples include: 1) individual factors, such as education completed, socioeconomic status (SES) and residence; and, 2) influential Latino cultural concepts such as machismo and fatalismo. Each component is discussed below in relation to Latino couples' unintended pregnancy prevention, sexual decision making, and communication.

Individual characteristics and Latino's cultural concepts Cultural characteristics and ethnic background have influence on gender dominance, family dynamics and ultimately, sexual decision making. Cromwell and Olson{Cromwell, 1975 #124} state that power is composed of three elements: (1) th bases of power, which are comprised of various resources including, money, employment and physical attractiveness the processes of power, which refers to types of interactions such as persuasion, assertiveness and problem solving: a the outcomes of power, including whose decision becomes the final one, and who makes the important decisions. Ba the individual's resources, partners use power within discussions to negotiate and make decisions. However, there is research suggesting that husbands who are more educated and formally employed tend to encourage shared decision making.{Mbweza, 2008 #3} Conversely, male partners were found to dominate decision making when they had less secondary school education, were in a lower SES, and/or were from a rural area.(Forrest & Frost, 1996; Mbweza et a

al., 2008; Speizer et al., 2005) This behavior can be explained by the concept of "machismo" (masculinity). The conc "machismo" is one of the most prominent Latino male characteristics. "Machismo" is a social behavioral pattern fou Latino males in which they demonstrate a dominating attitude to those inferior to them and demand subordinance. La men tend to express stronger "machismo" (masculinity) when they grow up with limited resources. In contrast, it ha found that Latinas feel more powerful when they supply valuable resources for the family,{Pearson, 2008 #5} experi some economic independence,{Becker, 2006 #43} have completed a higher level of education, and/or were physicall more attractive.{Harvey, 2002 #101} Given these culturally influenced gender characteristics, males are often more dominant in decision making in the areas of reproductive health as well as household matters (Amaro, 1988). In the a reproductive health, studies have shown that women demonstrated limited assertiveness about sexual practices and condom use (Gómez & Marín, 1996; Wood & Price, 1997). Tradition dictates that Latinas should not speak to men a sexual matters and preferences because these behaviors may be seen as promiscuous (Chavira-Prado, 1992). Cultural women are expected to demonstrate "marianismo", which means being like Mary (the mother of Christ) by performi dutiful mothers and wives.{Wood, 1997 #7} These traditional views of male and female roles are strongly held in the Latino population.{Chavira-Prado, 1992 #128} Thus, women find it difficult to actively participate in or initiate fami planning decision making.{Gómez, 1996 #10} However, it has been found that generally, Latina women actually bec less supportive of male-centered decision making as the number of children in the household rises, which may be du their increased interactions in the healthcare environment as a result of multiple pregnancies as well as their increase responsibilities in the home.{Agnew, 1999 #25}

"Fatalismo", or fatalism, is another cultural concept among Latinos. It refers to how much people feel that th destinies are beyond their control.{Cuéllar, 1995 #1} Fatalism, also referred to as powerlessness, is linked with Latin negative health outcomes and their ability to change their lifestyles to adopt healthy behaviors.{Torres, 2003 #11} Attitudes and initiative towards taking an active role in family planning may run counter to this belief. Most Latinos traditionally influenced by Catholic Christianity in their home countries. The influence of religion and spirituality on health among Latinas has been studied in the context of acculturation. Religiosity/spirituality has a significant negati association with acculturated young women of their prenatal and postpartum stress.{Mann, 2010 #2} Other research examined the relationships between religiosity, contraceptive use and individual factors and found that religiosity an years of education are associated with family size. However, they are not associated with contraceptive use.{Romo, #35} On the other hand, religiosity of Latinos may contribute positively to health. The degree to which religion and spirituality may affect Latinos' daily lives and couples' communication and sexual relationship power has not yet bee explored. Hill et al.{Hill, 2000 #4} distinguish between religiosity and spirituality as follows: spirituality refers to the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred, whereas religiosity is (a) the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred, AND/OR (b) a search for non-s goals, such as identity, belongingness, meaning, health, wellness in a context that has as its primary goal the facilitati (a), AND (c) the means and methods (e.g. rituals or prescribed behaviors) of the search that receive validation and su from within an identifiable group of people. From these definitions, spirituality seems as if it is a narrower concept, v religiosity is combination of the three factors mentioned above. Furthermore, religiosity identifies spirituality in combination with people's actions. And it tends to be more focused on specific activities people do to reflect their spirituality.{Campesino, 2006 #3} As such, religiosity may be a better reflection of what should be captured as an understanding of relationship between religiosity, couple communication, and sexual decision making.

Summary

Unintended pregnancy contributes to many negative consequences for families and, as such, should be kept t minimum. However, various factors affect Latino couples' communication and decision making about family planni including relationship power, relationship commitment, dyadic adjustment, individual background, and cultural characteristics. Little is known about how those factors interact to affect communication and decision making among Latino couples to better approach this sensitive issue. Therefore, there is a need to investigate the predictors of communication and sexual decision making so that we can understand how those factors relate to each other. In this we can design interventions to decrease unintended pregnancies and increase the quality of family lives within the La community. Decision making conversations among couples should optimally begin before the initiation of sexual act and continue throughout the couples' active sexual relationship. Couples communication facilitates making each othe will and thoughts known and helps to promote healthy reproductive and sexual lives. The proposed study will focus Latino couples by having both partners complete questionnaires exploring these topics. Partner responses will be con

and contrasted as a beginning step in this much needed trajectory of research.

VIII. PRELIMINARY PROGRESS/DATA REPORT

If available.

The researcher is conducting a pilot study titled "LATINAS' CONTRACEPTION EXPERIENCE AND PLANNING (L the proposed recruitment site (Richmond City Health District [RCHD]). The purpose of this pilot study is to obtair information from Latinas in their third trimester about contraception perception, experience and planning process a about the pregnant Latina population in the RCHD. Twenty women participants are anticipated. Each woman will demographic information (age, country of origin, length of relationship, number of pregnancy and birth, intention t continue relationship with current partner [father of the baby for this pregnancy after delivery]) and to fill out the bidimensional acculturation scale and sexual relationship power scale. In addition, interviews will be conducted wi participants to inquire about their previous experiences with contraception, their readiness for contraception planni delivery, and communication about contraception with their partners. Interviews are conducted in Spanish or Engli depending on the preference of the participant. All the interviews thus far have been conducted in Spanish. Descrip statistics will be obtained from the demographic information as well as from the two questionnaires. This study hel learn the characteristics of the population in the clinic. The interviews are recorded, transcribed and analyzed using content analysis technique. The researcher has been learning about the logistics of the recruitment at the RCHD fro pilot study. The analysis is still in progress.

IX. RESEARCH METHOD AND DESIGN

Include a brief description of the project design including the setting in which the research will be conducted and procedures. If applicable, include a description of procedures being performed already for diagnostic or treatment purposes.

A descriptive study of 40 heterosexual Latino couples whose female members are in the second or third tr of their pregnancies is proposed. Recruitment will take place from maternity clinics at the Virginia Department of (VDH), Richmond City Health District (RCHD), the CrossOver Ministry Clinics (please see Appendix A: Letters Support) and by word of mouth with pregnancy verification. The researcher will conduct a chart review to identify potential female participants. She briefly will describe the project to potential participants. Screening questions wil posed in a private location to determine eligibility. At this initial meeting, the researcher will explain the project in answer questions, and obtain consent from adults, if both partners of the couple are present in the clinic. If only fer partners are in the clinic, the study team will ask the women if they would be willing to speak to their spouses abou study, so that follow up can occur. Flyer will be given to aid in informing her partner about the study (please see A B). The study team (doctoral student [bilingual] and a bilingual Latino male research assistant) will visit the potent couples (with their permission) at their preferred location to explain further the study and obtain consent for partici (please refer to Appendix C: Informed Consent Form). Self-report measures will be obtained at the time of data co Paper forms will be used. These forms are written in English and Spanish, as are the consent documents. Some me are available both in Spanish and English. However, those that are not available in Spanish as well as informed cor form are translated and back translated using American Academy of Orthopaedic Surgeons' Institute for Work & H Guideline.{Beaton, 2002 #25} Two bilingual people whose native language is Spanish translate the English docun into Spanish. A bilingual moderator whose native language is also Spanish compares translations done by two peo synthesizes the documents into one. If questions arise, she contacts the original translators. Then, two bilingual pe whose native language is English back-translate the synthesized document into English. Another moderator whose language is English compares the back-translated documents to the original document to make sure that the conten accurately translated. Again, if question arise, she goes back to back-translators for clarification. At the end, the tra documents are administered to the population very similar to the target population of the study. After administering measures and explaining the consents, each individual is interviewed to probe what they thought the questions mea ensure its equivalence on the target population of this study. When completing the study measures, assistance by th team will be available if a participant prefers the questions be read to them or if they require clarifications about th

questionnaires. The researcher also will review the medical chart for data to determine the history of the female's pregnancies and current gestational age. Participants will be provided a $20.00 incentive per couple for their time an effort. Total time required for participation by each participant within the couple will be approximately 1 hour.

Questionnaires

Once informed consent is obtained, several measures will be obtained during a routine prenatal visit or at oth locations convenient for the couples. Paper and pencil measures will be given to each member of the couple individu Please refer to Table 1 for the list and details and study measures in Appendix D.

Personal Factor/ Demographic Information: Descriptive information will be collected on a demographic informat form including such items as length of stay in the U.S., length of relationship, the number of pregnancies and birth (v and without current partner), income, job status, education completed, religious preference and if provider has spoke the participants about postpartum contraception. At the end of all the questionnaires, a question is asked about their intention for postpartum contraception use and method they prefer.

Screening questions will address current gestation of this pregnancy, potential participants' age, country of origin, preferred language, partner status, intention to stay together after baby's birth and staying sexually active, and report sterilization procedure. Instruments are slightly different for female and male participants.

Sexual Relationship Power Scale (SRPS): This scale was created by Pulerwitz, Gortmaker and Dejong, because of need to quantify sexual relationship power that was deemed to be an important factor in HIV prevention (condom negotiation) and other sexual health protective behaviors for women.{Pulerwitz, 2000 #106} The SRPS consists of t subscales; relationship control subscale (RCS) (fifteen items), and decision making dominance subscale (DMDS) (ei items). The present study only uses the RCS subscale due to an overlapping concept between the decision making dominance subscale and the sexual decision making scale. The RCS uses a 4-point rating scale of 1=strongly agree t 4=strongly disagree and asks questions of how her partner reacts to various daily and sex-related behaviors.{Pulerwi 2000 #106} The higher scores represent higher sexual relationship power. The possible minimum score of the RCS i and the maximum score is 60. The scale was first tested for its validity and reliability with Latina women and other minority women. The RCS has good internal consistency (alpha= 0.85 and 0.89for English and Spanish, respectively).{Pulerwitz, 2000 #106} Construct validity was tested and showed an expected correlation between the and each background characteristics and condom use. The SRPS has been used with variety of populations in a broa range of topics such as sexual risky behavior, HIV, STI, and family planning as well as intimate partner violence and sexual dysfunction. (Lau, et al., 2006; Pulerwitz, et al., 2002; Ragsdale, et al., 2009; Teitelman, et al., 2008) In addition, the scale has been investigat various parts of the world from the U.S.A., Spain, South Africa, Thailand to China.{Ragsdale, 2009 #74}.{Dunkle, 2007 #98;Rasamimari, 2007 #97;Bermudez, 2010 #112} Even though the scale was originally developed for women, there have been studies administered the SRPS to men after appropriate modifications. For this study, wording will be appropriately change the scale will be administered to both male and female partners.

Machismo Scale: This scale measures "machismo", male dominance, one of the important cultural concepts among Latinos.{Cuéllar, 1995 #1} Cuellar et al. developed the scale along with other cultural value scales (e.g.fatalism) to s cultural constructs of Mexican Americans.{Cuéllar, 1995 #1} The original Machismo scale employs 17 items and co of True/False answer format. A higher machismo score represents a stronger belief of machismo. The original intern consistency was an alpha of 0.78.{Cuéllar, 1995 #1} Harvey modified the scale to 5-point rating scale from 1=do no at all to 5=completely agree. The internal consistency of her data was an alpha of 0.89 (men and women combined; r alpha=0.89; women, alpha=0.86).{Harvey, 2011 #52} The scale has been widely used and found to have evidence fo estimated internal consistency in mental health areas (i.e. from Depression in Latino adolescents [alpha=0.82]){Cesp 2008 #8} to legitimacy in hate crime [alpha=0.75]).{Dunbar, 2004 #9}

Marianismo Beliefs Scale: This scale is a 24-item scale that consist of five factors (family pillar, virtuous and chast subordinate to others, silencing self to maintain harmony, and spiritual pillar) per exploratory factor analysis with eigenvalues greater than 1.00.{Castillo, 2010 #16} Confirmatory factor analysis showed a adequate fit for 5-factor m Internal consistency of each of the five factor is 0.77, 0.79, 0.76, 0.78 and 0.85.{Castillo, 2010 #16} The instrument employs 4-point rating scale, and exists both in English and in Spanish.

Fatalism scale: This is an 8-item scale to measure the cultural concept of "fatalismo", fatalism. This scale was also d by Cuellar et al. as a part of the multiphasic assessment of cultural constructs.{Cuéllar, 1995 #1} Fatalism is about h much people feel that their destinies are beyond their control.{Cuéllar, 1995 #1} Respondents answer each statement true or false, higher scores indicate higher belief in fatalism. The original article (scale development) states that the i consistency of the fatalism scale was an alpha of .63.{Cuéllar, 1995 #1} Fatalism has been studied among Latino population with fair internal consistencies from cancer screening (alpha, not reported),{Randolph, 2002 #11} and m health disorders (alpha=0.75){Greenwell, 2009 #12} to academic attitudes and achievement (alpha=0.63){Guzman, #13}, because of its psychological effects on those behaviors. Fatalism is not associated always with the outcomes de in previous studies (i.e. fatalism did not have significant effect on pap smear use among older women). However, it h been studied in the context of pregnancy and family planning. For this study, we will be using 5-point rating scale to consistent with the other scale (machismo scale).

Dyadic Adjustment Scale-7 items short form (DAS-7): DAS was created by Spanier due to lack of a precise measurement for marriage quality.{Spanier, 1976 #15} It has been used widely in research to measure couples' quali terms of their relationship in various contexts, such as when a partner has chronic illness,{Zhou, 2010 #44} or couple have children that are ill.{Benzies, 2004 #45} The original scale consisted of 32 items, however a 7-item DAS has b created and validated because of the need to identify quickly dyadic adjustment scores. The 7-item DAS has alpha o and the means correlate with the relationship status of couples (happily married vs. divorced).{Sharpley, 1984 #16} Hunsley et al. also showed that the 7-item DAS has good reliability (female alpha=0.84, male alpha=0.79, and overal alpha=0.82) and similar correlations when compared with the DAS vs. other marital measures and DAS-7 vs. other m mesures.{Hunsley, 1995 #18} Therefore in the present study the researcher will use the 7-item scale to minimize the burden of the participants, while not compromising the quality of the measures obtained. DAS-7 asks about agreeme values and time spent between couples, as well as overall satisfaction with the relationship with the partner. The poss score is 0 to 36, and higher scores indicate higher relationship quality. Youngblut, Brooten and Menzies have tested t Spanish translation of the DAS (*C*ronbach alpha 0.67 to 0.93; Paired t-tests showed that the similarity was high betw the English and the Spanish versions of DAS [0.79 to .87]), however the study was done with the 32-item, not the 7-i version.{Youngblut, 2006 #47} No studies have reported validity and reliability of the Spanish version of DAS-7. Sp version of the scale has been obtained from Youngblut et al.

Communication with partner scale: This measure captures the general communication among members of a coupl daily basis. It is comprised 13 of items, and respondents answer what they do and how they perceive communication their partners from "almost always" to "almost never". The higher score indicates better communication between cou This scale is a part of the Couples Pre-Counseling Inventory (CPCI) created by Stuart in 1973 and revised in 1983.{S 1987 #50} CPCI consists of 13 sections. The CPCI has been used in clinical settings to identify therapy goals as well being employed in research settings.{Mostamandy, 2003 #48} Validity and reliability of a subsection of the CPCI ar available. However, overall alpha of the inventory is 0.91.{Mostamandy, 2003 #48}

Dyadic Sexual Communication Scale: This scale measures quality of sexual communication and consist of 13 item This scale asks more specific questions about communication related to sexual matter rather than communication sty (mentioned above). Both scales are used for this study. It uses 6-point Likert scale of 1=disagree strongly to 6=agree strongly. This scale has been used in high risk STI/HIV population (i.e. minority, young people and men have sex wi men).{Catania, 1998 #51}

Sexual Decision making: This is a 12-item scale that measures the participation/involvement of sexual decision mak with the partner. Participants respond to the degree of involvement with a 5-point rating scale from 1=not at all to 5= great deal. The minimum score is 12 and the maximum is 60. The scale was developed by Marie Harvey's research team,{Harvey, unknown #49} and the internal consistency was 0.82 (men and women combined; men, alpha=0.84; women, alpha=0.78).{Harvey, 2011 #52} She and her team examine HIV/STI prevention for immigrant Latino popu The team has given us permission to use the tool. It is available both in English and Spanish.

Relationship Commitment: This 16-item scale also has been developed by Harvey's research team,{Harvey, unkno #49} who does HIV/STI prevention for immigrant Latino population. The scale measures how much each person is committed to the existing relationship with the current partner. Respondents answer the degree of agreement from 0= not agree at all to 8=agree completely. The score ranges from 0 to 128. The alpha of the scale was 0.77. The team ha

given us permission to use the tool. It is available both in English and Spanish.

Contraception attitudes and perception scale: A 21-item scale to measure different aspects of contraception: denial/knowledge/ambivalence; norms; partner; side effects; hassle; and cost. Participants indicate the degree of agre from 1=do not agree at all to 5=completely agree. The score range is 21 to 105. This tool also was developed by Har research team,{Harvey, unknown #49} and we have gained permission to use it. The internal consistencies of the sca alphas of 0.76, 0.79, and 0.74 (men and women, men only and women only.{Harvey, 2011 #52}

Religiousness Commitment Inventory (RCI-10): This scale was developed by Worthington et al.{Worthington, 20 #6} and measures religious commitment, which is defined as the degree to which a person adheres to his religious va beliefs, and practices and the extent that he or she uses them in daily living. The scale was reduced from 17 items to items and has been validated with a variety of sample population (Christian married couples, college students, Buddh Muslims, Hindus). Respondents address various dimension of religiosity from 1=not at all true to me to 5=totally tru me.{Worthington, 2003 #6} The ranges of the scores are 10-50, and higher scores indicate more commitment to the religion in which one believes. It has not been translated into Spanish. However, it has good validity and reliability; coefficient alpha of the RCI-10 was 0.93, test-retest reliability was 0.87.{Worthington, 2003 #6} In addition, constru discriminant and criterion-related validity have been tested and resulted in significant results to establish validity.

X. PLAN FOR CONTROL OF INVESTIGATIONAL DRUGS, BIOLOGICS, AND DEVICES.

Investigational drugs and biologics: IF Investigational Drug Pharmacy Service (IDS) is not being used, attach the IDS confirmation of receipt of the management plan.

Investigational and humanitarian use devices (HUDs): Describe your plans for the control of investigational devices and HUDs including:

(1) how you will maintain records of the product's delivery to the trial site, the inventory at the site, the use by each subject, and the return to the sponsor or alternative disposition of unused product(s);

(2) plan for storing the investigational product(s)/ HUD as specified by the sponsor (if any) and in accordance with applicable regulatory requirements;

(3) plan for ensuring that the investigational product(s)/HUDs are used only in accordance with the approved protocol; and

(4) how you will ensure that each subject understands the correct use of the investigational product(s)/HUDs (if applicable) and check that each subject is following the instructions properly (on an ongoing basis).

N/A

XI. DATA ANALYSIS PLAN

For investigator–initiated studies.

Descriptive statistics will be obtained as well as numbers to describe the sample including calculating mea standard deviations, and ranges for the continuous variables, and counts with frequencies for the categorical variab three specific aims can be analyzed among men, women and couples.{Olson, 1983 #32} Furthermore, couples' ana can be done as women versus men, as a group and being paired analysis per couple. Olson and McCubbin present ways to analyze couples' score; couple mean scores, couple discrepancy score, and maximized couples score.{Olso #32} Mean scores are useful and give an overview of where couples stand on the measures of interest. It is effectiv when couples' scores are relatively similar. However, if their scores differ, the differences are not captured. Theref scoring system can be used depending on the similarities in the couples' score. Couple discrepancy scoring can loc difference of couples' scores. Depending on how the scores compare, this scoring system is thought to be useful in

study, as couples with small versus large score differences may have different characteristics in FP decision making a communication. Maximized couple scores take into account the significant characteristics that one partner has but no other. Again, this scoring system may not be used frequently but may be useful when one partner has characteristics are very different from his/her partner.

4. The first study aim is to examine the predictors of sexual relationship power. Potential predictors include the cultural values of male dominance and fatalism), attitudes and perceptions towards contraception, religion/spirituality, demographics/personal and couple factors (i.e. age, education, length of relationship, relationship status, and number of children the couples have together and separately), relationship adjustmen relationship commitment. This analysis is completed with the male and female data separately, then again wi couples' data. The Mean is meaningful if the couples' scores are similar. A difference in the couples' scores meaningful if the couples' scores are different. If there are larger differences between men and women's sco sexual relationship power differences will be larger. If there are small differences between men and women's scores, sexual relationship power differences will be smaller.
    a. Hypothesis 1: Higher scores on the masculinity scale predict lower sexual relationship power.
    b. Hypothesis 2: Number of completed years of education predicts sexual relationship power as follows
        iv. Greater number of completed years of education by the male partner predicts equal s relationship power.
        v. Lesser number of completed years of education completed by the male partner predi higher sexual relationship power for males.
        vi. Greater number of years of education completed by the female partner predicts high sexual relationship power for females.
    c. Hypothesis 3: The greater the number of children couples have together predicts increase in women' sexual relationship power.
5. The second aim of this study is to explore which demographics/personal factors and relationship variables pr communication. Potential predictors are demographic/personal factors (i.e. age, education completed, numbe children together, women's number of children, length of relationship, marital status); degree of dyadic adjus and relationship commitment; and sexual relationship power. In addition to testing each variable with communication, regression analysis is used for this analysis.

    Hypothesis 4: There is a significant relationship between the degree of dyadic adjustment and communi Men's, women's and couples' models are explored. For the couples' models, couples' mean or differenc scores will be used depending on what is appropriate based on the distribution of the scores.

    When couples' scores are similar, there are two possibilities how differences are distributed,

    - The relationship adjustment scores are similar and moderate to high
    - Both partners' scores are similar and lower

    When couples' scores are different, there are two types of differences.

    - men higher than women
    - women higher than men,

    Depending on the tendency in scores as noted above, communication may be predicted differently. Regression model is used for this analysis.

    a. Hypothesis 5: After controlling for or eliminating significant demographic/personal factors, degree c dyadic adjustment or relationship commitment, sexual relationship power still predicts communicati Regression model is used for this analysis.
6. The final study aim is to examine which demographic/personal factors and relationship variable/s predict sex decision making. Potential predictors are demographic/personal factors (i.e. age, education completed, numb children together, women's number of children, length of relationship, relationship status), degree of dyadic adjustment and relationship commitment and sexual relationship power. Again, in addition, regression analys will be done to test the following hypothesis: After controlling for or eliminating significant demographic/pe factors, degree of dyadic adjustment and relationship commitment, sexual relationship power still predicts se decision making. Regression model is used for this analysis. After finding the main variables that affect sexu

relationship power, communication and sexual decision-making including structural equation modeling (or multilevel modeling as appropriate for the data) to test the study model will be completed. Before finalizing t model, there will be testing of several alternative models against the hypothesized model to ensure there is n alternative that fits better than the developed model.

a. Hypothesis 6: Greater number of completed years of education by the male partner predicts higher decision making scores.(meaning active participation towards decision making and acknowledge the participation of his partners' decision making) Men's, women's and couples' models are explored. F couples' models, couples' mean or differences scores will be used depending on what is appropriate on the distribution of the scores.
b. Hypothesis 7: An increase in the number of children couples have together predicts increase in the decision making score in women. This analysis is done using couples' scores. Mean scores will be u the couples have the similar scores. Differences are used if couples' scores are different.
c. Hypothesis 8: After controlling for or eliminating significant demographic/personal factors, degree c dyadic adjustment and relationship commitment, sexual relationship power still predicts sexual decis making. Regression model is used for this analysis.

When couples' scores are similar, there are two possibilities how differences are distributed,

3. The relationship adjustment, relationship commitment and sexual relationship power scores are simi and moderate to high
4. Both partners' scores are similar and lower

When couples' scores are different, there are two types of differences.

3. men higher than women
4. women higher than men.

XII. DATA AND SAFETY MONITORING

- **If the research involves greater than minimal risk and there is no provision made for data and safety monitoring by any sponsor, include a data and safety-monitoring plan that is suitable for the level of risk to be faced by subjects and the nature of the research involved.**
- **If the research involves greater than minimal risk, and there is a provision made for data and safety monitoring by any sponsor, describe the sponsor's plan.**
- **If you are serving as a Sponsor-Investigator, identify the Contract Research Organization (CRO) that you will be using and describe the provisions made for data and safety monitoring by the CRO. Guidance on additional requirements for Sponsor-Investigators is available at http://www.research.vcu.edu/irb/wpp/flash/X-2.htm**

The study, which does not test any intervention and is not a clinical trial, will be overseen by the PI. The protocol v undergo its initial review by the study team after 10% of the anticipated enrollment with follow-up review if neces We believe that the protocol is low risk and that this should be adequate as this is a cross sectional interview study than an intervention study. Adverse event reporting will occur as necessary. The PI and/or study team will be avail hours a day by cell phone whenever subjects are on project; this number will be provided to subjects.

The student will manage data under the PI's supervision. The data from the proposed study will come from the questionnaire collected by the study team. Questionnaires are transferred to electronic database. All data will be st secure locations (paper measures are stored at locked cabinet at the PI's office, and database is electronically locke quality will be monitored for accuracy and validity under PI's supervision. Planned project involves minimal risk, adverse events are expected to occur as a direct result of subject participation. However, should any event occur th be related to project participation, the PI will assume responsibility for notification of the designated care providers any referral for recommended treatment, as well as notification to the VCU IRB. Adverse event reporting forms an procedures are available on-line at: http://www/orsp.vcu.edu/irb

XIII. MULTI-CENTER STUDIES

If VCU is the lead site in a multi-center project or the VCU PI is the lead investigator in a multi-center project, describe the plan for management of information that may be relevant to the protection of subjects, such as reporting of unexpected problems, project modifications, and interim results.

N/A

XIV. INVOLVEMENT OF NON-VCU INSTITUTIONS/SITES (DOMESTIC AND FOREIGN)

1. **Provide the following information for each non-VCU institution/site (domestic and foreign) that has agreed to participate:**
   - **Name of institution/site**
   - **Contact information for institution/site**
   - **Engaged in Research or not (if YES AND the research involves a DIRECT FEDERAL AWARD made to VCU, include FWA #). See OHRP's guidance on "Engagement of Institutions in Research" at http://www.hhs.gov/ohrp/policy/engage08.html.**
   - **Request for the VCU IRB to review on behalf of the Non-VCU institution?** See requirements found at http://www.research.vcu.edu/irb/wpp/flash/XVII-6.htm.
   - See VCU WPPs:
     http://www.research.vcu.edu/irb/wpp/flash/XVII-6.htm and
     http://www.research.vcu.edu/irb/wpp/flash/XVII-11.htm.

Name of Institution	Contact Information for Site	Engaged (Y/N) and FWA # if applicable	Request for VCU review on behalf non-VCU institu (Y/N)*
Richmond City Health Disctict (RCHD)	**Sherry Shrader**	**Y**	**N**
CrossOver Ministry Clinic	**Diana Naidoo**	**Y**	**N**

*NOTE: If a Non-VCU site is engaged in the research, the site is obligated to obtain IRB review or request that the VCU IRB review on its behalf.

2. Provide a description of each institution's role (whether engaged or not) in the research, adequacy of the facility (in order to ensure participant safety in the case of an unanticipated emergency), responsibilities of its agents/employees, and oversight that you will be providing in order to ensure adequate and ongoing protection of the human subjects. You should only identify institutions that have agreed to participate. If additional institutions agree to participate at a later time, they must be added by amendment to the protocol.

RCHD and CrossOver Ministry clinics both have licensed health care providers who can attend to any antic emergency. RCHD Spanish interpreter as well as bilingual secretary agrees to assist in identifying potential participants when their time allows in the waiting area. Health care providers at both clinics will be informe study recruitment before starting of the study. They will also provide a room for data collection as clinic sch allows (Please see Appendix A: Letters of Support). CrossOver Ministry Clinic has also agree to participate allowing the research team to recruit and collect data if clinic schedule allows (Please see Appendix A: the L of Support). Protection of human subjects is ensured at both facilities by the research team working closely institution personnel with a professional manner.

XV. HUMAN SUBJECTS INSTRUCTIONS

ALL sections of the Human Subjects Instructions must be completed with the exception of the section entitled "Special Consent Provisions." Complete that section if applicable.

A. DESCRIPTION

Provide a detailed description of the proposed involvement of human subjects or their private identifiable data.

The study will involve a sample of 40 heterosexual first generation Latino couples whose female partners are in th second or third trimester. Participants must meet outlined study criteria and must be able to read and speak Spanis Spanish and English. The potential female participants are identified through chart review and will be approached study team. Screening questions are asked prior to consent to ensure eligibility. Screenings are done in a private se Eligible participants and their partners will sign the consent and be asked to complete questionnaires. Both partner agree to participate in studies, since the study needs paired data. Participants will complete surveys. In addition, ch be reviewed for medical information about the pregnancies as needed. Total time required for participation will be approximately 1 hour.

B. SUBJECT POPULATION

Describe the subject population in terms of sex, race, ethnicity, age, etc., and your access to the population that will allow recruitment of the necessary number of participants. Identify the criteria for inclusion or exclusion of all targeted populations and include a justification for any exclusions. Explain the rationale for the involvement of special cases of subjects, such as children, pregnant women, human fetuses, neonates, prisoners or others who are likely to be vulnerable. If you plan to allow for the enrollment of Wards of the State (or any other agency, institution, or entity), you must specifically request their inclusion and follow guidance in VCU IRB WPP XV-3: Wards and Emancipated Minors available at http://www.research.vcu.edu/irb/wpp/flash/XV-3.htm.

The sample will be comprised of 40 adult (18 or older) heterosexual Latino couples. P inclusion criteria include

(g) Female partner in second or third trimester
(h) Both partners being born in any Latin American countries,
(i) Latinos who read and speak Spanish, or Spanish and English
(j) Couples who are in some form of close relationship (married or living together)
(k) Couples who have been and intend to be sexually active after delivery
(l) Both members of the couple want to participate in the study.

Exclusion criterion includes men with sterilization. NO the involvement of special cases of subjects, such as childre human fetuses, neonates, prisoners or others. Pregnant women will be in the research study. However, the risks are minimum.

C. RESEARCH MATERIAL

Identify the sources of research material obtained from individually identifiable living human subjects in the form of specimens, records, or data. Indicate whether the material or data will be obtained specifically for research purposes or whether use will be made of existing specimens, records, or data.

Data will be collected from participants using the questionnaires displayed on Appendix D. All data will be obtain specifically for research purposes.

D. RECRUITMENT PLAN

Describe <u>in detail</u> your plans for the recruitment of subjects including:

(1) how potential subjects will be identified (e.g., school personnel, health care professionals, etc),

(2) how you will get the names and contact information for potential subjects, and

(3) who will make initial contact with these individuals (if relevant) and how that contact will be done.

If you plan to involve special cases of subjects, such as children, pregnant women, human fetuses, neonates, prisoners or others who are likely to be vulnerable, describe any special recruitment procedures for these populations.

Chart review is conducted to determine the eligibility of the potential female participants at the recruitment sites. T women are approached during their routine clinic visits, when clinicians are not interacting with them. If their mal partners are present, he would be approached to join the study. If their male partners are not present and female pa are interested, the student will ask if the female partners would be willing to speak about the study to them to see i would be interested. The student will follow up with the female partners and if the male partners are interested, the and her research team member will meet with the potential participants at the place of their convenience. Screenin questions are administered in a private setting to ensure study eligibility. The participants will be all adults, and the will not harm their fetuses.

E. PRIVACY OF PARTICIPANTS

NOTE: Privacy refers to individuals and their interests in controlling access to their identities, their physical person, and how and what kind of information is obtained about them. Privacy also encompasses the interests of defined communities (e.g. those with a certain diagnosis or social circumstance) in controlling access to the group identity and information about the group or individuals as part of the group.

Describe how the privacy interests of subjects (and communities, if appropriate) will be protected including:

(1) in the research setting (e.g., in the identification, recruitment, and intervention settings) and

(2) with the information being sought and the way it is sought. For example, providing drapes or barriers, interviewing in a private room, and collecting only the amount of sensitive information needed for identification, recruitment, or the conduct of the study.

The data obtained from participants are not linked to their names, rather subject identification numbers so that privacy is ensured for this participant. Consent and questionnaires are stored in a locked office separately. All the study visits are conducted in a private room to ensure the participants' privacy.

F. CONFIDENTIALITY OF DATA

NOTE: Confidentiality refers to the way private, identifiable information about a subject or defined community is maintained and shared.

Check all of the following precautions that will be used to maintain the confidentiality of identifiable

information:

☒ Paper-based records will be kept in secure location and only accessed by authorized study personnel

☒ Electronic records will be made available only to those personnel in the study through the use of access controls and encryption

☒ Identifiers will be removed from study-related data (data is coded with a key stored in a separate secure location)

☐ For research involving web-based surveys, data is secured via passwords and encryption

☐ Audio or video recordings of subjects will be transcribed and then destroyed to prevent audio or visual identification. Note the date of destruction (e.g., 3 months from close of study; after transcription is determined to be error free).

☐ Obtaining a Certificate of Confidentiality

☐ Other precautions:

G. POTENTIAL RISKS

Describe potential risks (physical, psychological, social, legal, or other) and assess their likelihood and seriousness. Where appropriate, describe alternative treatments and procedures that might be advantageous to the subjects.

Potential risks include mild distress from completing the questionnaire packet. There may be some unpleasant mer that may be brought back from filling out the surveys. The student will explain to the participants that they have a of not answering certain questions if they do not wish to do so. However, the likelihood of experiencing mild distr minimal.

Breach of confidentiality and invasion of privacy is a potential risk. However, all systems and procedures are in pl avoid it from happening. The student will explain that their information is securely stored and has no link to gover police. She will also explain and ensure that the information will be de-identified and will not be in public or to he for any reason. If intimate partner violence is indicated, appropriate referral will be made to ensure the participants

H. RISK REDUCTION

Describe procedures for protecting against or minimizing potential risk. Where appropriate, discuss provisions for ensuring necessary medical or professional intervention in the event of adverse events to the subjects. Describe the provisions for monitoring the data collected to ensure the safety of subjects, if any.

As part of the process involved in obtaining written informed consent, participants will be explained and given a c the informed consent form. Contact information for the PI and the student are provided on the consent form for the participants to ask questions freely. Confidentiality is assured before and throughout the study visit. When intimate violence is indicated, appropriate referral and assistance will be sought to ensure the participants' safety. If need fo resources arise, appropriate referral will be made.

I. ADDITIONAL SAFEGUARDS FOR VULNERABLE PARTICIPANTS

Describe any additional safeguards to protect the rights and welfare of participants if you plan to involve special cases of subjects such as children, pregnant women, human fetuses, neonates, prisoners or others

who are likely to be vulnerable.

Safeguards to protect the rights and welfare of participants might relate to Inclusion/Exclusion Criteria: ("Adults with moderate to severe cognitive impairment will be excluded." "Children must have diabetes. No normal controls who are children will be used.") Consent: ("Participants must have an adult care giver who agrees to the participant taking part in the research and will make sure the participant complies with research procedures." "Adults must be able to assent. Any dissent by the participant will end the research procedures.") Benefit: ("Individuals who have not shown benefit to this type of drug in the past will be excluded.").

The risk to the pregnant women is not greater than minimal. Potential risks are described in the consent. At times, questions in the study may remind of past and current unpleasant experiences of the participants. However, the par can stop answering questions in this case. If additional resources are needed, appropriate referral will be made.

J. RISK/BENEFIT

Discuss why the risks to participants are reasonable in relation to the anticipated benefits to subjects and in relation to the importance of the knowledge that may reasonably be expected to result. If a test article (investigational new drug, device, or biologic) is involved, name the test article and supply the FDA approval letter.

There are no direct benefits to the subjects in this study as we are seeking information to understand factors that af couples' communication such as sexual relationship power. It is possible that participants in this project will gain i benefits from the knowledge that they are participating in a research project and become aware the importance of c communication about family planning. The risk is minimal and this information may benefit individuals, couples a families in the future. In addition, the findings of the current study may have future benefits for other Latino coupl

K. COMPENSATION PLAN

Compensation for participants (if applicable) should be described, including possible total compensation, pro-rating, any proposed bonus, and any proposed reductions or penalties for not completing the project.

Participants as couples will receive a $20 incentive at the completion of the study visit.

L. CONSENT ISSUES

1. CONSENT PROCESS

Indicate who will be asked to provide consent/assent, who will obtain consent/assent, what language (e.g., English, Spanish) will be used by those obtaining consent/assent, where and when will consent/assent be obtained, what steps will be taken to minimize the possibility of coercion or undue influence, and how much time will subjects be afforded to make a decision to participate.

The participants are asked to provide consent by the study team in their preferred language (English or Spanish) af members of the couples agree and are willing to participate in the study. The research team members are frequent i English and Spanish. Thus, they are able to answer any questions that participants have in their preferred language potential participants are approached during their clinic visit, or preferred location of the potential participants. The consent is obtained at a private setting. Potential participants can take as much time as needed to read or discuss th consent with the PI, student, family or friends before making their decision. Furthermore, explanation of the study provided verbally and in writing. Patients will be allowed to ask questions or call the PI or student to discuss any c

at any time. The student is not a clinic staff, and she will ensure to explain the potential participants that not participating the study would not affect their medical care they receive at the clinic.

2. SPECIAL CONSENT PROVISIONS

If some or all subjects will be cognitively impaired, or have language/hearing difficulties, describe how capacity for consent will be determined. Consider using the VCU Informed Consent Evaluation Instrument available at http://www.research.vcu.edu/irb/guidance.htm. If you anticipate the need to obtain informed consent from legally authorized representatives (LARs), please describe how you will identify an appropriate representative and ensure that their consent is obtained. Guidance on LAR is available at http://www.research.vcu.edu/irb/wpp/flash/XI-3.htm.

Since it is anticipated that the majority of the participants prefer being interviewed in Spanish, The consent form is prepared in English and Spanish. The participants are given choices of language (English or Spanish) for the conse and the interview. The consent form is translated and back translated per American Academy of Orthopaedic Surg Institute for Work & Health Guildeline[98] to ensure accuracy.

3. ASSENT PROCESS

If applicable, explain the Assent Process for children or decisionally impaired subjects. Describe the procedures, if any, for re-consenting children upon attainment of adulthood. Describe procedures, if any, for consenting subjects who are no longer decisionally impaired. Guidance is available at http://www.research.vcu.edu/irb/wpp/flash/XV-2.htm and http://www.research.vcu.edu/irb/wpp/flash/XVII-7.htm.

N/A

4. REQUESTS FOR WAIVERS OF CONSENT (COMPLETE IF REQUESTING ANY TYPE OF WAIVER OF CONSENT OR ASSENT)N/A

4-A. REQUEST TO WAIVE SOME OR ALL ELEMENTS OF INFORMED CONSENT FROM SUBJECTS OR PERMISSION FROM PARENTS: A waiver of informed consent means that the IRB is not requiring the investigator to obtain informed consent OR the IRB approves a consent form that does not include or alters some/all of the required elements of consent. **Guidance is available at http://www.research.vcu.edu/irb/wpp/flash/XI-1.htm. NOTE: Waiver is not allowed for FDA-regulated research unless it meets FDA requirements for Waiver of Consent for Emergency Research (see below).**

4-A.1. Explain why a waiver or alteration of informed consent is being requested.

4-A.2. Describe how this study meets ALL FOUR of the following conditions for a waiver or alteration:

- The research involves no more than minimal risk to the participants. → Explain how your study meets this criteria:
- The waiver or alteration will not adversely affect the rights and welfare of participants. → Explain how your study meets this criteria:
- The research could not practicably be carried out without the waiver or alteration. → Explain how your study meets this criteria:
- Will participants be provided with additional pertinent information after participation?
  ☐ Yes

  ☐ No → Explain why not:

4-B. REQUEST TO WAIVE DOCUMENTATION OF CONSENT: A waiver of documentation occurs when the consent process occurs but participants are not required to sign the consent form. Guidance is available at http://www.research.vcu.edu/irb/wpp/flash/wpp_guide.htm#XI-2.htm. One of the following two conditions must be met to allow for consenting without signed documentation. Choose which condition is applicable and explain why (explanation required):

☐ The only record linking the participant and the research would be the informed consent form. The principal risk to the participant is the potential harm resulting from a breach of confidentiality. Each participant will be asked whether he/she wants documentation linking the participant with the research and the participants wishes will govern. → Explain how your study fits into the category:

☐ The research presents no more than minimal risk of harm to participants & involves no procedures for which signed consent is normally required outside of the research context. → Explain how your study fits into the category:

4-C. REQUEST TO WAIVE SOME OR ALL ELEMENTS OF ASSENT FROM CHILDREN ≥ AGE 7 OR FROM DECISIONALLY IMPAIRED INDIVIDUALS: A waiver of assent means that the IRB is not requiring the investigator to obtain assent OR the IRB approves an assent form that does not include some/all of the required elements. Guidance is available at http://www.research.vcu.edu/irb/wpp/flash/XV-2.htm.

4-C.1. Explain why a waiver or alteration of informed consent is being requested.

In order for the IRB to approve a request for waiver of assent, the conditions for 4-C.2, 4-C.3, OR 4-C.4 must be met. Check which ONE applies and explain all required justifications.

4-C.2. ☐ **Some or all of the individuals age 7 or higher will not be capable of providing assent based on their developmental status or impact of illness**. → Explain how your study meets this criteria:

4-C.3. ☐ **The research holds out a prospect of direct benefit not available outside of the research**. → Explain how your study meets this criteria:

4-C.4. ☐ **Describe how this study meets <u>ALL FOUR</u> of the following conditions**:

- The research involves no more than minimal risk to the participants. → Explain how your study meets this criteria:
- The waiver or alteration will not adversely affect the rights and welfare of participants. → Explain how your study meets this criteria:
- The research could not practicably be carried out without the waiver or alteration. → Explain how your study meets this criteria:
- Will participants be provided with additional pertinent information after participation?
  ☐ Yes

  ☐ No → Explain why not:

4-D. REQUEST TO WAIVE CONSENT FOR EMERGENCY RESEARCH: Describe how the study meets the criteria for emergency research and the process for obtaining LAR consent is appropriate. See guidance at http://www.research.vcu.edu/irb/wpp/flash/XVII-16.htm.

5. GENETIC TESTING

If applicable, address the following issues related to Genetic Testing.

5-A. FUTURE CONTACT CONCERNING FURTHER GENETIC TESTING RESEARCH

Describe the circumstances under which the subject might be contacted in the future concerning further participation in this or related genetic testing research.

N/A

5-B. FUTURE CONTACT CONCERNING GENETIC TESTING RESULTS

If planned or possible future genetic testing results are unlikely to have clinical implications, then a statement that the results will not be made available to subjects may be appropriate. If results might be of clinical significance, then describe the circumstances and procedures by which subjects would receive results. Describe how subjects might access genetic counseling for assistance in understanding the implications of genetic testing results, and whether this might involve costs to subjects. Investigators should be aware that federal regulations, in general, require that testing results used in clinical management must have been obtained in a CLIA-certified laboratory.

N/A

5-C. WITHDRAWAL OF GENETIC TESTING CONSENT

Describe whether and how subjects might, in the future, request to have test results and/or samples withdrawn in order to prevent further analysis, reporting, and/or testing.

N/A

5-D. GENETIC TESTING INVOLVING CHILDREN OR DECISIONALLY IMPAIRED PARTICIPANTS

Describe procedures, if any, for consenting children upon the attainment of adulthood. Describe procedures, if any, for consenting participants who are no longer decisionally impaired.

N/A

5-E. CONFIDENTIALITY OF GENETIC INFORMATION

Describe the extent to which genetic testing results will remain confidential and special precautions, if any, to protect confidentiality.

N/A

Appendices

Appendix A: Letters of Support, Richmond City Health District & CrossOver Ministry Clinic

Appendix B: Advertisements (English and Spanish)

Appendix C: Consent Forms (English and Spanish)

Appendix D: Study Measures (English and Spanish)

References

Virginia Department of Health

Office of Minority Health and Public Health Policy//Institutional Review Board

109 Governor Street, 10th Floor East; PO Box 2448

Richmond, VA 23218-2448

STATE USE ONLY
ID #:
Date Rec'd:
Expedited ☐
Full ☐

REQUEST FOR REVIEW AND CLEARANCE OF A PROJECT INVOLVING HUMAN SUBJECTS

*Submit **EITHER** 1 electronic copy (preferred) to the chair of the VDH IRB **OR** 7 hard copies forFull Board Review/ 2 hard copies for Expedited Review of this completed form along with the protocol, other supporting documents, and CV or resume of the Principal Investigator to the above address.*

Title of Protocol

PREDICTORS OF COMMUNICATION AND FAMILY PLANNING DECISION MAKING AMONG LATINO COUPLES

Name and Title of Principal Investigator	Email Address
McGrath, Jacqueline, M, PhD, RN, FNAP, FAAN Associate Professor	Jmmcgrath@vcu.edu
Name of Institution	Telephone Number
Virginia Commonwealth University (VCU) School of Nursing	804-828-1930

Address

P.O. Box 980567 1100 East Leigh St. Richmond, VA 23298

Name and Title of Department of Health Collaborator, if included in study and different from Principal Investigator	Email Address
Address	Telephone Number

Proposed Dates for Project

Beginning: As soon as VDH IRB and VCU IRB approval have been obtained

Ending: when recruit 40 couples

Assurance of Confidentiality

1. The undersigned hereby agrees to the following terms and conditions related to a request for approval for research:

2. No data will be published or released in any form if a particular individual supplying the information or described in it is identifiable without the written permission of the subject(s) involved.

3. The identifying information will be used only for statistical purposes in medical and health research.

4. The identifying information will not be used as a basis for legal, administrative, or other actions which may directly affect those particular individuals as a result of their specific identification in this project.

5. The identifying information will be used only for the study or project proposed and the purposes described in the attached document. Use of the information for a research project other than the one described will not be undertaken until after a separate request is made to the Virginia Department of Health.

6. While identifiers still appear, access to paper, hardware and software will be secured. Paper records will be kept in locked cabinets and computers will be kept locked or have password protection.

7. All statements made to the Virginia Department of Health are correct.

Signature of Principal Investigator	Date
Name of Requester, if different from Investigator (Print) Yui Matsuda (Doctoral student at VCU School of Nursing)	Title
Signature of Requestor	

REQUEST FOR REVIEW AND CLEARANCE OF A PROJECT

INVOLVING HUMAN SUBJECTS

(Continued)

STATE USE ONLY

ID #:

1. Name(s) of any other IRBs reviewing this project.

VCU IRB

2. Summarize the study protocol or project activities (attach a copy of the full protocol to this request for reference). Indicate specifically the way data will be collected and used.
VCU IRB research plan is attached in appendix A.

One in six U.S. Americans are Latinos;{Bureau, 2010 #10} their growth rate accounts for over 50% of the U.S. population in the last 10 years.{Center, 2008 #2} Moreover, Latinos are estimated to be nearly 30% of the U.S. population by 2050.{Beureau, 2011 #3} Concurrently, Latinos are experiencing an increase in unintended pregnancies (UP).{Finer, 2006 #5} UP, defined as a pregnancy that is considered either mistimed or unwanted at the time of conception.{Brown, 1995 #4} Women with UP are more likely to delay prenatal care{Cheng, 2009 #3} and as a result, the pregnancy may be inadequately managed.{Evers, 2004 #3} And as such, UP negatively affect aspects of health for both women and their infants. Moreover, UP disrupts optimum birth spacing; which may negatively affect mother and infant health outcomes.{Fuentes-Afflick, 2000 #4;Conde-Agudelo, 2007 #5;Bhutta, 2002 #6}

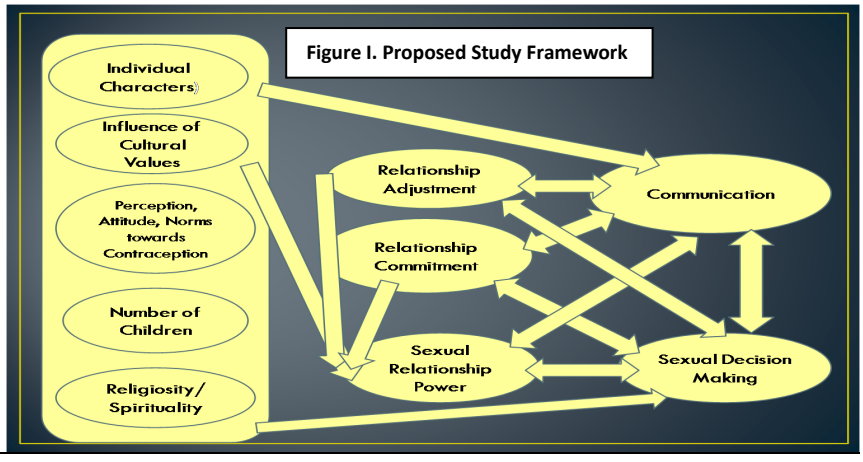
According to the World Health Organization(WHO), family planning (FP) refers to the ability of individuals and couples, through their own intent, to determine their desired number of children and the spacing and timing of their births.{Organization, 2011 #3} Despite the WHO definition of FP is a couples' process, FP interventions have traditionally been directed at women and this delivery method has been shown to be unsuccessful.{Becker, 1996 #27;Becker, 1998 #26;Kerns, 2003 #28} However, sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) prevention intervention initiatives have successfully worked with couples.{Kraft, 2007 #1;Harvey, 2009 #2;Harvey, 2009 #2;El-Bassel, 2003 #24} Considered these finding in tandem, FP interventions might benefit from focusing on couples communication skills rather than targeting only women.

Couples' decision-making is affected by gender norms which are socially constructed and make up the social context, self-concepts, beliefs, and expectations for behavior.{Potuchek, 1992 #29} Open communication between partners about FP has been found to increases contraceptive use.{Harvey, 2006 #8;Harvey, 2006 #31;Beckman, 2006 #95} Lack of FP communication and FP decision-making and irregular contraceptive usage could increase the risk of UP, which could lead to inadequate birth spacing and parenting difficulties.{El-Kamary, 2004 #2} FP decision-making conversations among couples should optimally begin before the initiation of sexual activity and continue throughout the couples' active sexual relationship. Furthermore, couples' FP discussions have the potential to promote a sound family dynamic, since children often learn from their parent's example. As such, couples become role models for healthy relationships for their children. Synchronizing the pieces applicable in Latino couples' family planning communication and decision- making, the proposed study framework was designed using Fishbein's Integrative model (which has been created by using components of the Theory of Reasoned Action, Social Cognitive Theory and Health Belief Model){Fishbein, 2000 #12} and Harvey's structural model of condom use intention as well as the current literature, the framework for the current study is shown in Figure 1.The proposed study will test the associations of listed variables and ultimately build a model to best illuminate interrelationships of the identified variables.

Individual personal factors, as well as the couple's relationship dynamic affect their FP communication and decision-making in a complex manner. Each couple creates its own relationship dynamics that affects their FP decision-making. Yet, sexual relationship power (SRP), defined as the ability or skill to influence or control another person's actions,{Ragsdale, 2009 #74} has the potential to change the dynamics in relationships. SRP may be affected by many factors, including: (a) the cultural values of male dominance{Wood, 1997 #14} (the quality, state or degree of being masculine{Dictionary, 2011 #6}) and fatalism, which refers to the degree to which people feel their destinies are beyond their control{Cuéllar, 1995 #1}); (b) attitudes and perceptions towards contraception{Harvey, 2006 #9}; (c) religiosity/spirituality; (d) length of relationship; and (e) number of shared children; and, (f) number of children from previous relationships. Other influencing factors are relationship commitment{Harvey, 2006 #9} and dyadic adjustment to the relationship.{Spanier, 1976 #15} UP prevention is a complex issue, involving multiple social and cultural elements. To date, there has been limited research investigating factors related to FP decision-making among Latino couples, despite the consequences.

Study Aims:

Aim 1 is to examine the relationships within factors of sexual relationship power. Potential factors include the cultural values of male dominance and fatalism, attitudes and perceptions towards contraception, religion/spirituality, demographic, personal and couple factors (i.e. age, education, length of relationship, relationship status, and number of children the couples have together and separately), relationship adjustment and relationship commitment. Aim 2 is to explore which demographic/personal factors and relationship variables predict communication styles (variables described in aim 1). Hypothesis: After controlling for significant demographic/ personal factors, the degree of dyadic



adjustment or relationship commitment, sexual relationship power still predicts communication. Aim 3 is to determine which demographic/personal factors and relationship variable/s predict sexual decision-making. Hypothesis: After controlling for or eliminating significant demographic/personal factors, degree of dyadic adjustment and relationship commitment, sexual relationship power still predicts sexual decision-making.

Design and Method:

A descriptive study of 40 heterosexual Latino couples whose female members are in the second or third trimester of their pregnancies is proposed. Recruitment will take place from maternity clinics at the Virginia Department of Health (VDH), Richmond City Health District (RCHD) (please see Letters of Support attached to this application) and by word of mouth with pregnancy verification. The researcher will conduct a chart review to identify potential female participants. She briefly will describe the project to potential participants. Screening questions will be posed in a private location to determine eligibility. At this initial meeting, the researcher will explain the project in detail, answer questions, and obtain consent from adults, if both partners of the couple are present in the clinic. If only female partners are in the clinic, the study team will ask the women if they would be willing to speak to their spouses about the study, so that follow up can occur. Flyer will be given to aid in informing her partner about the study (Appendix D). The study team (doctoral student [bilingual] and a bilingual Latino male research assistant) will visit the potential couples (with their permission) at their preferred location to explain further the study and obtain consent for participation (please refer to Appendix C: Informed Consent Form). Self-report measures will be obtained at the time of data collection. Paper forms will be used. These forms are written in English and Spanish, as are the consent documents. The researcher also will review the medical chart for data to determine the history of the female's pregnancies and current gestational age. Participants will be provided a $20.00 incentive per couple for their time and effort. Total time required for participation by each participant within the couple will be approximately 1 hour.

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3. List the potential risks to study participants.

Potential risks include mild distress from completing the questionnaire packet. There may be some unpleasant memories that may be brought back from filling out the surveys. The student will explain to the participants that they have a choice of not answering certain questions if they do not wish to do so. However, the likelihood of experiencing mild distress is minimal.

Breach of confidentiality and invasion of privacy is a potential risk. However, all systems and procedures are in place to avoid it from happening. The student will explain that their information is securely stored and has no link to government or police. She will also explain and ensure that the information will be de-identified and will not be in public or to her partner for any reason. If intimate partner violence is indicated, appropriate referral will be made to ensure the participants' safety.

4. List any potential benefits to study participants and/or to society.

There are no direct benefits to the subjects in this study as we are seeking information to understand factors that affects couples' communication such as sexual relationship power. It is possible that participants in this project will gain indirect benefits from the knowledge that they are participating in a research project and become aware the importance of couples' communication about family planning. The information obtained for this study may benefit individuals, couples and their families in the future. In addition, the findings of the current study may have future benefits for other Latino couples.

5. Do your subjects include any of the following:

a. Pregnant women or children (persons who have not attained the legal age for consent to treatments or procedures involved in the research)? □ Yes □ No

b. Institutionalized mentally infirm people? □ Yes X□ No

c. Inmates/Prisoners? □ Yes X□ No

Since these subjects - and others like them who are either not competent or not free to give their

own consent - are particularly vulnerable to coercion and undue influence, investigators must incorporate safeguards in the research plan, and be certain to document fully their informed consent or the informed consent of their legal representatives.

REQUEST FOR REVIEW AND CLEARANCE OF A PROJECT INVOLVING HUMAN SUBJECTS

(Continued)

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ID #:

6. Informed consent must be obtained from the subjects or, in the case of children, the parent or legal guardian. Do you intend to use an informed consent form?
   □ Yes □ No

   If yes, please enclose a copy of the form, which should include all of the elements mentioned in the sample found in Appendix C. ALL SUBJECTS MUST BE TOLD AND UNDERSTAND THAT THEY CAN DECLINE PARTICIPATION IN THE RESEARCH. If you DO NOT intend to use a consent form, please explain your reasons here:

7. In what form and to whom will the results of your study or activities be released?

   The results of the study will be presented to the Health Department clinic staff, professional conferences and/or scientific journals. No identifiable information is released at that time.

8. Describe how your organization will store and maintain the confidentiality of the identifying information.

   The data obtained from participants are not linked to their names, rather subject identification numbers so that confidentiality is ensured for the participants. Consent and questionnaires are stored in a locked office separately. Recorded data do not contain identifying information and also stored in a locked office that only the study team has access to.

9. Describe the disposition of identifying information (method and intended time frame).

   All personal identifying information will be kept in password protected files, and these files will be deleted in 7 years after the study ends (per VCU research protocol). A data and safety monitoring plan is established.

10. Please provide any other information that would be helpful to the IRB.

    None

VCU Memo

Virginia Commonwealth University

Office of Research Subjects Protection
BioTechnology Research Park
BioTech One, 800 E. Leigh Street, #114
P.O. Box 980568
Richmond, Virginia 23298-0568
(804) 828-3992
(804) 827-1448 (fax)

DATE: November 2, 2011

TO: Jacqueline M. McGrath, PhD, RN, FNAP, FAAN
Family and Community Health Nursing
Box 980567

FROM: Lisa M. Abrams, PhD
Chairperson, VCU IRB Panel B
Box 980568

RE: **VCU IRB #: HM13944**
Title: Predictors of Communication and Sexual Decision Making among Latino Couples

On November 2, 2011, the following research study was ***approved*** by expedited review according to 45 CFR 46.110 Category 7. The approval reflects the revisions received in the Office of Research Subjects Protection on October 25, 2011, and October 27, 2011. This approval includes the following items reviewed by this Panel:

RESEARCH APPLICATION/PROPOSAL: None

PROTOCOL (Research Plan): Predictors of Communication and Sexual Decision Making among Latino Couples, received 9/21/11, version 1, dated 8/24/11

- VCU IRB Study Personnel Roster, received 9/21/11, version date 8/24/11
- Screening Questions (Female) – *English version*, received 10/27/11, version 2, dated 10/21/11
- Screening Questions (Female) – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Screening Questions (Male) – *English version*, received 10/27/11, version 2, dated 10/21/11
- Screening Questions (Male) – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Demographic Form (Female) – *English version*, received 10/27/11, version 2, dated 10/20/11
- Demographic Form (Female) – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Demographic Form (Male) – *English version*, received 10/27/11, version 2, dated 10/20/11
- Demographic Form (Male) – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Dyadic Adjustment Scale – *English version*, received 10/27/11, version 2, dated 10/20/11
- Dyadic Adjustment Scale – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Dyadic Sexual Communication Scale – *English version*, received 10/27/11, version 2, dated 10/20/11
- Dyadic Sexual Communication Scale – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Machismo Scale – *English version*, received 10/27/11, version 2, dated 10/20/11
- Machismo Scale – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Marianismo Beliefs Scale – *English version*, received 10/27/11, version 2, dated 10/20/11
- Marianismo Beliefs Scale – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Fatalism Scale – *English version*, received 10/27/11, version 2, dated 10/20/11
- Fatalism Scale – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Communication with Partner – *English version*, received 10/27/11, version 2, dated 10/20/11
- Communication with Partner – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Sexual Relationship Power Scale – *English version*, received 10/27/11, version 2, dated 10/20/11

(Continued...)

- Sexual Relationship Power Scale – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Sexual Decision Making – *English version*, received 10/27/11, version 2, dated 10/20/11
- Sexual Decision Making – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Religiousness Commitment Inventory – *English version*, received 10/27/11, version 2, dated 10/20/11
- Religiousness Commitment Inventory – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Religious Commitment – *English version*, received 10/27/11, version 2, dated 10/20/11
- Religious Commitment – *Spanish version*, received 10/27/11, version 2, dated 10/20/11
- Contraception Attitudes and Perceptions – *English version*, received 10/27/11, version 2, dated 10/20/11
- Contraception Attitudes and Perceptions – *Spanish version*, received 10/27/11, version 2, dated 10/20/11

HIPAA PROCESS:

**The following pathway for accessing and/or using PHI has been approved:*

- Partial Waiver of Authorization for Recruitment

CONSENT/ASSENT (attached):

- Research Subject Information and Consent Form – *English version*, received 10/25/11, version 3, dated 10/25/11, 4 pages
- Research Subject Information and Consent Form – *Spanish version*, received 10/25/11, version 3, dated 10/25/11, 4 pages

ADDITIONAL DOCUMENTS (attached):

- Flyer: You are invited to participate in a Latino couples study – *English version*, received 10/27/11
- Flyer: You are invited to participate in a Latino couples study – *Spanish version*, received 10/27/11

Please Note: The VCU IRB acknowledges receipt of the VCU IRB Appendix A: HIPAA for Research form on October 27, 2011.

This approval expires on October 31, 2012. Federal Regulations/VCU Policy and Procedures require continuing review prior to continuation of approval past that date. Continuing Review report forms will be mailed to you prior to the scheduled review.

The Primary Reviewer assigned to your research study is Lou Usry, RN. If you have any questions, please contact Ms. Usry at lusry@mcvh-vcu.edu and 828-9229; or you may contact Jennifer Rice, IRB Coordinator, VCU Office of Research Subjects Protection, at irbpanelb@vcu.edu and 828-3992.

[Attachment – Conditions of Approval]

Conditions of Approval:

In order to comply with federal regulations, industry standards, and the terms of this approval, the investigator must *(as applicable):*

1. Conduct the research as described in and required by the Protocol.

2. Obtain informed consent from all subjects without coercion or undue influence, and provide the potential subject sufficient opportunity to consider whether or not to participate (unless Waiver of Consent is specifically approved or research is exempt).

3. Document informed consent using only the most recently dated consent form bearing the VCU IRB "APPROVED" stamp (unless Waiver of Consent is specifically approved).

4. Provide non-English speaking patients with a translation of the approved Consent Form in the research participant's first language. The Panel must approve the translated version.

5. Obtain prior approval from VCU IRB before implementing any changes whatsoever in the approved protocol or consent form, unless such changes are necessary to protect the safety of human research participants (e.g., permanent/temporary change of PI, addition of performance/collaborative sites, request to include newly incarcerated participants or participants that are wards of the state, addition/deletion of participant groups, etc.). Any departure from these approved documents must be reported to the VCU IRB immediately as an Unanticipated Problem (see #7).

6. Monitor all problems (anticipated and unanticipated) associated with risk to research participants or others.

7. Report Unanticipated Problems (UPs), including protocol deviations, following the VCU IRB requirements and timelines detailed in VCU IRB WPP VIII-7):

8. Obtain prior approval from the VCU IRB before use of any advertisement or other material for recruitment of research participants.

9. Promptly report and/or respond to all inquiries by the VCU IRB concerning the conduct of the approved research when so requested.

10. All protocols that administer acute medical treatment to human research participants must have an emergency preparedness plan. Please refer to VCU guidance on http:/www.research.vcu.edu/irb/guidance.htm.

11. The VCU IRBs operate under the regulatory authorities as described within:
    a) U.S. Department of Health and Human Services Title 45 CFR 46, Subparts A, B, C, and D (for all research, regardless of source of funding) and related guidance documents.
    b) U.S. Food and Drug Administration Chapter I of Title 21 CFR 50 and 56 (for FDA regulated research only) and related guidance documents.
    c) Commonwealth of Virginia Code of Virginia 32.1 Chapter 5.1 Human Research (for all research).

010507

RESEARCH SUBJECT INFORMATION AND CONSENT FORM

TITLE: Predictors of Communication and Sexual Decision Making among Latino Couples

VCU IRB NO.: 13944

This consent form may contain words that you do not understand. Please ask the study staff to explain any words that you do not clearly understand. You may take an unsigned copy of this consent form home to think about or discuss the research study with family or friends before making your decision.

PURPOSE OF THE STUDY

The purpose of this research study is to examine factors related to family planning, decision making, and communication among Latino couples. You are being asked to participate in this study because you are either a Latina woman in your second or third trimester of pregnancy who is married or living with a Latino partner **or** you are a Latino man, married to or living with a Latina partner who is in her second or third trimester of pregnancy.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

If you decide to be in this research study with your partner, you will be asked to sign this consent form after your questions have been answered and you fully understand what will occur throughout the duration of the study.

In this study you will be asked to fill out some questionnaires separately from your partner. If you require assistance in order to read and completely comprehend the questionnaires, a study staff member who speaks both English and Spanish will read them to you. The questionnaire session will be held in a private room, and the study visit will last about 1 hour. Approximately forty couples will participate in this study.

RISKS AND DISCOMFORTS

Sometimes answering questions about these subjects can be unpleasant or cause people to become upset. Some questions about the relationship between you and your partner will be asked. You do not have to answer questions that you do not want to answer. If you become upset or sad, the study staff will give you names of counselors to contact so you can get help in dealing with these issues.

BENEFITS TO YOU AND OTHERS

You may not get any direct benefit from this study, but the information we learn from this study may help us design better family planning programs for Latinos.

COSTS

There are no costs for participating in this study other than the time you spend in filling out the questionnaires.

PAYMENT FOR PARTICIPATION

After both of you fill out the questionnaires, you will receive a $20.00 compensation per couple for your time and effort.

ALTERNATIVES

Your alternative is to not participate in this study.

CONFIDENTIALITY

Potentially identifiable information about you will consist of screening questions and questionnaires. Data is being collected only for research purposes. All of the study documents will be identified with a random number. All of the documents will be stored in a locked office, and only study stuff will have access to these documents. All personal identifying information will be kept in password- protected files, and these files will be deleted in 7 years after the study ends.

We will not tell anyone about the answers you give us; however, information from the study and from your medical records and the consent form you signed may be looked at or copied for research purposes by Virginia Commonwealth University.

What we find from this study may be presented at meetings or published in papers, but your name or any other identifiable information will never be used in these presentations or papers.

We will not tell anyone the answers you give us. However, if you tell us that someone is hurting you, or that you might hurt yourself or someone else, the law says that we have to let people in authority know so that they can protect you.

IF AN INJURY OR ILLNESS HAPPENS

If you are either injured by or become ill from participating in this study, please contact your study stuff immediately. Medical treatment is available through the Virginia Commonwealth University Health System (VCUHS). Your study coordinator will arrange for short-term emergency care at the VCUHS or for a referral if it is needed.

Fees for such treatment may be billed to you or to an appropriate third party insurance. Your health insurance company may or may not pay for treatment of injuries or illness as a result of your participation in this study.

To help avoid research-related injury or illness, it is very important to follow all study directions.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

You do not have to participate in this study. If you choose to participate, you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked of you in this study. Your decision to withdraw will involve no penalty or loss of care, service, or benefits to which you are otherwise entitled from the clinic.

Your participation in this study may be stopped at any time by the study staff without your consent. The reasons might include:

- The study staff thinks it necessary for your health or safety;
- You have not followed study instructions;
- Administrative reasons require your withdrawal.

QUESTIONS

In the future, you may have questions about your participation in this study. If you have any questions, complaints, or concerns about the research, contact:

Jacqueline M. McGrath, PhD, RN, FNAP, FAAN

Associate Professor, Department of Family and Community Health Nursing
School of Nursing
Virginia Commonwealth University
Box 980567
Richmond, VA 23298
(804) 828-1930 office

(804) 840-9707 Spanish line

If you have any questions about your rights as a participant in this study, you may contact:

Office for Research

Virginia Commonwealth University

800 East Leigh Street, Suite 113

P.O. Box 980568

Richmond, VA 23298

Telephone: 804-827-2157

You may also contact this number for general questions, concerns, or complaints about the research. Please call this number if you cannot reach the research team or wish to talk to someone else. Additional information about participation in research studies can be found at http://www.research.vcu.edu/irb/volunteers.htm.

CONSENT

I have been given the opportunity to read this consent form. I understand the information about this study. Questions that I had about the study have been answered. My signature says that I am willing to participate in this study. I will receive a copy of the consent form once I have agreed to participate.

Participant name printed *Participant signature* *Date*

_____

Name of Person Conducting Informed Consent

Discussion / Witness [3]

(Printed)

_____ _____

Signature of Person Conducting Informed Consent Date

Discussion / Witness

_____ _____

Principal Investigator Signature (if different from above) Date

INFORMACIÓN Y FORMULARIO DE CONSENTIMIENTO DEL PARTICIPANTEEN EL ESTUDIO

TÍTULO: Investigación de factores importantes de comunicación y toma de decisiones sexuales entre parejas latinas.

VCU IRB NO.: 13944

Este formulario de consentimiento puede contener palabras que usted no entienda. Por favor pregunte al personal del estudio el significado de cualquier palabra que no entienda claramente. Se puede llevar una copia sin firma de este formulario para pensar y discutir el estudio de investigación con su familia o amigos antes de tomar una decisión.

PROPÓSITO DEL ESTUDIO

El propósito de este estudio de investigación es examinar los factores relacionados con la planificación familiar, toma de decisiones y la comunicación entre parejas latinas. Se le pide participar en este estudio porque es una mujer latina en el segundo o tercer trimestre de embarazo que está casada/acompañada/juntada/vive en unión libre con una pareja latina **o** es un hombre latino casado/acompañado/juntado/vive en unión libre con una pareja latina que está en el segundo o tercer trimestre de embarazo.

DESCRIPCIÓN DEL ESTUDIO Y SU PARTICIPACIÓN

Si decide estar en este estudio de investigación con su pareja, se le pedirá que firme este formulario de consentimiento después de que sus preguntas hayan sido respondidas y haya entendido completamente lo que ocurrirá durante el transcurso de este estudio.

En este estudio se le pedirá que llene algunos cuestionarios separado de su pareja. Si prefiere ayuda para leer y comprender completamente los cuestionarios, un miembro del personal bilingüe (que habla español e ingles) del estudio se los leerá. La sesión de cuestionamiento se llevará a cabo en un cuarto privado, y durará cerca de una hora. Aproximadamente cuarenta parejas van a participar en este estudio.

RIESGOS E INCOMODIDADES

A veces responder preguntas acerca de estos temas puede ser desagradable o causar molestia a la persona. Se le harán algunas preguntas acerca de la relación entre usted y su pareja. No tiene que responder preguntas que no quiere responder. Si se siente molesto o triste, el personal de estudio le facilitará nombres de consejeros que puede contactar y buscar ayuda para tratar estos problemas.

BENEFICIOS PARA USTED Y OTROS

Tal vez usted no obtenga un beneficio directo de este estudio, pero la información que obtengamos nos va a ayudar a diseñar mejores programas de planificación familiar para latinos.

COSTOS

No hay un costo por participar en este estudio, excepto el tiempo que se llevará en llenar los cuestionarios.

PAGO POR LA PARTICIPACIÓN

Después de que ambos hayan llenado los cuestionarios, recibirán 20 dólares de compensación como pareja por su tiempo y esfuerzos.

ALTERNATIVAS

Su alternativa es no participar en este estudio.

CONFIDENCIALIDAD

Información potencialmente identificable sobre usted consistirá en preguntas preliminares y cuestionarios. La información es obtenida solo para propósitos de investigación. Todos los documentos del estudio se identificarán con un número al azar. Todos los documentos se guardarán en una oficina bajo llave y solo el personal del estudio tendrá acceso a estos documentos. Toda la información de identidad personal se guardará en archivos protegidos con contraseñas, y estos expedientes se borrarán 7 años después de que el estudio haya terminado.

No compartiremos la información que usted nos ha proporcionado; sin embargo, información sobre la investigación y su historial médico así como el formulario de consentimiento que usted firma podría ser revisado o copiado para propósitos de investigación por la Universidad de Virginia Commonwealth.

Los resultados de este estudio podrían ser presentados en conferencias o ser publicados en revistas, pero su nombre y cualquier otro tipo de información identificable nunca se usará en estas conferencias o artículos.

No compartiremos la información que usted nos ha proporcionado. Sin embargo, si nos comenta que alguien le está lastimando, o que usted podría lastimarse a sí misma o alguien más, la ley establece que tenemos que informar a las autoridades para que puedan protegerle.

EN CASO DE ALGUNA LESIÓN O ENFERMEDAD

Si usted llega a tener alguna lesión o enfermedad a causa de participar en este estudio, por favor contacte inmediatamente al personal del estudio. Hay tratamiento médico disponible a través del Sistema de Salud de la Universidad Commonwealth (VCUHS). El coordinador del estudio hará los arreglos para el cuidado de emergencias a corto plazo en el VCUHS o le referirá a otro centro de ser necesario.

El costo del tratamiento podría ser cobrado a usted o a su compañía de seguro médico. Su compañía de seguro medico podría o no pagar el tratamiento por las lesiones o enfermedades causados por su participación en este estudio.

Para prevenir lesiones o enfermedades relacionadas con la investigación, es muy importante seguir todas las instrucciones del estudio.

PARTICIPACIÓN VOLUNTARIA Y RETRACCIÓN (ABANDONAR EL ESTUDIO)

Usted no tiene que participar en este estudio. Si decide participar, sepa que puede abandonar el estudio cualquier momento sin ninguna penalidad. También puede decidir no responder a ciertas preguntas que se le hagan en el estudio. Su decisión de retractarse no le causará ninguna penalidad ni afectará la asistencia, servicios o beneficios que recibe de la clínica.

Su participación en este estudio puede ser detenida en cualquier momento por el personal del estudio sin su consentimiento. La razón pueden ser que:

- El personal del estudio piensa que es necesario por su salud o seguridad;
- No ha seguido las instrucciones del estudio;
- Razones administrativas requieren su retracción (retiro/abandonamiento).

PREGUNTAS

En el futuro, usted puede tener preguntas sobre su participación en este estudio. Si tiene alguna preguntas, quejas o inquietudes sobre la investigación, contacte a:

Jacqueline M. McGrath, PhD, RN, FNAP, FAAN

Profesora Asociada,

Departamento de Enfermería de la Salud de la Familia y la Comunidad

Escuela de Enfermería

Universidad de Virginia Commonwealth
Box 980567, Richmond, VA 23298
(804) 828-1930 Oficina , (804) 840-9707 Línea en español

Si tiene alguna pregunta sobre sus derechos como participante de este estudio, puede contactar a:

Oficina de investigación

Universidad de Virginia Commonwealth

800 East Leigh Street, Suite 113

P.O. Box 980568

Richmond, VA 23298

Teléfono: 804-827-2157

También puede llamar a este número para preguntas generales, inquietudes o quejas sobre la investigación. Por favor llame a este número si no puede comunicarse con el equipo de investigación o si desea hablar con alguien más. Información adicional sobre la participación en estudios de investigación puede encontrarse en http://www.research.vcu.edu/irb/volunteers.htm.

CONSENTIMIENTO

Se me ha dado la oportunidad de leer este formulario de consentimiento. Entiendo la información sobre el estudio. Preguntas que tenía sobre el estudio han sido respondidas. Mi firma indica que estoy dispuesto a participar en el estudio. Recibiré una copia del formulario de consentimiento una vez que haya decidido participar.

_____

Nombre del participante (escrito) Fecha

_____

Firma del participante

_____

Nombre de la persona que realizó la discusión sobre la información de consentimiento/ Testigo (Escrito) Fecha

_____

Firma de la persona que realizó la discusión sobre la información de consentimiento/ Testigo

_____

Firma del investigador principal (si es diferente a la de arriba) Fecha

COMMONWEALTH of VIRGINIA
Department of Health

KAREN REMLEY, MD, MBA, FAAP
STATE HEALTH COMMISSIONER

November 1, 2011

Jacqueline M. McGrath, PhD.
Virginia Commonwealth University
School of Nursing
P. O. Box 980567
1100 East Leigh Street
Richmond, Virginia 23298

Dear Dr. McGrath:

Study #:	40142
Study Title:	Predictors of Communication and Family Planning Decision Making Among Latino Couples
Principal Investigator:	Jacqueline M. McGrath, PhD, RN, FNAP, FAAN
Type of Review:	Expedited

This letter is to advise you that the above referenced study has been reviewed by the Virginia Department of Health (VDH) Institutional Review Board (IRB) and has been approved with the following recommendations:

- There a few typos in the questionnaires. Please use spell-check or grammar check.
- For questionnaires (e.g., Sexual Power Relationship) that will be used by both female and male partners, the use of "s/he" (for she or he) may be confusing for someone whose primary language is Spanish, but they are completing the form in English. Can you develop separate forms for female and male participants that are gender-specific in use of pronouns and that apply specifically to male and female partners?
- See above comment in regards to the Sexual Decision Making questionnaire. Similar recommendation for using text other than "[NAME]" in the form, unless the researcher intends to give explicit instructions to participants on how to read and complete the form.
- See second comment in regards to the Contraception Attitudes and Perceptions questionnaire, the use of "I/my partner" may be confusing.

A Continuation Review form will need to be completed and returned annually for all ongoing research projects, a reminder letter and form will be sent to you six weeks prior to the November 1, 2012 annual review due date. A brief study summary report is to be submitted to the VDH IRB within 90 days of the conclusion of the research project.

Expected adverse events (those noted on the consent form) need not be reported to the VDH IRB on an individual basis. At the time of continuation review, the principal investigator should report the incidence of these adverse events. If, in the course of conducting the study, the principal investigator finds that the

expected adverse events are occurring with a greater frequency or at a higher level of severity than expected, or if there is an occurrence of an unanticipated adverse event, he/she should report this to the VDH IRB within ten business days of when this finding is noted. Finally, the death of any study subject should be reported immediately to the VDH IRB. The only exception is when the study is conducted among subjects who are expected to have a high rate of mortality from their underlying condition, and the investigator has absolutely ruled out any connection between any study procedure and the subject's death.

Should the project undergo substantial changes (e.g., changes in the consent procedure, addition of potentially sensitive items to research instruments, changes in treatment procedure) in the protocol or subject population, another request for IRB review must be filed.

On behalf of the members of the VDH IRB, I wish you well on your research project.

Sincerely,

Diane Helentjaris MD

Diane Helentjaris, MD, MPH
Chair, VDH IRB

Appendix B

Science on Predictors of Sexual Relationship Power, Communication and Family Planning Decision Making among Latino Couples

Study Measures

(English and Spanish)

Screening questions (female)

1. How many weeks are you into your pregnancy?
   _____weeks *(not eligible if less than(<) 13th week)*

2. How old are you?
   _____ years old *(not eligible if less than (<) 18 years old)*

3. Where were you born?
   _Mexico

   _Guatemala

   _El Salvador

   _Honduras

   _Other:_____

   (not eligible if not born in a Latin American country)

4. 4a.What is your primary language?
   _Spanish

   _English

   _Spanish and English

   _Mixteco

   _Kaqchiquel

   _Other:_____

   (if chosen a language other than Spanish, go to 4b.)

   4b. How fluent do you speak Spanish?

   _little

   _moderately fluent

   _fluent

   (not eligible if she speaks little Spanish)

5. Do you have a male partner?
   _Yes

   _No(*Not eligible if answer is no)*

6. What is the relationship status with your partner
   _married

   _cohabitating/being together

   _dating (*Not eligible if answer is dating)*

7. Where was he born?
   _Mexico

   _Guatemala

   _El Salvador

   _Honduras

   _Other: _____

   (not eligible if not born in a Latin American country)

8. How old is he?
   ____ years old *(not eligible if less than (<) 18 years old)*

9. 9a. Are you sexually active with your partner?
   _Yes

   _No (*go to 9b)*

   9b. Is it because of the pregnancy?

   _Yes

   _No (*Not eligible if answer is no)*

10. Are you planning to be sexually active with your partner after delivery?
    _Yes

    _No (*Not eligible if answer is no)*

11. Has your partner had surgery to stop having babies?
    _No

    _Yes(*Not eligible if answer is yes)*

    Eligible: Yes No

    Subject ID: | | | |

Screening questions in English (male)

1. Are you _____ (relationship status referred by female partner) with _____?
   _Yes

   _No *(not eligible if answer is no)*

2. How old are you?
   _____ years old *(not eligible if less than (<) 18 years old)*

3. Where were you born?
   _Mexico

   _Guatemala

   _El Salvador

   _Honduras

   _Other: _____

   (not eligible if not born in a Latin American country)

4. 4a. What is your primary language?
   _Spanish

   _English

   _Spanish and English

   _Mixteco

   _Kaqchiquel

   _Other:_____

   (if chosen a language other than Spanish, go to 4b.)

   4b. How fluent do you speak Spanish?

   _little

   _moderately fluent

   _fluent

   (not eligible if she speaks little Spanish)

5. 5a. Are you sexually active with your partner?
   _Yes

   _No (*go to 5b)*

   5b. Is it because of the pregnancy?

   _Yes

   _No (*Not eligible if answer is no)*

6. Are you planning to be sexually active with your partner after her delivery?
   _Yes

   _No (*Not eligible if answer is no)*

7. Have you had surgery to stop having babies?
   _No

   _Yes (*Not eligible if answer is yes)*

   Eligible: Yes No

   Subject ID: | | | |

Demographic Form (female)

1. How many weeks are you in your pregnancy (ask if data collection is not on the same date as the date administered the screening form, in case of any changes)?
   _____weeks

2. How long have you been together with your partner?
   ___months/___years

3. How many times have you been pregnant?
   __times

4. How many times have you been pregnant with your current partner?
   __times

5. How many times have you given birth?
   __times

6. How many times have you given birth with your current partner?
   __times

7. How many children live with you right now?
   _children

   _None

8. What is your job (briefly describe your job)?
   _Work full-time: _____

   _Work part-time:_____

   _Work as needed:_____

   _Stay at home (housework, take care of children etc.)

   _Unemployed:_____

   _On welfare:_____

   _Other:_____

9. What is the estimated monthly household income (including earnings, welfare, child support etc.)?
   $ _____

10. How many people does the total income support?
    __people

11. What is the highest education you have completed?
    _1-6

    _7-8

_9-12

_1-2years of college

_3-4years of college

_college graduate and higher

12. How long have you lived in the United States?
___years ___months

13. What is your religious preference?
_Evangelical wit

_Catholic

_Other:_____

14. Has your provider talked with you and your partner about contraception after you give birth?
_Yes, with me

_Yes, with me and my partner

_No

15. Do you and your partner plan to use a contraceptive method after the baby is born?
_No. Why not? _____

_Yes. Why?_____

16. Which method are you/your partner planning to use (check all that apply)?
_Pill

_Shot

_Implant

_Contraceptive patch

_IUD

_Vaginal Ring

_Condom

_Natural family planning (rhythm method, withdrawal etc.)

_I don't know

_Other (please specify):_____

17. Why are you choosing this method (or these methods)?

Demographic Form (male)

1. How long have you been together with your partner?
   ___months/___years

2. How many children do you have?
   __children

3. How many children do you have with your current partner?
   __children

4. How many children live with you right now?
   _children

   _None

5. What is your job (briefly describe your job)?
   _Work full-time: _____

   _Work part-time:_____

   _Work as needed:_____

   _Stay at home (housework, take care of children etc.)

   _Unemployed:_____

   _On welfare:_____

   _Other:_____

6. What is the estimated monthly household income (including earnings, welfare, child support etc.)?
   $ _____

7. How many people does the total income support?
   __people

8. What is the highest education you have completed?
   _1-6

   _7-8

   _9-12

   _1-2years of college

   _3-4years of college

   _college graduate and higher

9. How long have you lived in the United States?
   ___years ___months

10. What is your religious preference?

    _Evangelical Christian

    _Catholic

    _Other_____

11. Has your provider talked with you and your partner about contraception after your partner gives birth?
    _Yes with me

    _Yes with me and my partner

    _No

12. Do you and your partner plan to use a contraceptive method after the baby is born?
    _No. Why not? _____

    _Yes. Why?_____

13. Which method are you/your partner planning to use (check all that apply)?
    _Pill

    _Shot

    _Implant

    _Contraceptive patch

    _IUD

    _Vaginal Ring

    _Condom

    _Natural family planning (rhythm method, withdrawal etc.)

    _I don't know

    _Other (please specify):_____

14. Why are you choosing this method (or these methods)?
    _____

Machismo scale

		a	b	c	d	e
1	A man should not marry a woman who is taller than him.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
2	It is the mother's special responsibility to provide her children with proper religious training.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
3	Boys should not be allowed to play with dolls, and other girls' toys.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
4	Parents should maintain stricter control over their daughters than their sons.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
5	There are some jobs that women simply should not have.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
6	It is more important for a woman to learn how to take care of the house and the family than it is for her to get a college education.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
7	A wife should never contradict her husband in public.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
8	Men are more intelligent than women.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	No matter what people say, women really like dominant men.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	Some equality in marriage is a good thing, but by and large the father ought to have the main say so in family matters.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	For the most part, it is better to be a man than a woman.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	I would be more comfortable with a male boss than with a female boss.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	Most women have little respect for weak men.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	It is important for a man to be strong.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	Girls should not be allowed to play with boys' toys such as soldiers and footballs.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	Wives should respect the man's position as head of the household.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
	The father always knows what is best for the family.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree

Communication with Partner (female version)

Circle the words that describe my communication with my partner.

	Item					
1	I listen attentively when I feel that my partner is speaking to me.	Almost Always	Often	Sometimes	Rarely	Almost Never
2	I feel that my partner listens attentively when I speak.	Almost Always	Often	Sometimes	Rarely	Almost Never
3	I feel that my partner understands what I communicate.	Almost Always	Often	Sometimes	Rarely	Almost Never
4	I feel that I understand what my partner communicates.	Almost Always	Often	Sometimes	Rarely	Almost Never
5	I am comfortable about asking my partner to do things for me.	Almost Always	Often	Sometimes	Rarely	Almost Never
6	I feel that my partner often asks me to do various things.	Almost Always	Often	Sometimes	Rarely	Almost Never
7	I express appreciation for the things my partner does for me in response to my requests.	Almost Always	Often	Sometimes	Rarely	Almost Never
8	My partner expresses appreciation for the things I do in response to his requests.	Almost Always	Often	Sometimes	Rarely	Almost Never
9	I feel that my partner tells me too many negative things about myself or our relationship.	Almost Always	Often	Sometimes	Rarely	Almost Never
10	I feel that I tell my partner too many negative things about him/her/it or our relationship.	Almost Always	Often	Sometimes	Rarely	Almost Never
11	I am comfortable expressing disagreement with things my partner says or does.	Almost Always	Often	Sometimes	Rarely	Almost Never
12	I respond constructively when my partner disagrees with things I say or do.	Almost Always	Often	Sometimes	Rarely	Almost Never
13	I enjoy just sitting and talking with my partner.	Almost Always	Often	Sometimes	Rarely	Almost Never

Communication with Partner (male version)

Circle the words that describe my communication with my partner.

	Item					
1	I listen attentively when I feel that my partner is speaking to me.	Almost Always	Often	Sometimes	Rarely	Almost Never
2	I feel that my partner listens attentively when I speak.	Almost Always	Often	Sometimes	Rarely	Almost Never
3	I feel that my partner understands what I communicate.	Almost Always	Often	Sometimes	Rarely	Almost Never
4	I feel that I understand what my partner communicates.	Almost Always	Often	Sometimes	Rarely	Almost Never
5	I am comfortable about asking my partner to do things for me.	Almost Always	Often	Sometimes	Rarely	Almost Never
6	I feel that my partner often asks me to do various things.	Almost Always	Often	Sometimes	Rarely	Almost Never
7	I express appreciation for the things my partner does for me in response to my requests.	Almost Always	Often	Sometimes	Rarely	Almost Never
8	My partner expresses appreciation for the things I do in response to her requests.	Almost Always	Often	Sometimes	Rarely	Almost Never
9	I feel that my partner tells me too many negative things about myself or our relationship.	Almost Always	Often	Sometimes	Rarely	Almost Never
10	I feel that I tell my partner too many negative things about him/her/it or our relationship.	Almost Always	Often	Sometimes	Rarely	Almost Never
11	I am comfortable expressing disagreement with things my partner says or does.	Almost Always	Often	Sometimes	Rarely	Almost Never
12	I respond constructively when my partner disagrees with things I say or do.	Almost Always	Often	Sometimes	Rarely	Almost Never
13	I enjoy just sitting and talking with my partner.	Almost Always	Often	Sometimes	Rarely	Almost Never

Dyadic Sexual Communication Scale

Instructions: This is a list of statements different people have made about discussing sex with their primary partner. Please answer how much you agree or disagree with it.

		1	2	3	4	5	6
1	My partner rarely responds when I want to talk about our sex life.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
2	Some sexual matters are too upsetting to discuss with my sexual partner.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
3	There are sexual issues or problems in our sexual relationship that we have never discussed.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
4	My partner and I never seem to resolve our disagreements about sexual matters.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
5	Whenever my partner and I talk about sex, I feel like she or he is lecturing me.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
6	My partner often complains that I am not very clear about what I want sexually.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
7	My partner and I have never had a heart-to-heart talk about our sex life together.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
8	My partner has no difficulty in talking to me about his or her sexual feelings and desires.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
9	Talking about sex is a satisfying experience for both of us.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
10	My partner and I can usually talk calmly about our sex life.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
11	I have little difficulty in telling my partner what I do or don't do sexually.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly
12	I seldom feel embarrassed when talking about the details of our sex life with my partner.	disagree strongly	disagree somewhat	disagree slightly	agree slightly	agree somewhat	agree strongly

Sexual Relationship Power Scale (Female, English Version)

		1	2	3	4
1	If I asked my partner to use a condom, he would get violent.	Strongly agree	Agree	Disagree	Strongly disagree
2	If I asked my partner to use a condom, he world get angry.	Strongly agree	Agree	Disagree	Strongly disagree
3	Most of the time, we do what my partner wants to do.	Strongly agree	Agree	Disagree	Strongly disagree
4	My partner won't let me wear certain things.	Strongly agree	Agree	Disagree	Strongly disagree
5	When my partner and I are together, I am pretty quiet.	Strongly agree	Agree	Disagree	Strongly disagree
6	My partner has more say than I do about important decisions that affect us.	Strongly agree	Agree	Disagree	Strongly disagree
7	My partner tells me who I can spend time with.	Strongly agree	Agree	Disagree	Strongly disagree
8	If I asked my partner to use a condom, he would think I'm having sex with other people.	Strongly agree	Agree	Disagree	Strongly disagree
9	I feel trapped or stuck in our relationship.	Strongly agree	Agree	Disagree	Strongly disagree
10	My partner does what he wants, even if I do not want him to.	Strongly agree	Agree	Disagree	Strongly disagree
11	I am more committed to our relationship than my partner is.	Strongly agree	Agree	Disagree	Strongly disagree
12	When my partner and I disagree, he gets his ways most of the time.	Strongly agree	Agree	Disagree	Strongly disagree
13	My partner gets more out of our relationship than I do.	Strongly agree	Agree	Disagree	Strongly disagree
14	My partner always wants to know where I am.	Strongly agree	Agree	Disagree	Strongly disagree
15	My partner might be having sex with someone else.	Strongly agree	Agree	Disagree	Strongly disagree

Sexual Relationship Power Scale Page 2 (Female, English Version)

		1	2	3
1	Who usually has more say about whose friends to go out with?	Your partner	Both of you equally	You
2	Who usually has more say about whether you have sex?	Your partner	Both of you equally	You
3	Who usually has more say about what you do together?	Your partner	Both of you equally	You
4	Who usually has more say about how often you go out without your children?	Your partner	Both of you equally	You
5	Who usually has more say about when you talk about serious things?	Your partner	Both of you equally	You
6	In general, who do you think has more power in your relationship?	Your partner	Both of you equally	You
7	Who usually has more say about whether you use condom?	Your partner	Both of you equally	You
8	Who usually has more say about what types of sexual acts you do?	Your partner	Both of you equally	You

Sexual Relationship Power Scale (Male, English Version)

		1	2	3	4
1	If I asked my partner to use a condom, she would get violent.	Strongly agree	Agree	Disagree	Strongly disagree
2	If I asked my partner to use a condom, she world get angry.	Strongly agree	Agree	Disagree	Strongly disagree
3	Most of the time, we do what my partner wants to do.	Strongly agree	Agree	Disagree	Strongly disagree
4	My partner won't let me wear certain things.	Strongly agree	Agree	Disagree	Strongly disagree
5	When my partner and I are together, I am pretty quiet.	Strongly agree	Agree	Disagree	Strongly disagree
6	My partner has more say than I do about important decisions that affect us.	Strongly agree	Agree	Disagree	Strongly disagree
7	My partner tells me who I can spend time with.	Strongly agree	Agree	Disagree	Strongly disagree
8	If I asked my partner to use a condom, she would think I'm having sex with other people.	Strongly agree	Agree	Disagree	Strongly disagree
9	I feel trapped or stuck in our relationship.	Strongly agree	Agree	Disagree	Strongly disagree
10	My partner does what she wants, even if I do not want her to.	Strongly agree	Agree	Disagree	Strongly disagree
11	I am more committed to our relationship than my partner is.	Strongly agree	Agree	Disagree	Strongly disagree
12	When my partner and I disagree, he gets his ways most of the time.	Strongly agree	Agree	Disagree	Strongly disagree
13	My partner gets more out of our relationship than I do.	Strongly agree	Agree	Disagree	Strongly disagree
14	My partner always wants to know where I am.	Strongly agree	Agree	Disagree	Strongly disagree
15	My partner might be having sex with someone else.	Strongly agree	Agree	Disagree	Strongly disagree

Sexual Relationship Power Scale (English)

		1	2	3
1	Who usually has more say about whose friends to go out with?	Your partner	Both of you equally	You
2	Who usually has more say about whether you have sex?	Your partner	Both of you equally	You
3	Who usually has more say about what you do together?	Your partner	Both of you equally	You
4	Who usually has more say about how often you go out without your children?	Your partner	Both of you equally	You
5	Who usually has more say about when you talk about serious things?	Your partner	Both of you equally	You
6	In general, who do you think has more power in your relationship?	Your partner	Both of you equally	You
7	Who usually has more say about whether you use condom?	Your partner	Both of you equally	You
8	Who usually has more say about what types of sexual acts you do?	Your partner	Both of you equally	You

CONTRACEPTION ATTITUDES & PERCEPTIONS (female version)

In answering the next few questions, please answer how much you agree or disagree with the following statements about using birth control including condoms.

		1	2	3	4	5
a	I just don't think about using birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
b	I don't think I will get pregnant.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
c	I don't care if I get pregnant	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
d	I don't have sex very often.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
e	It doesn't matter if I use birth control-when it's my time to get pregnant, it will happen again.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
f	I want to get pregnant again.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
g	I don't know how to get birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
h	I don't know where to get birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
i	It is wrong to use birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
j	Birth control is the woman's responsibility.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
k	Using birth control is against my religious beliefs.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
l	Discussing birth control with my partner is embarrassing.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
m	My partner does not want me to use birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
n	If I use birth control, my partner would think I'm planning to have sex.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
o	I worry about the side effects of birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
p	My partner worries about the side effects of birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
q	Having sex is sometimes unexpected.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
r	Sometimes there is no time to prepare for sex.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
s	Sex is more romantic when we don't use birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
t	I am afraid to go to the doctor to get birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
u	I don't use birth control because it costs too much.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree

CONTRACEPTION ATTITUDES & PERCEPTIONS

In answering the next few questions, please answer how much you agree or disagree with the following statements about using birth control including condoms.

		1	2	3	4	5
a	I just don't think about using birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
b	I don't think my partner will get pregnant.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
c	I don't care if my partner gets pregnant	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
d	I don't have sex very often.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
e	It doesn't matter if I use birth control-when it's my partner's time to get pregnant, it will happen again.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
f	I want to get my partner pregnant again.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
g	I don't know how to get birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
h	I don't know where to get birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
i	It is wrong to use birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
j	Birth control is the woman's responsibility.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
k	Using birth control is against my religious beliefs.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
l	Discussing birth control with my partner is embarrassing.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
m	My partner does not want me to use birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
n	If I use birth control, my partner would think I'm planning to have sex.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
o	I worry about the side effects of birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
p	My partner worries about the side effects of birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
q	Having sex is sometimes unexpected.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
r	Sometimes there is no time to prepare for sex.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
s	Sex is more romantic when we don't use birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
t	I am afraid to go to the doctor to get birth control.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
u	I don't use birth control because it costs too much.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree

SEXUAL DECISION MAKING (female version)

These next questions are about *how sexual partners make decisions*. When answering these questions Please *think about your relationship with your partner and how much responsibility you and your partner have when making each of these decisions* using the choices below:

a	In your relationship with your partner, how much have you taken part in deciding whether or not to get pregnant?	1 Not at all	2	3	4	5 A great deal
b	In your relationship with your partner, how much have you taken part in deciding whether or not to use something to keep from getting pregnant?	1 Not at all	2	3	4	5 A great deal
c	In your relationship with your partner, how much have you taken part in deciding whether or not to use a condom?	1 Not at all	2	3	4	5 A great deal
d	In your relationship with your partner, how much have you taken part in deciding whether or not you protect yourselves from HIV and other sexually transmitted infections (STIs)?	1 Not at all	2	3	4	5 A great deal
e	In your relationship with your partner, how much have you taken part in deciding whether or not to have sex?	1 Not at all	2	3	4	5 A great deal
f	In your relationship with your partner, how much have you taken part in deciding what kinds of things you do when you have sex?	1 Not at all	2	3	4	5 A great deal
g	In your relationship with partner, how much has he taken part in deciding whether or not to get you pregnant?	1 Not at all	2	3	4	5 A great deal
h	In your relationship with your partner, how much has he taken part in deciding whether or not to use something to keep from getting you pregnant?	1 Not at all	2	3	4	5 A great deal
i	In your relationship with your partner, how much has he taken part in deciding whether or not to use a condom?	1 Not at all	2	3	4	5 A great deal
j	In your relationship with your partner, how much has he taken part in deciding whether or not you protect yourselves from HIV and other STIs?	1 Not at all	2	3	4	5 A great deal
k	In your relationship with your partner, how much has he taken part in deciding whether or not to have sex?	1 Not at all	2	3	4	5 A great deal
l	In your relationship with your partner, how much has he taken part in deciding what kinds of things you do when you have sex?	1 Not at all	2	3	4	5 A great deal

SEXUAL DECISION MAKING (male version)

These next questions are about *how sexual partners make decisions*. When answering these questions Please *think about your relationship with your partner and how much responsibility you and your partner have when making each of these decisions* using the choices below:

a	In your relationship with your partner, how much have you taken part in deciding whether or not to get her pregnant?	1 Not at all	2	3	4	5 A great deal
b	In your relationship with your partner, how much have you taken part in deciding whether or not to use something to keep from getting her pregnant?	1 Not at all	2	3	4	5 A great deal
c	In your relationship with your partner, how much have you taken part in deciding whether or not to use a condom?	1 Not at all	2	3	4	5 A great deal
d	In your relationship with your partner, how much have you taken part in deciding whether or not you protect yourselves from HIV and other sexually transmitted infections (STIs)?	1 Not at all	2	3	4	5 A great deal
e	In your relationship with your partner, how much have you taken part in deciding whether or not to have sex?	1 Not at all	2	3	4	5 A great deal
f	In your relationship with your partner, how much have you taken part in deciding what kinds of things you do when you have sex?	1 Not at all	2	3	4	5 A great deal
g	In your relationship with partner, how much has she taken part in deciding whether or not to get pregnant?	1 Not at all	2	3	4	5 A great deal
h	In your relationship with your partner, how much has she taken part in deciding whether or not to use something to keep from getting pregnant?	1 Not at all	2	3	4	5 A great deal
i	In your relationship with your partner, how much has she taken part in deciding whether or not to use a condom?	1 Not at all	2	3	4	5 A great deal
j	In your relationship with your partner, how much has she taken part in deciding whether or not you protect yourselves from HIV and other STIs?	1 Not at all	2	3	4	5 A great deal
k	In your relationship with your partner, how much has she taken part in deciding whether or not to have sex?	1 Not at all	2	3	4	5 A great deal
l	In your relationship with your partner, how much has she taken part in deciding what kinds of things you do when you have sex?	1 Not at all	2	3	4	5 A great deal

RELATIONSHIP COMMITMENT

Please answer how much you agree with each of the following statements with respect to your relationship with your partner.

a	I wanted our relationship to last a very long time.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
b	I was committed to maintaining my relationship with my partner.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
c	I would not have felt very upset if our relationship had ended in the near future.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
d	It is likely that I would have dated someone other than my partner within the next year.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
e	I felt very attached to our relationship -- very strongly linked to my partner.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
f	I wanted our relationship to last forever.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
g	I was oriented toward the long-term future of my relationship (for example, I imagined being with my partner several years from now).	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
h	I intended to stay in this relationship.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely

Now please answer how much you agree with each statement about your relationship with your partner.

a	My partner was committed to maintaining our relationship.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
b	My partner felt very attached to our relationship – very strongly linked to me.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
c	My partner was oriented toward the long-term future of our relationship (for example, imagined being with me several years from now).	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
d	My partner wanted our relationship to last a very long time.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
e	My partner would not have felt very upset if our relationship had ended in the near future.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
f	My partner was likely to date someone other than me within the next year.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
g	My partner wanted our relationship to last forever.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely
h	My partner intended to stay in this relationship.	0 1 2 3 4 5 6 7 8 Do Not Agree At All — Agree Somewhat — Agree Completely

Marianismo Beliefs Scale

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

A Latina…	1	2	3	4
1.) must be a source of strength for her family.	strongly disagree	disagree	agree	strongly agree
2.) is considered the main source of strength of her family.	strongly disagree	disagree	agree	strongly agree
3.) mother must keep the family unified.	strongly disagree	disagree	agree	strongly agree
4.) should teach her children to be loyal to the family.	strongly disagree	disagree	agree	strongly agree
5.) should do things that make her family happy.	strongly disagree	disagree	agree	strongly agree
6.) should remain a virgin until marriage.	strongly disagree	disagree	agree	strongly agree
7.) should wait until after marriage to have children.	strongly disagree	disagree	agree	strongly agree
8.) should be pure.	strongly disagree	disagree	agree	strongly agree
9.) should adopt the values taught by her religion.	strongly disagree	disagree	agree	strongly agree
10.) should be faithful to her partner.	strongly disagree	disagree	agree	strongly agree
11.) should satisfy her partner's sexual needs without argument.	strongly disagree	disagree	agree	strongly agree
12.) should not speak out against men.	strongly disagree	disagree	agree	strongly agree
13.) should respect men's opinions even when she does not agree.	strongly disagree	disagree	agree	strongly agree
14.) should avoid saying no to people.	strongly disagree	disagree	agree	strongly agree
15.) should do anything a male in the family asks her to do.	strongly disagree	disagree	agree	strongly agree
16.) should not discuss birth control.	strongly disagree	disagree	agree	strongly agree
17.) should not express her needs to her partner.	strongly disagree	disagree	agree	strongly agree
18.) should feel guilty about telling people what she needs.	strongly disagree	disagree	agree	strongly agree
19.) should not talk about sex.	strongly disagree	disagree	agree	Strongly agree

20.) should be forgiving in all aspects.	strongly disagree	disagree	agree	strongly agree
21.) should always be agreeable to men's decisions.	strongly disagree	disagree	agree	strongly agree
22.) should be the spiritual leader of the family.	strongly disagree	disagree	agree	strongly agree
23.) is responsible for taking family to religious services.	strongly disagree	disagree	agree	strongly agree
24.) is responsible for the spiritual growth of the family.	strongly disagree	disagree	agree	strongly agree

Dyadic Adjustment Scale (short form 7 items)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

		5	4	3	2	1	0
1	Philosophy of life	always agree	almost always agree	occasionally disagree	frequently disagree	almost always disagree	always disagree
2	Aims, goals, and things believed important	always agree	almost always agree	occasionally disagree	frequently disagree	almost always disagree	always disagree
3	Amount of time spent together	always agree	almost always agree	occasionally disagree	frequently disagree	almost always disagree	always disagree

How often do the following occur between you and your mate

		0	1	2	3	4	5
4	Have a stimulating exchange of ideas	never	less than a month	once or twice a month	once or twice a week	once a day	more often
5	Calmly discuss something	never	less than a month	once or twice a month	once or twice a week	once a day	more often
6	Work together on a project	never	less than a month	once or twice a month	once or twice a week	once a day	more often

7. The dots on the following line represent different degrees of happiness in your relationship. The point, "happy", represents the degree of happiness of most relationships. Please circle the dot that best describes the degree of happiness, all things considered of your relationship.

0	1	2	3	4	5	6
.	.	.	.	.	.	.
Extremely Unhappy	fairly unhappy	a little unhappy	happy	very happy	extremely happy	perfect

Fatalism Scale

English Version

		1	2	3	4	5
1	It is more important to enjoy life now than to plan for the future.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
2	People die when it is their time and there is not much that can be done about it.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
3	We must live for the present, who knows what the future may bring.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
4	If my doctor said I was disabled, I would believe it even if I disagreed.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
5	It is not always wise to plan too far ahead because many thing turn out to be a matter of good and bad fortune anyway.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
6	It doesn't do any good to try to change the future because the future is in the hands of God.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
7	When I make plans, I am almost certain I can make them work.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree
8	I sometimes feel that someone controls me.	Do not agree at all	Somewhat agree	Moderately agree	Mostly agree	Completely agree

Religiousness Commitment Inventory

		1	2	3	4	5
1	I often read books and magazines about my faith.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
2	I make financial contributions to my religious organization.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
3	I spend time trying to grow in understanding of my faith.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
4	Religion is especially important to me because it answers many questions about the meaning of life.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
5	My religious beliefs lie behind my whole approach to life.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
6	I enjoy spending time with others of my religious affiliation.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
7	Religious beliefs influence all my dealings in life.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
8	It is important to me to spend periods of time in private religious thought and reflection.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
9	I enjoy working in the activities of my religious organization.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me
10	I keep well informed about my local religious group and have some influence in its decisions.	not at all true of me	somewhat true of me	moderately true of me	mostly true of me	totally true of me

Preguntas Preliminares (femenino)

1. ¿Cuántas semanas tiene de embarazo?
   _____semanas *(no es elegible si tiene menos de 13 semanas)*

2. ¿Cuántos años tiene usted?
   _____ años *(no es elegible si tiene menos de 18 años)*

3. ¿Dónde nació?
   _México

   _Guatemala

   _El Salvador

   _Honduras

   _Otro lugar:_____

   (no es elegible si no nació en un país latinoamericano)

4. 4a.¿Cuál es su idioma principal?
   _Español

   _Ingles

   _Español e inglés

   _Mixteco

   _Kaqchiquel

   _Otro:_____

   (Si escogió idioma que no es español, sigue a 4b.)

   4b. ¿Qué tan fluido habla español?

   _Poco

   _Moderado

   _Fluido

   (no es elegible si ha habla poco español)

5. ¿Tiene una pareja que es hombre?
   _Si

   _No (*No es elegible si responde no)*

6. ¿Cuál es el estatus de su relación con su pareja?
   _Casada

   _ Acompañada, juntada, viven en unión libre

   _novios (no es elegible si responde novios)

7. ¿Dónde nació él?
   _México

   _Guatemala

   _El Salvador

   _Honduras

   _Otro lugar: _____

   (no es elegible si no nació en un país latinoamericano)

8. ¿Cuántos años tiene?
   ____ años *(no es elegible si tiene menos de 18 años)*

9. 9a.¿Esta sexualmente activa con su pareja?
   _Si

   _No (*No, sigue a 9b)*

   9b. ¿Esto ha sido a causa del embarazo?

   _Si

   _No *(No es elegible si responde no)*

10. ¿Está planeando estar sexualmente activa con su pareja después de su embarazo?
    _Si

    _No (*No es elegible si responde no)*

11. ¿Su pareja se ha hecho una cirugía para no tener más bebés?
    _No

    _Si (*No es elegible si responde sí)*

    Eligible: Si No

    Subject ID: | | | |

Preguntas Preliminares (masculino)

1. ¿Está usted (casado, acompañado, juntado, vive en unión libre; estatus de la relación referida por la pareja femenina) con _____?
   _Si

   _No *(no es elegible si responde no)*

2. ¿Cuántos años tiene usted?
   _____ años *(no es elegible si es menor de 18 años)*

3. ¿Dónde nació?
   _México

   _Guatemala

   _El Salvador

   _Honduras

   _Otro lugar: _____

   (no es elegible si no nació en un país latinoamericano)

4. 4a.¿Cuál es su idioma principal?
   _Español

   _Ingles

   _Español e inglés

   _Mixteco

   _Kaqchiquel

   _Otro:_____

   (Si escogió idioma que no es español, sigue a 4b.)

   4b. ¿Qué tan fluido habla español?

   _Poco

   _Moderado

   _Fluido

   (No es elegible si ha habla poco español)

5. 5a.¿Esta sexualmente activo con su pareja?
   _Si

   _No (*No, sigue a 5b)*

   5b. ¿Esto ha sido a causa del embarazo?

   _Si

   _No *(No es elegible si responde no)*

6. ¿Está planeando estar sexualmente activo con su pareja después de su embarazo?
   _Si

   _No (*No es elegible si responde no)*

7. ¿Se ha hecho una cirugía para no tener más bebés?
   _No

   _Si (*No elegible si responde sí)*

   Eligible: Si No

   Subject ID: | | | |

Formulario Demográfico (femenina)

1. ¿Cuántas semanas tiene de embarazo (haga esta pregunta si la entrevista no fue hecho el mismo día que hizo las preguntas preliminares, o si ha habido algún cambio)?
   _____semanas

2. ¿Cuánto tiempo ha estado juntos con su pareja?
   ___meses/___años

3. ¿Cuántas veces ha estado embarazada?
   __veces

4. ¿Cuántas veces ha estado embarazada con su pareja actual?
   __veces

5. ¿Cuántas veces ha dado a luz?
   __veces

6. ¿Cuántas veces ha dado a luz con su pareja actual?
   __veces

7. ¿Cuántos hijos viven con usted?
   _hijos

   _Ninguno

8. ¿Cuál es su trabajo (descríbalo brevemente)?
   _Trabaja tiempo completo: _____

   _Trabaja medio tiempo:_____

   _Trabaja conforme cuando haya trabajo: _____

   _Se queda en casa (trabaja en el hogar, ama de casa, cuida a sus hijos etc.)

   _Desempleado:_____

   _Ayuda de gobierno: _____

   _Otro:_____

9. ¿Cuál es su ingreso estimado mensual (incluyendo las entradas de usted y su pareja, welfare, manutención de su hijo, u otro apoyo social)?
   $ _____

10. ¿Cuántas personas mantiene con el ingreso total?
    __personas

11. ¿Cuál es el grado de educación más alto que ha completado?
    _1-6

    _7-8

    _9-12

    _1-2 años de universidad

    _3-4 años de universidad

    _graduado de la universidad o más estudio

12. ¿Por cuánto tiempo ha vivido en los Estados Unidos?
    ____años ___meses
13. ¿Cuál es su preferencia religiosa?
    _Cristiano/Evangélico

    _Católico

    _Otra religión: _____

14. ¿Ha hablado su médico con usted y su pareja acerca de los métodos anticonceptivos después de que dé a luz?
    _Si, conmigo

    _Si, conmigo y mi pareja

    _No

15. ¿Usted y su pareja planean usar métodos anticonceptivos después de que nazca el bebé?
    _No. ¿Por qué no? _____

    _Yes. ¿Por qué?_____

    Si contesta si, por favor vaya a próxima pregunta.

    Si contesta no, es el fin de este cuestionario.

16. ¿Cuál método planea usar usted y/o su pareja (marque todas las respuesta que se apliquen)?
    _Pastilla anticonceptivas

    _Inyección

    _Implante

    _Parche Anticonceptivo

    _DIU (dispositivo intrauterino)

    _Anillo Vaginal

_Condón

_Método natural (ritmo, eyacular afuera etc.)

_No sé

_Otro (por favor especifique):_____

17. ¿Por qué escogió este método(s) ¿

_____

_____

Formulario Demográfico (masculino)

1. ¿Cuánto tiempo has estado con su pareja?
   ___meses/___años

2. ¿Cuántos hijos tiene?
   __hijos

3. ¿Cuántos hijos tiene con su pareja actual?
   __hijos

4. ¿Cuántos hijos viven con usted?
   _hijos

   _Ninguno

5. ¿Cuál es su trabajo (descríbalo brevemente)?
   _Trabaja tiempo completo: _____

   _Trabaja medio tiempo:_____

   _Trabaja conforme cuando haya trabajo: _____

   _Se queda en casa (trabaja en el hogar, cuida a sus hijos etc.)

   _Desempleado:_____

   _Ayuda de gobierno: _____

   _Otro:_____

6. ¿Cuál es su ingreso estimado mensual (incluyendo las entradas de usted y su pareja, welfare, manutención de su hijo, u otro apoyo social)?
   $ _____

7. ¿Cuántas personas mantiene con el ingreso total?
   __personas

8. ¿Cuál es el grado de educación más alto que ha completado?
   _1-6

   _7-8

   _9-12

   _1-2 años de universidad

   _3-4 años de universidad

   _graduado de la universidad o más estudio

9. ¿ Por cuánto tiempo ha vivido en los Estados Unidos?
   ____años ___meses

10. ¿Cuál es tu preferencia religiosa?
    _Cristiano/Evangélico

    _Católico

    _Otra religión: _____

11. ¿Ha hablado su médico con usted y su pareja acerca de los métodos anticonceptivos después de que dé a luz su pareja?
    _Si, conmigo

    _Si, conmigo y mi pareja

    _No

12. ¿Usted y su pareja planean usar métodos anticonceptivos después de que nazca el bebé?
    _No. ¿Por qué no? _____

    _Yes. ¿Por qué?_____

    Si contesta si, por favor vaya a próxima pregunta.

    Si contesta no, es el fin de este cuestionario.

13. ¿Cuál método planea usar usted/su pareja (marque todas las respuesta que se apliquen)?
    _Pastilla anticonceptivas

    _Inyección

    _Implante

    _Parche Anticonceptivo

    _DIU (dispositivo intrauterino)

    _Anillo Vaginal

    _Condón

    _Método natural (ritmo, eyacular afuera etc.)

    _No sé

    _Otro (por favor especifique):_____

14. ¿Por qué escogió este método(s) ¿

Machismo Scale (femenina, español)

		a	b	c	d	e
1	Un hombre no se debe casar con una mujer más alta que él.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
2	Es la responsabilidad de la madre dar a sus hijos un entrenamiento religioso apropiado.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
3	No se debe permitir que los niños varones jueguen con muñecas o con otros juguetes de niñas.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
4	Los padres deben tener un control más estricto sobre sus hijas que de sus hijos.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
5	Existen algunos empleos que, sencillamente, no deben ser para mujeres.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
6	Es más importante que una mujer aprenda a ocuparse de su hogar y de su familia, en vez de una educación universitaria.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
7	Una mujer nunca debe contradecir a su esposo en público.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
8	Los hombres son más inteligentes que las mujeres.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
9	No importa lo que diga la gente, a las mujeres realmente les gustan los hombres dominantes.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
10	Es bueno que haya cierta igualdad en el matrimonio, pero en general, el padre debe tener la última palabra en los asuntos familiares.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
11	En general, es mejor ser hombre que mujer.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
12	La mayoría de las mujeres tienen poco respeto por los hombres débiles.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
13	Me sentiría más cómoda si tuviera un jefe en lugar de una jefa.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
14	Es importante que un hombre sea fuerte.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
15	No se debe permitir que las niñas jueguen con juguetes de niños como soldados o pelotas de fútbol.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
16	Las esposas deben respetar la posición del hombre como jefe de familia.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
17	El padre siempre sabe qué es lo mejor para la familia.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo

Machismo Scale (masculino, español)

		a	b	c	d	e
1	Un hombre no se debe casar con una mujer más alta que él.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
2	Es la responsabilidad de la madre dar a sus hijos un entrenamiento religioso apropiado.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
3	No se debe permitir que los niños varones jueguen con muñecas o con otros juguetes de niñas.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
4	Los padres deben tener un control más estricto sobre sus hijas que de sus hijos.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
5	Existen algunos empleos que, sencillamente, no deben ser para mujeres.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
6	Es más importante que una mujer aprenda a ocuparse de su hogar y de su familia, en vez de una educación universitaria.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
7	Una mujer nunca debe contradecir a su esposo en público.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
8	Los hombres son más inteligentes que las mujeres.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
9	No importa lo que diga la gente, a las mujeres realmente les gustan los hombres dominantes.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
10	Es bueno que haya cierta igualdad en el matrimonio, pero en general, el padre debe tener la última palabra en los asuntos familiares.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
11	En general, es mejor ser hombre que mujer.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
12	La mayoría de las mujeres tienen poco respeto por los hombres débiles.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
13	Me sentiría más cómodo si tuviera un jefe en lugar de una jefa.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
14	Es importante que un hombre sea fuerte.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
15	No se debe permitir que las niñas jueguen con juguetes de niños como soldados o pelotas de fútbol.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
16	Las esposas deben respetar la posición del hombre como jefe de familia.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
17	El padre siempre sabe qué es lo mejor para la familia.	Para nada de acuerdo	Relativa-mente de acuerdo	Mediana-mente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo

Comunicación con su Pareja (femenina)

Encierre con un círculo las palabras que describan la comunicación con su pareja

	Artículo					
1	Escucho atentamente cuando siento que mi pareja me está hablando.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
2	Siento que mi pareja escucha atentamente cuando hablo.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
3	Siento que mi pareja entiende lo que comunico.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
4	Siento que entiendo lo que mi pareja comunica.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
5	Me siento confortable pedirle a mi pareja hacer cosas por mí.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
6	Siento que mi pareja frecuentemente me pide que haga varias cosas.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
7	Expreso apreciación por las cosas que mi pareja hace por mí en respuesta a mis peticiones.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
8	Mi pareja expresa apreciación por las cosas que hago en respuesta a sus peticiones.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
9	Siento que mi pareja me dice muchas cosas negativas de mí o de nuestra relación.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
10	Siento que le digo a mi pareja muchas cosas negativas de él o nuestra relación.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
11	Me siento confortable expresar desacuerdo a cosas que mi pareja dice o hace.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
12	Respondo constructivamente cuando mi pareja está en desacuerdo con cosas que digo o hago.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
13	Disfruto sentarme y platicar con mi pareja.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca

Comunicación con su Pareja (masculino)

Encierre con un círculo las palabras que describan la comunicación con su pareja

	Artículo					
1	Escucho atentamente cuando siento que mi pareja me está hablando.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
2	Siento que mi pareja escucha atentamente cuando hablo.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
3	Siento que mi pareja entiende lo que comunico.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
4	Siento que entiendo lo que mi pareja comunica.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
5	Me siento confortable pedirle a mi pareja hacer cosas por mí.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
6	Siento que mi pareja frecuentemente me pide que haga varias cosas.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
7	Expreso apreciación por las cosas que mi pareja hace por mí en respuesta a mis peticiones.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
8	Mi pareja expresa apreciación por las cosas que hago en respuesta a sus peticiones.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
9	Siento que mi pareja me dice muchas cosas negativas de mí o de nuestra relación.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
10	Siento que le digo a mi pareja muchas cosas negativas de ella o nuestra relación.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
11	Me siento confortable expresar desacuerdo a cosas que mi pareja dice o hace.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
12	Respondo constructivamente cuando mi pareja está en desacuerdo con cosas que digo o hago.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca
13	Disfruto sentarme y platicar con mi pareja.	Casi Siempre	Frecuentemente	A veces	Rara vez	Casi nunca

Escala de Comunicación Diádica Sexual (femenina)

Instrucciones: Esta es una lista de declaraciones que diferentes personas han hecho acerca de discutir sobre sexo con su pareja principal. Por favor responda cuanto está de acuerdo o en desacuerdo con esto.

	Articulo	1	2	3	4	5	6
1	Mi pareja raramente responde cuando yo quiero hablar acerca de nuestra vida sexual.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
2	Algunos temas sexuales son muy molestos para conversar con mi pareja.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
3	Hay asuntos sexuales o problemas en nuestra relación que nunca hemos conversado.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
4	Pareciera que mi pareja y yo nunca resolvemos nuestros desacuerdos acerca de temas sexuales.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
5	Cuando mi pareja y yo hablamos de sexo, siento que él me está sermoneando.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
6	Mi pareja frecuentemente se queja de que no soy muy clara acerca de lo que quiero sexualmente.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
7	Mi pareja y yo nunca hemos tenido una conversación sincera y franca acerca de nuestra vida sexual juntos.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
8	Mi pareja no tiene dificultad en hablarme acerca de sus sentimientos y deseos sexuales.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
9	Hablar acerca de sexo es una experiencia satisfactoria para ambos.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
10	Mi pareja y yo podemos usualmente hablar calmadamente acerca de nuestra vida sexual.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
11	Tengo poca dificultad en decirle a mi pareja lo que hago o no hago sexualmente	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
12	Rara vez me siento avergonzada cuando hablo acerca de detalles de nuestra vida sexual con mi pareja.	muy en descuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo

Escala de Comunicación Diádica Sexual (Masculino)

Instrucciones: Esta es una lista de declaraciones que diferentes personas han hecho acerca de discutir sobre sexo con su pareja principal. Por favor responda cuanto está de acuerdo o en desacuerdo con esto.

	Articulo	1	2	3	4	5	6
1	Mi pareja raramente responde cuando yo quiero hablar acerca de nuestra vida sexual.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
2	Algunos temas sexuales son muy molestos para conversar con mi pareja.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
3	Hay asuntos sexuales o problemas en nuestra relación que nunca hemos conversado.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
4	Pareciera que mi pareja y yo nunca resolvemos nuestros desacuerdos acerca de asuntos sexuales.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
5	Cuando mi pareja y yo hablamos de sexo, siento que ella me está sermoneando.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
6	Mi pareja frecuentemente se queja de que no soy muy claro acerca de lo que quiero sexualmente.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
7	Mi pareja y yo nunca hemos tenido una conversación sincera y franca acerca de nuestra vida sexual juntos.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
8	Mi pareja no tiene dificultad en hablarme acerca de sus sentimientos y deseos sexuales.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
9	Hablar acerca de sexo es una experiencia satisfactoria para ambos.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
10	Mi pareja y yo podemos usualmente hablar calmadamente acerca de nuestra vida sexual.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
11	Tengo poca dificultad en decirle a mi pareja lo que hago o no hago sexualmente.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo
12	Rara vez me siento avergonzado cuando hablo acerca de detalles de nuestra vida sexual con mi pareja.	muy en des-acuerdo	Relativa-mente en desacuerdo	un poco des-acuerdo	un poco de acuerdo	Relativa-mente de acuerdo	muy de acuerdo

Sexual Relationship Power Scale (female, Spanish Version)

		1	2	3	4
1	Si yo le pidiera a mi pareja que usara un condón, el se pondría violento.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
2	Si yo le pidiera a mi pareja que usara un condón, el se pondría furioso.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
3	La mayor parte del tiempo hacemos lo que mi pareja quiere hacer.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
4	Si yo le pidiera a mi pareja que usara un condón, el pensaría que yo estoy teniendo sexo con otras personas.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
5	Cuando mi pareja y yo estamos juntos, yo suelo estar más bien callada.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
6	Mi pareja hace lo que el quiere, aun si yo no quiero que lo haga.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
7	Me siento atrapada o encerrada en nuestra relación.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
8	Mi pareja no me deja usar cierto tipo de ropa.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
9	Mi pareja tiene más peso que yo en las decisiones importantes que nos afectan.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
10	Cuando mi pareja y yo estamos en desacuerdo, el casi siempre se sale con la suya.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
11	Yo estoy más dedicada a la relación que mi pareja.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
12	Mi pareja podría estar teniendo sexo con alguien más.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
13	Mi pareja me dice con quién puedo pasar mi tiempo	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
14	En general, mi pareja se beneficia más o saca más de la relación que yo.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
15	Mi pareja siempre quiere saber donde estoy.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo

Sexual Relationship Power Scale (page 2, Female, Spanish Version)

		1	2	3
1	¿Quién tiene usualmente mayor peso acerca de con cuales amigos salir?	Su pareja	ambos por igual	Usted
2	¿Quién tiene usualmente mayor peso acerca de si tener sexo juntos?	Su pareja	ambos por igual	Usted
3	¿Quién tiene usualmente mayor peso acerca de que hacen ustedes juntos?	Su pareja	ambos por igual	Usted
4	¿Quién tiene usualmente mayor peso acerca de con que frecuencia salen juntos sin niños?	Su pareja	ambos por igual	Usted
5	¿Quién tiene usualmente mayor peso acerca de cuándo hablar de cosas serias?	Su pareja	ambos por igual	Usted
6	¿En general, quien cree usted que tiene más poder en su relación?	Su pareja	ambos por igual	Usted
7	¿Quién tiene usualmente mayor peso acerca de cuándo usar condones juntos?	Su pareja	ambos por igual	Usted
8	¿Quién tiene usualmente mayor peso acerca de actos sexuales hacer juntos?	Su pareja	ambos por igual	Usted

Sexual Relationship Power Scale (Male, Spanish Version)

		1	2	3	4
1	Si yo le pidiera a mi pareja que usara un condón, ella se pondría violenta.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
2	Si yo le pidiera a mi pareja que usara un condón, ella se pondría furiosa.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
3	La mayor parte del tiempo hacemos lo que mi pareja quiere hacer.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
4	Si yo le pidiera a mi pareja que usara un condón, ella pensaría que yo estoy teniendo sexo con otras personas.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
5	Cuando mi pareja y yo estamos juntos, yo suelo estar más bien callado.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
6	Mi pareja hace lo que ella quiere, aun si yo no quiero que lo haga.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
7	Me siento atrapado o encerrado en nuestra relación.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
8	Mi pareja no me deja usar cierto tipo de ropa.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
9	Mi pareja tiene más peso que yo en las decisiones importantes que nos afectan.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
10	Cuando mi pareja y yo estamos en desacuerdo, ella casi siempre se sale con la suya.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
11	Yo estoy más dedicado a la relación que mi pareja.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
12	Mi pareja podría estar teniendo sexo con alguien más.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
13	Mi pareja me dice con quién puedo pasar mi tiempo.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
14	En general, mi pareja se beneficia más o saca más de la relación que yo.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo
15	Mi pareja siempre quiere saber dónde estoy.	Muy de acuerdo	De acuerdo	En desacuerdo	Muy en desacuerdo

Sexual Relationship Power Scale (page 2, Male, Spanish Version)

		1	2	3
1	¿Quién tiene usualmente mayor peso acerca de con cuales amigos salir?	Su pareja	ambos por igual	Usted
2	¿Quién tiene usualmente mayor peso acerca de si tener sexo juntos?	Su pareja	ambos por igual	Usted
3	¿Quién tiene usualmente mayor peso acerca de que hacen ustedes juntos?	Su pareja	ambos por igual	Usted
4	¿Quién tiene usualmente mayor peso acerca de con que frecuencia salen juntos sin niños?	Su pareja	ambos por igual	Usted
5	¿Quién tiene usualmente mayor peso acerca de cuándo hablar de cosas serias?	Su pareja	ambos por igual	Usted
6	¿En general, quien cree usted que tiene más poder en su relación?	Su pareja	ambos por igual	Usted
7	¿Quién tiene usualmente mayor peso acerca de cuándo usar condones juntos?	Su pareja	ambos por igual	Usted
8	¿Quién tiene usualmente mayor peso acerca de actos sexuales hacer juntos?	Su pareja	ambos por igual	Usted

POSTURAS Y PERCEPCIONES EN RELACIÓN CON LOS ANTICONCEPTIVOS (Femenina)

Al responder las siguientes preguntas, indique en qué medida está de acuerdo o no con las siguientes declaraciones acerca del uso de métodos anticonceptivos, incluidos los condones. Elija como respuesta una de las opciones que aparecen abajo.

		1	2	3	4	5
a	Simplemente no pienso en usar métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
b	No creo que yo me vaya a quedar embarazada otra vez.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
c	No me preocupa si yo quedo embarazada otra vez.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
d	No tengo relaciones sexuales con mucha frecuencia.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
e	No importa si uso métodos anticonceptivos. Cuando yo tenga que quedar embarazada, sucederá.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
f	Quiero quedar embarazada otra vez.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
g	No sé cómo se obtienen los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
h	No sé dónde se obtienen los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
i	No es correcto usar métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
j	Los métodos anticonceptivos son responsabilidad de la mujer.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
k	El uso de métodos anticonceptivos va contra mis creencias religiosas.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
l	Hablar con mi pareja acerca de los métodos anticonceptivos es vergonzoso.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
m	Mi pareja no quiere que use métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
n	Si uso métodos anticonceptivos, mi pareja pensaría que planeo tener relaciones sexuales.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
o	Me preocupan los efectos secundarios de los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
p	A mi pareja le preocupan los efectos secundarios de los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo

q	A veces, las relaciones sexuales no son planeadas.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
r	A veces, no hay tiempo de prepararse para tener relaciones sexuales.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
s	El sexo es más romántico cuando no se usan métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
t	Me da miedo ir al médico para obtener un método anticonceptivo.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
u	No uso métodos anticonceptivos porque son muy caros.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo

POSTURAS Y PERCEPCIONES EN RELACIÓN CON LOS ANTICONCEPTIVOS (Masculino)

Al responder las siguientes preguntas, indique en qué medida está de acuerdo o no con las siguientes declaraciones acerca del uso de métodos anticonceptivos, incluidos los condones. Elija como respuesta una de las opciones que aparecen abajo.

		1	2	3	4	5
a	Simplemente no pienso en usar métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
b	No creo que mi pareja vaya a quedar embarazada otra vez.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
c	No me preocupa si mi pareja queda embarazada otra vez.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
d	No tengo relaciones sexuales con mucha frecuencia.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
e	No importa si uso métodos anticonceptivos. Cuando mi pareja tenga que quedar embarazada, sucederá.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
f	Mi pareja quiere quedar embarazada otra vez.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
g	No sé cómo se obtienen los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
h	No sé dónde se obtienen los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
i	No es correcto usar métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
j	Los métodos anticonceptivos son responsabilidad de la mujer.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
k	El uso de métodos anticonceptivos va contra mis creencias religiosas.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
l	Hablar con mi pareja acerca de los métodos anticonceptivos es vergonzoso.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
m	Mi pareja no quiere que use métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
n	Si uso métodos anticonceptivos, mi pareja pensaría que planeo tener relaciones sexuales.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
o	Me preocupan los efectos secundarios de los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
p	A mi pareja le preocupan los efectos secundarios de los métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo

q	A veces, las relaciones sexuales no son planeadas.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
r	A veces, no hay tiempo de prepararse para tener relaciones sexuales.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
s	El sexo es más romántico cuando no se usan métodos anticonceptivos.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
t	Me da miedo ir al médico para obtener un método anticonceptivo.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo
u	No uso métodos anticonceptivos porque son muy caros.	Para nada de acuerdo	Relativamente de acuerdo	Medianamente de acuerdo	En gran medida de acuerdo	Totalmente de acuerdo

TOMA DE DECISIONES CON RESPECTO AL SEXO (Femenina)

Las siguientes preguntas se tratan sobre la forma *en que las parejas toman decisiones*.
Al responder estas preguntas, *piense en su relación con su pareja y en el grado de responsabilidad que usted y su pareja tienen al tomar cada una de las decisiones*.

a	En su relación con su pareja, ¿en qué medida ha participado en la decisión de evitar o no el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
b	En su relación con su pareja, ¿en qué medida ha participado en la decisión de utilizar o no algún método para evitar el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
c	En su relación con su pareja, ¿en qué medida ha participado en la decisión de utilizar o no condón?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
d	En su relación con su pareja, ¿en qué medida ha participado en la decisión de protegerse o no del VIH y otras enfermedades transmitidas sexualmente (ETS)?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
e	En su relación con su pareja, ¿en qué medida ha participado en la decisión de tener o no relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
f	En su relación con su pareja, ¿en qué medida ha participado en la decisión de qué tipo de cosas hagan al tener relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
g	En su relación con su pareja, ¿en qué medida ha participado **el** en la decisión de evitar o no el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
h	En su relación con su pareja, ¿en qué medida ha participado **el** en la decisión de utilizar o no un método para evitar el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
i	En su relación con su pareja, ¿en qué medida ha participado **el** en la decisión de utilizar o no condón?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
j	En su relación con su pareja, ¿en qué medida ha participado **el** en la decisión de protegerse o no del VIH y otras ETS?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
k	En su relación con su pareja, ¿en qué medida ha participado **el** en la decisión de tener o no relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
l	En su relación con su pareja, ¿en qué medida ha participado **el** en la decisión de qué tipo de cosas hagan al tener relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad

TOMA DE DECISIONES CON RESPECTO AL SEXO (Masculino)

Las siguientes preguntas se tratan sobre la forma *en que las parejas toman decisiones*. Al responder estas preguntas, *piense en su relación con su pareja y en el grado de responsabilidad que usted y su pareja tienen al tomar cada una de las decisiones*.

a	En su relación con su pareja, ¿en qué medida ha participado en la decisión de evitar o no el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
b	En su relación con su pareja, ¿en qué medida ha participado en la decisión de utilizar o no algún método para evitar el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
c	En su relación con su pareja, ¿en qué medida ha participado en la decisión de utilizar o no condón?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
d	En su relación con su pareja, ¿en qué medida ha participado en la decisión de protegerse o no del VIH y otras enfermedades transmitidas sexualmente (ETS)?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
e	En su relación con su pareja, ¿en qué medida ha participado en la decisión de tener o no relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
f	En su relación con su pareja, ¿en qué medida ha participado en la decisión de qué tipo de cosas hagan al tener relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
g	En su relación con su pareja, ¿en qué medida ha participado ella en la decisión de evitar o no el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
h	En su relación con su pareja, ¿en qué medida ha participado ella en la decisión de utilizar o no un método para evitar el embarazo?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
i	En su relación con su pareja, ¿en qué medida ha participado ella en la decisión de utilizar o no condón?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
j	En su relación con su pareja, ¿en qué medida ha participado ella en la decisión de protegerse o no del VIH y otras ETS?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
k	En su relación con su pareja, ¿en qué medida ha participado ella en la decisión de tener o no relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad
l	En su relación con su pareja, ¿en qué medida ha participado ella en la decisión de qué tipo de cosas hagan al tener relaciones sexuales?	1 Ninguna Responsabilidad	2	3	4	5 Mucha Responsabilidad

COMPROMISO EN LAS RELACIONES (Femenina)

Las próximas preguntas serán acerca de *sus sentimientos con respecto a su relación con su pareja*. Indique en qué medida está de acuerdo con las siguientes declaraciones acerca de su relación con su pareja.

a	Deseo que nuestra relación dure mucho tiempo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
b	Tengo el compromiso de mantener mi relación con mi pareja.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
c	No me afectaría mucho si nuestra relación terminara en el futuro cercano.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
d	Es probable que dentro del próximo año salga con una persona que no sea mi actual pareja.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
e	Me siento muy comprometida con nuestra relación, tengo una conexión muy fuerte con mi pareja.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
f	Deseo que nuestra relación dure para siempre.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
g	Pienso que mi relación tiene un futuro a largo plazo (por ejemplo, imagino que voy a estar con mi pareja durante varios años más).	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
h	Tengo intenciones de seguir adelante con esta relación.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo

Desearía que me diga en qué medida está de acuerdo con cada uno de las siguientes declaraciones acerca de su relación con su pareja.

a	Mi pareja tiene el compromiso de mantener nuestra relación.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
b	Mi pareja se siente muy comprometida con nuestra relación, tiene una conexión muy fuerte conmigo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
c	Mi pareja piensa que nuestra relación tiene un futuro a largo plazo (por ejemplo, imagina que estará conmigo durante varios años más).	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
d	Mi pareja desea que nuestra relación dure mucho tiempo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
e	A mi pareja no le afectaría mucho si nuestra relación terminara en el futuro próximo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
f	Es probable que mi pareja salga con otra persona dentro del próximo año.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
g	Mi pareja desea que nuestra relación dure para siempre.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
h	Mi pareja tiene intenciones de seguir adelante con esta relación.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo

COMPROMISO EN LAS RELACIONES (Masculino)

Las próximas preguntas serán acerca de *sus sentimientos con respecto a su relación con su pareja*. Indique en qué medida está de acuerdo con las siguientes declaraciones acerca de su relación con su pareja.

a	Deseo que nuestra relación dure mucho tiempo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
b	Tengo el compromiso de mantener mi relación con mi pareja.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
c	No me afectaría mucho si nuestra relación terminara en el futuro cercano.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
d	Es probable que dentro del próximo año salga con una persona que no sea mi actual pareja.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
e	Me siento muy comprometido con nuestra relación, tengo una conexión muy fuerte con mi pareja.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
f	Deseo que nuestra relación dure para siempre.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
g	Pienso que mi relación tiene un futuro a largo plazo (por ejemplo, imagino que voy a estar con mi pareja durante varios años más).	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
h	Tengo intenciones de seguir adelante con esta relación.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo

Desearía que me diga en qué medida está de acuerdo con cada uno de las siguientes declaraciones acerca de su relación con su pareja.

a	Mi pareja tiene el compromiso de mantener nuestra relación.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
b	Mi pareja se siente muy comprometida con nuestra relación, tiene una conexión muy fuerte conmigo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
c	Mi pareja piensa que nuestra relación tiene un futuro a largo plazo (por ejemplo, imagina que estará conmigo durante varios años más).	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
d	Mi pareja desea que nuestra relación dure mucho tiempo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
e	A mi pareja no le afectaría mucho si nuestra relación terminara en el futuro próximo.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
f	Es probable que mi pareja salga con otra persona dentro del próximo año.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
g	Mi pareja desea que nuestra relación dure para siempre.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo
h	Mi pareja tiene intenciones de seguir adelante con esta relación.	0 1 2 3 4 5 6 7 8 Para nada de acuerdo — Relativamente de acuerdo — Totalmente de acuerdo

Marianismo Beliefs Scale

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

Una Latina	1	2	3	4
1.) debería de ser una fuente de fortaleza para la familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
2.) es considerada la fuente principal de fuerza para su familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
3.) madre debería de mantener a su familia unida.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
4.) debería de enseñarles a sus niños ser leales a su familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
5.) debería de hacer cosas que hagan feliz a su familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
6.) debería permanecer virgen hasta el matrimonio.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
7.) debe de esperar hasta después del matrimonio para tener hijos.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
8.) debería de ser pura.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
9.) debería de adoptar los valores inculcados por su religión.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
10.) debería serle fiel a su pareja.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
11.) debería satisfacer las necesidades sexuales de su pareja sin quejarse.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
12.) no debería alzar su voz contra los hombres.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
13.) debería respetar las opiniones de los hombres aunque no esté de acuerdo.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
14.) debe de evitar decirles “no” a la gente.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
15.) debería hacer cualquier cosa que le pida un hombre de la familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
16.) no debe de hablar de métodos anticonceptivos.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
17.) no debe expresar sus necesidades a su pareja.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
18.) debe de sentirse culpable por decirle a la gente sus necesidades.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
19.) no debe de hablar del sexo.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo

20.) debe perdonar en todos aspectos.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
21.) siempre debería estar de acuerdo con las decisiones de los hombres.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
22.) debería de ser el líder espiritual de la familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
23.) es responsable de llevar a su familia a servicios religiosos.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo
24.) es responsable del crecimiento espiritual de su familia.	Fuertemente No De Acuerdo	No de Acuerdo	De Acuerdo	Fuertemente De Acuerdo

Dyadic Adjustment Scale

(Escala de Adaptación Diádica, femenina)

La mayor parte de las personas tiene desacuerdos en sus relaciones. Por favor indica la cantidad de acuerdos o desacuerdos entre usted y su pareja para cada punto descrito en la lista de oraciones siguientes tomando **en cuenta las últimas 2 semanas incluyendo hoy**.

		5	4	3	2	1	0
1	Filosofía de la vida.	En acuerdo siempre	En acuerdo casi siempre	En desacuerdo de vez en cuando	En desacuerdo a menudo	En des-acuerdo casi siempre	En desacuerdo siempre
2	Objetivos, metas y cosas que cree que son importantes.	En acuerdo siempre	En acuerdo casi siempre	En desacuerdo de vez en cuando	En desacuerdo a menudo	En des-acuerdo casi siempre	En desacuerdo siempre
3	Cantidad del tiempo que pasan juntos.	En acuerdo siempre	En acuerdo casi siempre	En desacuerdo de vez en cuando	En desacuerdo a menudo	En des-acuerdo casi siempre	En desacuerdo siempre

¿Con que frecuencia ocurren estas actividades entre usted y su pareja?

		0	1	2	3	4	5
4	Tienen intercambios de ideas estimulantes (llenas de intereses y emocionales).	Nunca	Menos de una vez al mes	1-2 veces al mes	1-2 veces a la semana	Una vez al día	Más a menudo
5	Calmadamente discuten ideas.	Nunca	Menos de una vez al mes	1-2 veces al mes	1-2 veces a la semana	Una vez al día	Más a menudo
6	Trabajan juntos en un proyecto.	Nunca	Menos de una vez al mes	1-2 veces al mes	1-2 veces a la semana	Una vez al día	Más a menudo

7. Los puntitos abajo indicados representan la variedad de distintos grados de felicidad en su relación. El punto medio indica "contenta", el cual representa el nivel de felicidad de la majoria de las relaciones. Por favor circule el puntito que mejor describa su nivel de felicidad. Por favor considere todos los aspectos de su relación.

0	1	2	3	4	5	6
.	.	.	.	.	.	.
Bien Infeliz	Bastante Infeliz	Un Poco Infeliz	Contenta	Bien Feliz	Extremadamente Feliz	Perfecto

Dyadic Adjustment Scale (Masculino)

La mayor parte de las personas tiene desacuerdos en sus relaciones. Por favor indica la cantidad de acuerdos o desacuerdos entre usted y su pareja para cada punto descrito en la lista de oraciones siguientes tomando **en cuenta las últimas 2 semanas incluyendo hoy**.

		5	4	3	2	1	0
1	Filosofía de la vida.	En acuerdo siempre	En acuerdo casi siempre	En desacuerdo de vez en cuando	En desacuerdo a menudo	En des-acuerdo casi siempre	En desacuerdo siempre
2	Objetivos, metas y cosas que cree que son importantes.	En acuerdo siempre	En acuerdo casi siempre	En desacuerdo de vez en cuando	En desacuerdo a menudo	En des-acuerdo casi siempre	En desacuerdo siempre
3	Cantidad del tiempo que pasan juntos.	En acuerdo siempre	En acuerdo casi siempre	En desacuerdo de vez en cuando	En desacuerdo a menudo	En des-acuerdo casi siempre	En desacuerdo siempre

¿Con que frecuencia ocurren estas actividades entre usted y su pareja?

		0	1	2	3	4	5
4	Tienen intercambios de ideas estimulantes (llenas de intereses y emocionales).	Nunca	Menos de una vez al mes	1-2 veces al mes	1-2 veces a la semana	Una vez al día	Más a menudo
5	Calmadamente discuten ideas.	Nunca	Menos de una vez al mes	1-2 veces al mes	1-2 veces a la semana	Una vez al día	Más a menudo
6	Trabajan juntos en un proyecto.	Nunca	Menos de una vez al mes	1-2 veces al mes	1-2 veces a la semana	Una vez al día	Más a menudo

7. Los puntitos abajo indicados representan la variedad de distintos grados de felicidad en su relación. El punto medio indica "contento", el cual representa el nivel de felicidad de la majoria de las relaciones. Por favor circule el puntito que mejor describa su nivel de felicidad. Por favor considere todos los aspectos de su relación.

0	1	2	3	4	5	6
.	.	.	.	.	.	.
Bien	Bastante	Un Poco	Contento	Bien Feliz	Extremadamente	Perfecto
Infeliz	Infeliz	Infeliz			Feliz	

Escala de Fatalismo

Versión en Español, femenina

		1	2	3	4	5
1	Es más importante disfrutar de la vida ahora que planear para el futuro.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
2	La gente muere cuando es su hora y no hay mucho que se pueda hacer al respecto.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
3	Debemos vivir el presente, quien sabe lo que el futuro pueda traer.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
4	Si mi doctor dijera que estoy discapacitada, le creería aunque estuviera en desacuerdo.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
5	No siempre es sabio planear muy al futuro porque de todas formas muchas cosas se vuelven asuntos de buena o mala suerte.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
6	No es nada bueno tratar de cambiar el futuro porque el futuro está en las manos de Dios.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
7	Cuando hago planes, casi estoy segura que los puedo llevar a cabo.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
8	A veces siento que alguien me controla.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo

Escala de Fatalismo

Versión en Español , Masculino

		1	2	3	4	5
1	Es más importante disfrutar de la vida ahora que planear para el futuro.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
2	La gente muere cuando es su hora y no hay mucho que se pueda hacer al respecto.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
3	Debemos vivir el presente, quien sabe lo que el futuro pueda traer.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
4	Si mi doctor dijera que estoy discapacitado, le creería aunque estuviera en desacuerdo.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
5	No siempre es sabio planear muy al futuro porque de todas formas muchas cosas se vuelven asuntos de buena o mala suerte.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
6	No es nada bueno tratar de cambiar el futuro porque el futuro está en las manos de Dios.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
7	Cuando hago planes, casi estoy seguro que los puedo llevar a cabo.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo
8	A veces siento que alguien me controla.	No estoy de acuerdo	Un poco de acuerdo	Moderada-mente de acuerdo	Mayormente de acuerdo	Completa-mente de acuerdo

Evaluación de su Compromiso Religioso, femenina

		1	2	3	4	5
1	Frecuentemente leo libros y revistas acerca de mi fe.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
2	Hago contribuciones financieras a mi organización religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
3	Paso tiempo tratando de crecer en el entendimiento de mi fe.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
4	La religión es especialmente importante para mí porque responde a muchas preguntas sobre el significado de la vida.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
5	Mis creencias religiosas son la base del enfoque que tengo de la vida.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
6	Disfruto pasar tiempo con otras personas de mi afiliación religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
7	Mis creencias religiosas influyen en todos los aspectos de mi vida.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
8	Es importante para mí pasar períodos de tiempo a solas en meditación y reflexión religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
9	Disfruto trabajar en actividades de mi organización religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
10	Me mantengo bien informada sobre mi grupo religioso local y tengo cierta influencia en sus decisiones.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto

Evaluación de su Compromiso Religioso, Masculino

		1	2	3	4	5
1	Frecuentemente leo libros y revistas acerca de mi fe.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
2	Hago contribuciones financieras a mi organización religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
3	Paso tiempo tratando de crecer en el entendimiento de mi fe.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
4	La religión es especialmente importante para mí porque responde a muchas preguntas sobre el significado de la vida.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
5	Mis creencias religiosas son la base del enfoque que tengo de la vida.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
6	Disfruto pasar tiempo con otras personas de mi afiliación religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
7	Mis creencias religiosas influyen en todos los aspectos de mi vida.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
8	Es importante para mí pasar períodos de tiempo a solas en meditación y reflexión religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
9	Disfruto trabajar en actividades de mi organización religiosa.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto
10	Me mantengo bien informado sobre mi grupo religioso local y tengo cierta influencia en sus decisiones.	nada cierto	algo cierto	moderadamente cierto	mayormente cierto	totalmente cierto

Vita

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Doctoral Candidate, 2006-present
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National Student Nursing Association, Virginia Student Nursing Association, and Liberty University Nursing Association, 2002-2005.

Licenses:

Virginia Board of Nursing, 2005-current

Publications:

Peer-reviewed Publications

Arif-Rabu, M, Fisher, D., & **Matsuda, Y.** (2011). Biobehavioral measures for pain in the noncommunicative pediatric patient. *Pain Management Nursing.* Available online on February 3, 2011. doi:10.1016/j.pmn.2010.10.036

Matsuda, Y., McGrath, J.M., & Jallo, N. (2012, in press). Use of the Sexual Relationship Power Scale in Research: An Integrative Review. *Hispanic Health Care International.*

Matsuda, Y. Masho, S.W., & McGrath, J.M. (2012, in press). The relationship between repeat unintended pregnancy and current contraceptive use: NSFG 2006-08 data. *Journal of Community Health Nursing.*

Other Publications

Matsuda, Y. (2011). International report: Hispanic couples' family planning in the United States (In Japanese). *Japanese Journal for Midwives, 65(6), 514-518.*

Matsuda, Y., & McGrath, J.M. (2011). Global village: Cultural competency and collaboration with families through interpreters. *Newborn and Infant Nursing Reviews, 11(3), 102-103.*

Peer-reviewed Abstract

Matsuda, Y., McGrath, J.M., & Jallo, N. (March, 2012). Use of the Sexual Relationship Power Scale in Research: An Integrative Review. Women's Health 2012 Congress, Washington D.C.

Poster Presentations:
Matsuda, Y., McGrath, J.M., & Jallo, N. (March, 2012). Use of the Sexual Relationship Power Scale in Research: An Integrative Review. Women's Health 2012 Congress, Washington D.C.

Matsuda, Y., & McGrath, J.M. (February, 2012). Latinas' Contraception Experience and Planning (LCEP): A pilot study. Southern Nursing Research Society Annual Conference, New Orleans, LO.

Matsuda, Y., & McGrath, J.M. (February, 2011). Theory-based integrated literature review on family planning for Latino couples. Southern Nursing Research Society Annual Conference, Jacksonville, FL.

Matsuda, Y., Masho, S.W., & McGrath, J.M. (September, 2010). The relationship between repeat unintended pregnancies and current contraceptive use. 2010 State of the Science Congress on Nursing Research**,** Washington, D.C.

Matsuda, Y., & McGrath, J.M. (April, 2010) Systematic review of research studies with the sexual relationship power scale. Graduate Research Symposium, Richmond, VA.

Matsuda, Y., & McGrath, J.M. (April, 2010) Systematic review of research studies with the sexual relationship power scale. Women's Health Research Day, Richmond, VA.

Matsuda, Y., & McGrath, J.M. (February, 2010) Systematic review of research studies with the sexual relationship power scale. Southern Nursing Research Society Annual Conference, Austin, TX.

Matsuda, Y., Masho, S.W., & McGrath, J.M. (November, 2009). The relationship between repeat unintended pregnancies and current contraceptive use. American Public Health Association Annual Conference, Philadelphia, PA.

Matsuda, Y., Masho, S.W., & McGrath, J. M. (September, 2009). The relationship between repeat unintended pregnancies and current contraceptive use. Health Equity Conference, Glen Allen, VA.

Matsuda, Y. (May, 2009). Integrated review of family planning within Hispanic couples. VCU Health System Nurses' week, Richmond, VA.

Matsuda, Y. (April, 2009). Impact of obesity in life satisfaction. MPH research day, Department of Epidemiology and Community Health, Richmond, VA.

Matsuda, Y. (February, 2009).Integrated review of family planning within Hispanic couples. Southern Nursing Research Society Annual Conference, Baltimore, MD.

Matsuda, Y. (June 2008-February 2009). Five wishes: promoting families to speak about end of life choices (English and Spanish). Medical Respiratory Intensive Care Unit. VCU Health System, Richmond, VA.

Research Support:

Predictors of Sexual Relationship Power, Communication and Sexual Decision Making among Latino Couples. 2011 Council for Advancement of Nursing Science (CANS)/Southern Nursing Research Society (SNRS) Dissertation Award ($3000), Awarded in November 2011.

Predictors of Sexual Relationship Power, Communication and Sexual Decision Making among Latino Couples.Sigma Theta Tau International Gamma Omega Chapter; Nursing Research Grant (Dissertation award, $1000), Awarded in May 2011.