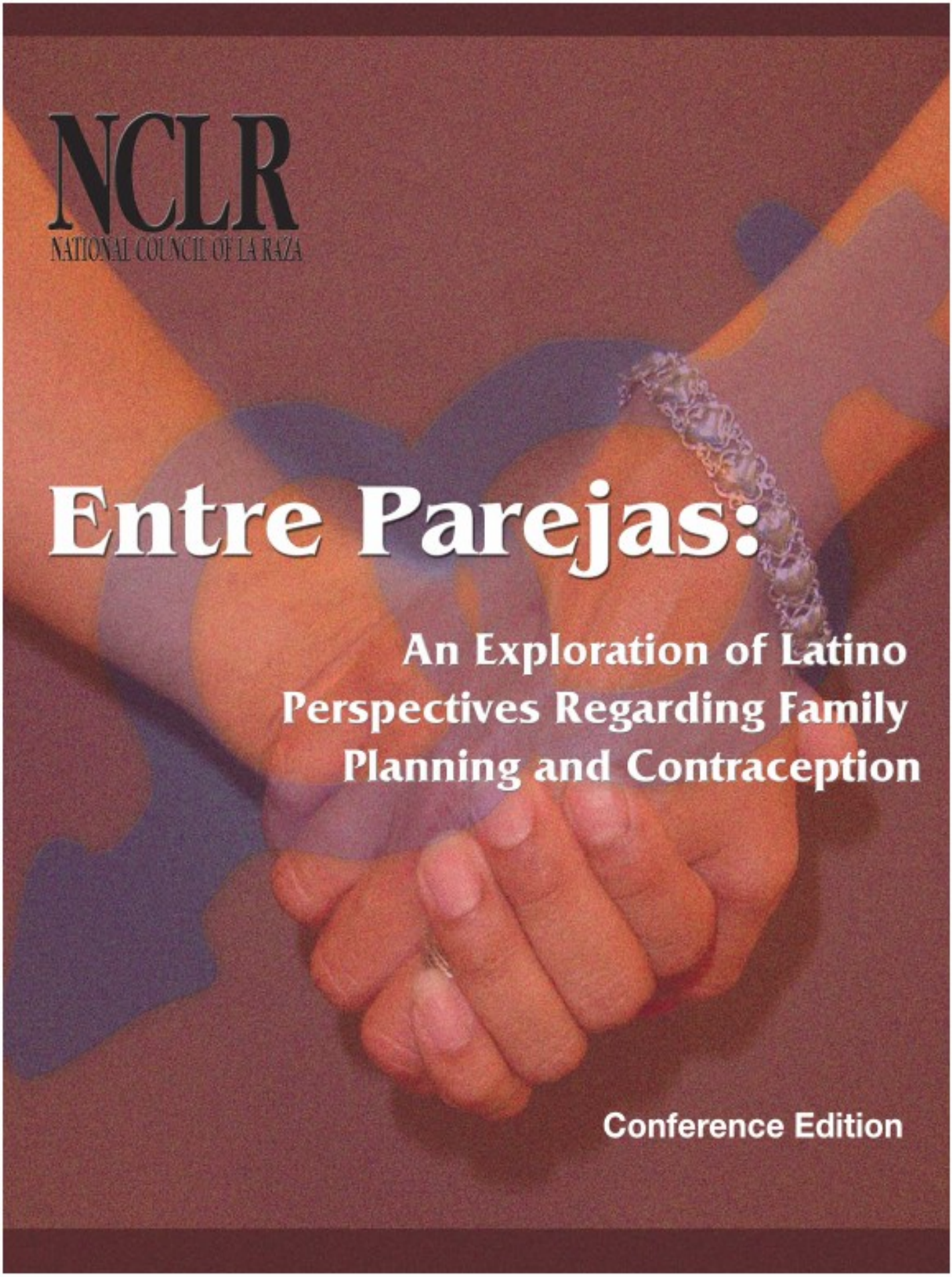
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Entre Parejas:
An Exploration of Latino Perspectives Regarding Family Planning and Contraception
Conference Edition

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I. Introduction

The Latino* community is the largest minority group in the United States, having experienced a 58% increase in population between 1990 and 2000.[1] Latinos currently constitute 14.2% of the United States population (not including the residents of Puerto Rico).[2] One of the most salient characteristics of Hispanics is their youthfulness, especially relative to other Americans. For example, the median age of Hispanics is 26 years old compared to a median age of 35 for the total U.S. population.[3] Moreover, nearly half (48.3%) of the Hispanic population is under the age of 29.[4] The youthfulness of the Hispanic population and the fact that nearly a quarter of the population is in its prime reproductive years necessitates an understanding of how Latinos make decisions about their sexual and reproductive health, particularly with regards to contraception. Despite this need, what little information exists on decision-making and contraception among Latinos focuses primarily on women, and more information is warranted on these issues for the community as a whole.

With this in mind, the National Council of La Raza's (NCLR) Institute for Hispanic Health (IHH), in partnership with Berlex, Inc., designed a study to explore knowledge, attitudes, practices, and beliefs among Latinos related to family planning, contraceptive use, and the decision-making process surrounding contraception.

The study had two principal objectives within a reproductive health framework:

1. To explore specific aspects of sexual and reproductive health with an emphasis on family planning methods among Latinos in four communities: Monterey Park, California; New York, New York; Orlando, Florida; and Silver Spring, Maryland.
2. To explore male and female perspectives in choosing family planning methods and the decision-making process surrounding contraceptive use.

This report summarizes the major findings identified by the focus group discussions (FGDs) and will be widely disseminated to aid in the development of linguistically- and culturally-relevant educational materials and programs for the Latino community. Please see Appendix A for the methodology employed for the FGDs.

* The terms "Latino" and "Hispanic" are used interchangeably by the U.S. Census Bureau and throughout this document to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, and Spanish descent; they may be of any race.

II. Summary of Key Findings

Taken together, the findings for groups in all four cities suggest the following**:**

- ***In terms of overall knowledge, there was no clear distinction made between sexual and reproductive health, and the major connection for all groups was on pregnancy and childbirth.*** For all groups, the primary association with sexual and reproductive health was on having healthy children. A secondary association in all 16 groups was on the topics of prevention and protection against diseases. Among younger women (ages 18 – 34), additional issues were raised, including sexual pleasure and autonomy over their bodies. Older women (ages 35 – 49), by contrast, focused on medical examinations to have knowledge about their status with respect to sexually transmitted infections (STIs). Men echoed many of the same sentiments that the women did in relation to sexual and reproductive health; however, they also defined the topic more broadly to include the act of intercourse and the feelings the act invokes. In addition, the men reflected on their ability to discuss sex more openly than women. Not surprisingly, among the *promotores de salud,* the issues they associated with sexual and reproductive health were more broadly defined and included protection of health and prevention of diseases.

- ***Various barriers discourage Latino couples from talking about sexual health and sexual satisfaction, but family planning discussions are viewed as less of a problem.*** There seemed to be universal agreement that communication among couples about issues related to sexual health is difficult and infrequent, and barriers to talking about sexual health are wide-ranging. The barriers include cultural upbringing and machismo;[†] inadequate education; daily struggles with immigration status; lack of insurance and limited access to regular, quality health care; and economic issues.

  Conversations about family planning seem to be more frequent among couples who are in an established relationship. Interestingly, while women participants stated they do not talk enough with their partners about sexual and reproductive health, the men stated that they talk with their partners "as needed." Men equated sexual and reproductive health discussions with giving permission to use contraceptives or exploring whether their partner is in the mood for sex. Communications for women revolve around feelings of love, desire, permission, and trust.

  Despite the barriers participants felt they faced, both men and women felt it was important for Latino couples to discuss sexual and reproductive health with each other. Some older women mentioned that as they have gotten older they have "lost all shame" and feel more open to communicating about sexual and reproductive health. However, younger women who have resided in the U.S. for a long period of time appear more

[†] According to Galanti, "machismo dictates that men are expected to behave valiantly to protect the honor and welfare of their families. A man with machismo is one with a strong work ethic, who is a good provider, and who lives up to his responsibilities. On the negative side, a man with machismo can also refer to someone who is a heavy drinker and can hold his alcohol, traits that are both socially acceptable and proof of manhood. Machismo may also entail men's active subjugation of women and performance of high-risk activities to prove their masculinity." (Galanti, G., "The Hispanic Family and Male-Female Relationships: An Overview," *Journal of Transcultural Nursing,* Vol. 14, No. 3, July 2003, 180-185.)

likely than older women who have been in the U.S. a short time to have overcome the aforementioned barriers and speak more broadly to their partners about sexual and reproductive health.

- ***Generally, the responsibility for using birth control and the decision about family planning rests with the Latina woman.*** Although most women who participated in the FGDs believe that both partners should share equally in the family planning decision-making process, many echoed the sentiment expressed by a *promotora* from New York who stated that the responsibility falls "99.9% on the woman." Women generally initiate the family planning process, decide on the physician or clinic – with or without involvement of their partners – and decide on what contraceptive method to use.

  Many women report not discussing contraception with their partner. At least one woman in each group reported that she uses birth control without the knowledge of her husband, fearing disapproval or accusations of infidelity (i.e., that they are using birth control as a way to have intimate relations with other men).

  On the other hand, men assume responsibility for protected sex when engaging in casual relationships, or if they have multiple partners. They report using condoms to protect against sexually transmitted diseases (STDs) or HIV/AIDS, rather than to avoid unintended pregnancies.

  In spite of the fact that women are generally viewed as responsible for contraception, men are willing to assume the responsibility of contraceptive use if they perceive that their partner experiences side effects from hormonal contraception. Additionally, among both men and women, there appeared to be a preference for condoms since they prevent not only pregnancy but also STIs and HIV.

- ***Lack of Spanish-speaking health care providers, materials in Spanish, and access to health care are barriers to routine sexual and reproductive health maintenance.*** Most women said that their previous experiences with physicians and health clinics were uncomfortable and made them feel reluctant to return for further reproductive health services. Among the reasons cited were a lack of culturally-adequate materials, the sterile atmosphere of the facilities, and discomfort with being treated by non-Latino physicians.

  Overwhelmingly, participants agreed that the most useful information was provided face-to-face, not only by doctors and nurses, but also by people in the community who were knowledgeable. The women said that they would be more comfortable receiving information and health services in locations that were inviting and familiar, such as community centers or churches, where people knew them and would be able to spend more time explaining their options to them. All groups noted that they wished to see more materials in Spanish; the 18- to 34-year-old women wanted materials that were in both Spanish and English.

Perhaps related to the lack of access, participants report that Latinos living in the United States order contraceptive products from their countries of origin or ask others to bring them back. They also report that they purchase contraception in *bodegas* (neighborhood convenience stores). As stated by one Maryland woman, "birth control injections are provided in secret by a trusted source."

- ***Other noteworthy barriers that affect overall sexual health and well-being include discrimination on the basis of language, ethnicity, or immigration status, and general concerns related to immigration.*** Latinas who seek reproductive health care – particularly patients with limited English fluency – do not perceive that they are treated respectfully or fairly by providers. In addition, all groups mentioned concerns about seeking information, services, or treatment, particularly for those immigrants who are undocumented or do not speak English and do not know how to navigate the system.

- ***While women were more knowledgeable about the range of contraceptive options, both men and women lack sufficient understanding of the safety and efficacy of various methods.*** Generally, women were mistrustful of hormonal methods of contraception, citing concerns over weight gain, health risks, and other factors that made them wary. Also, women were not always clear on the method of action of hormonal contraceptives. They were not able to articulate how various hormonal methods functioned to prevent pregnancy, nor were they able to explain how the various delivery systems differed.

  Likewise, men were also mistrustful of hormones. While women's concerns about hormones ranged from health risks to physical concerns, men tended to focus on the physical and emotional side effects of hormones on their partners, such as weight gain and moodiness. In some instances, men became responsible for contraception and used condoms because they did not like the side effects their partners experienced using hormonal contraception.

  Overall, intrauterine devices (IUDs) were not seen as a major alternative method of birth control. Women in the groups said they would not consider using an IUD, citing negative personal experiences (related to weight gain and other side effects) or warnings they had received from relatives about the potential risks associated with IUDs.

  Sterilization was named in each of the sessions as a method of contraception, and it was correctly identified as an option taken when the decision had been made not to have additional children. However, women did not view sterilization as a preferred method of contraception. One young woman referred to it as a form of mutilation. Others agreed with a promotora from Los Angeles who referred to sterilization as "leaving the woman empty."

III. Details of Key Findings

Knowledge, Attitudes, and Behaviors about Sexual and Reproductive Health

Women

Women did not express a clear distinction between sexual health and reproductive health. Many participants identify both terms with children, pregnancies, sexually transmitted diseases, sexual organs, family planning, and contraception. Additionally, all participants associated sexual health and reproductive health with prevention and protection against STIs, including HIV.

While the majority of women did not express a distinction between sexual and reproductive health, the groups of young women (18-34 years old) at all four sites did mention some additional aspects to sexual health not mentioned by the older women, including protection against STIs, sexual health being related to sexual pleasure and desire, and having autonomy over their bodies and their power in deciding with whom to share it.

The older women viewed sexual health as having to do with medical examinations that they should undergo to prevent diseases. They emphasized examinations for pap smears and HIV. HIV testing was especially salient as one woman from New York stated they did not know "what men did when they were in the streets."

In general, the women placed importance on childbearing and the care they need to take with their bodies in order to give birth rather than on preventing disease. For example, the older women from New York felt it was important to prevent STIs because repeated STIs can lead to infertility and frustration from the inability to conceive. One participant in the group stated that "if you cannot procreate, you will get frustrated and cannot become a complete woman."

Men

Similar to women, men at all sites viewed sexual and reproductive health as being related to childbirth, protecting oneself, STIs such as HIV/AIDS, sexual organs, intercourse, and family planning. One key difference was that men viewed sexual health more broadly. For example, men's first thoughts when hearing the term "sexual health" had to do with intercourse and good feelings. Men reflected on the societal permission they had to discuss sex openly. This sentiment was reflected by the men in California and Florida, who mentioned that "sex" was the first word that came to mind when they heard the terms "sexual and reproductive health." This was not the case for the women.

Among men only, staying healthy was considered very important to be able to have children. As one New York participant expressed, "You have to think about the children that are going to come. A person could be infected (with AIDS) and he does not know it." In addition, men said that maintaining their health was a factor in their ability to provide pleasure to their partner.

According to the men from New York, the neighborhood in which they reside is low-income and heavily Latino. The men agreed that drug use was common in the neighborhood and that they

believe that "many women use drugs when they are pregnant and the babies are born addicted." With regard to reproductive health, the men mentioned that women should avoid drug use during pregnancy. Additionally, the men from New York mentioned the need to know your partner's sexual history because you "can get pregnant" or become infected with HIV if you have sex with a woman that has HIV/AIDS.

Promotores

The *promotores* also did not make a clear distinction between sexual and reproductive health. The first thoughts that came to the minds of the *promotores* when asked about sexual and reproductive health was pregnancy, having healthy children, menstruation, STIs and AIDS, protection from diseases and unplanned pregnancies, reproduction, information, and family planning.

Prevention and protection were mentioned as very important as it relates to sexual health. Many *promotores* felt that prevention and protection from STIs were important to sexual and reproductive health because they relate to one's ability to become a parent. Like the other groups, the *promotores* mentioned examinations, such as the Pap smear and HIV testing, as important. HIV was considered especially important. Unlike the other groups, the *promotores* from Florida mentioned abstinence and sex education.

While there was no clear distinction between sexual and reproductive health, some *promotores* viewed reproductive health as being more sacred than sexual health because it pertained to having healthy children. Thus, they also saw a woman taking care of herself prior to and during pregnancy as part of reproductive health.

Two *promotores* (one from Maryland and one from California) discussed sexual and reproductive health in the context of homosexual couples as well as heterosexual. The Maryland *promotor* stated it made her "think about what two individuals feel, be they of the same sex or different sex, the attraction that two people feel and want to express physically through sexual contact."

Promotores felt that Latinos do not speak about sex with others. They felt that women did not speak about it because they did not want to be viewed as sexually experienced. Like the women's groups, they felt that machismo contributes to the avoidance of communication because women do not want to offend their partner. However, one Maryland *promotora* offered this comment, "In my opinion, it is important to empower women to learn different ways to say 'no.' It is all right to say to her partner, 'I do not like that position. I want this way.' Or, even dare to ask him 'Do you like it?' But immediately, the man asks the woman, 'How do you know that?'"

The *promotores* from California echoed the sentiment that Latinos do not speak about sex and added that women are denied sexual exploration and pleasure. Another participant stated that some individuals think that a woman's sexual organs are only for reproduction and not for pleasure. Others felt that this opinion was attributable to fear on the part of the woman to accept her own sexuality, a lack of dialogue and information about this topic, and fear of unknown

diseases. Additionally, a *promotora* from California stated, "women need to have children, and if they do not have children they do not please their husband. This is something prevalent in the Latino culture."

Promotores echoed the sentiment of a Maryland *promotora* who felt that communication "also depends a lot on the level of education of the couple. There are many ways to talk about pleasure between two people, but if you don't have the education, it is difficult to speak about that."

Factors that Contribute to a Healthy Sexual and Reproductive Life

Women

Participants across all of the women's groups believe that communication is an important element in a relationship. However, they do not necessarily communicate openly, honestly, and directly because they fear their partners' reactions of mistrust and jealousy.

According to the women in Maryland and New York, expressing opinions or needs related to their sexuality raises their partner's mistrust. The women expressed two contradictory sentiments on communication. On the one hand, they understood the need to have open communication with their partner. However, they expressed their inability to communicate openly because the "men think that if women are talking about sex, it is because she is involved with other men or that another man is teaching her."

This contradiction is best explained by the concept of machismo, which stresses the man's authority concerning issues in the family. The idea of discussing sexuality with one's partner is perceived as a threat by the man and, as such, the topic is rarely touched.

Despite this sociocultural barrier, the women feel the necessity to express themselves and they employ strategies that will allow them to do so within the limitations of Latino cultural values. For example, women will speak in the third person or state that they heard something on television or heard it on the radio. This allows them to communicate their needs to their partners without identifying themselves as the source of the question or information being provided.

While several women from all sites did state that they do discuss STIs and their sexual desires with their partners, overwhelmingly women across all groups said it was more common to discuss reproduction, rather than sexuality, with their primary or stable partner.

None of the women expressed having satisfactory communication with their partner. In fact, despite their need to communicate and their development of strategies to attempt to communicate with their partners, it was obvious from the discussions that most women barely touch the subject of sexuality and family planning with their partners. One woman from the 18- to 34-year-old group from Maryland said, "I cannot speak with a person who cannot read, gets home tired, asks for his dinner, asks to make love, and then falls asleep. It is impossible!"

Other women agreed that the less educated a couple is, the less opportunity there is to talk. They implied that a well-educated couple would talk more frequently about these issues, echoing the sentiments expressed by many of the *promotores*.

In addition to communication, women also mentioned fidelity between the couple as an important factor in maintaining a healthy and sexual reproductive life. One woman in the 35- to 49- year-old group from California stated, "The woman is more faithful than the man." In addition, participants stated that there is always the chance that a man can infect a woman with a disease, especially an STI or HIV/AIDS.

Men

Men confirmed the comments of women with regard to communication. Men were fearful of discussing their sexual desires with their partners for the same reasons that women did not discuss their desires with men – accusations of infidelity. Men felt that their partners would accuse them of being unfaithful if they spoke to their partners about their desires. As the women stated, men speak to them about when they wanted to have intercourse. One man stated, "The truth is I only speak when I want sex." The majority of the men echoed this sentiment and felt it constituted sufficient communication.

The men from Maryland felt that they spoke to their partners about sexual and reproductive health, but as the conversation progressed, it was clear that the conversation centered on children. For example, they would discuss how many children they wanted and who would care for the children. However, many men felt it was difficult to speak about when to have children. When thir partner wants to start a family and they do not feel ready, men fear that their partner will think they are not serious about the relationship. The New York group found this conversation particularly difficult when the woman is nearing 40 years of age and has not given birth.

Men, like women, felt that examinations/screenings are important to maintaining a healthy and sexual reproductive life. HIV/AIDS tests were considered extremely important as they determine whether one is healthy and allow a person to discontinue the use of condoms if the partner has also been tested.

Other factors mentioned by men during the FGDs were money and level of formal education. For all men in the New York group, having access to monetary resources allows them to provide for their families. Their priority is to have "food on the table and covering other very basic needs." Education was viewed as important because lack of education brings negative consequences, such as "looking for sex on the street," an example suggested by men from California.

Interestingly, the 35- to 49-year-old men from Florida and New York, in addition to mentioning what the other groups mentioned, also added that having a dialogue with one's partner, maintaining good hygiene, having a good attitude, not being a "bandit,"[‡] and eating well are

[‡] A "bandit" refers to being unfaithful to one's partner.

important factors to a healthy sexual and reproductive life. These factors were not mentioned by men in any of the other cities.

Promotores

Promotores felt that routine checkups contributed to achieving a healthy sexual and reproductive life. The checkups they mentioned were Pap smears and screenings for STIs. While educational level was viewed as important in both Maryland and New York, it was not elaborated on. However, in Florida and California, education was viewed as extremely important. *Promotores* felt that education, especially for parents, was an important factor that can benefit and contribute to adolescents opting for healthier behaviors and actions.

Barriers to Achieving a Healthy Sexual and Reproductive Life

Women

Most of the women felt that the barriers to having a healthy sexual and reproductive health were related to socioeconomic, cultural, and structural factors. The barriers mentioned by most were immigration status, poverty, lack of health insurance, the high cost of health services, lack of Spanish-speaking providers and information in Spanish, location of services, hours of operation, and discrimination. The women felt that these barriers made access to sexual and reproductive health services not only difficult but virtually impossible for the Latino community.

Women in all groups placed a great deal of emphasis on discrimination as a barrier. Discrimination was viewed as a violation of a value that Latinos hold dear – respect. Participants mentioned being discriminated against and treated disrespectfully by providers. For example, one participant stated, "She treats me so bad, that I swear I did not come back. She treats me that bad because I did not know the language." However, while the women from Florida and California described negative experiences with health care providers, they still felt that their interactions with the health care system were positive overall.

The structural barriers to accessing sexual and reproductive health care services focused on the enormous effort it takes to get to services and navigate the system. For example, the lack of transportation, the waiting time to get an appointment, and the documents required to access services necessitate taking a day off from work. This is not feasible, given the employment environment that Latinos face. One Maryland woman stated, "You know that most of the people who require these services do not have valid documents or do not have a job. People who have great jobs and salaries do not go to these places. I believe it is unfair that they ask for all that stuff only to receive [birth control] pills."

Latino cultural values were also viewed as a barrier. Specifically, *marianismo*[§] emerged as a barrier to achieving optimal sexual and reproductive health. *Marianismo* deals with the concept

[§] According to Cofresi, "Marianismo, the traditional sexual code of behavior for Latinas, specifies chastity before marriage, sexual passivity after marriage, and the subordination of women to men." Cofresi, N. I., "The influence of Marianismo on psychoanalytic work with Latinas. Transference and countertransference implications," *The Psychoanalytic Study of the Child*, Vol. 57, 2002, 435-431.

of the sacrifices a woman makes for her family, such that a woman would prefer to maintain harmony in the home than confront her husband about his promiscuity or infidelity outside of the home. This sacrifice endangers her health and, in turn, her life. One Maryland woman from the 35 – 49 year-old groups stated that, "Although we know about our spouses' infidelity, we prefer to close our eyes instead of confronting the reality and remain silent for the sake of our families." Women passively accept this behavior as a natural part of life and do not demand that their partners use condoms. The 35- to 49-year-old women from Florida felt that the passivity of women led to them "taking care of their family, taking care of the world, their father, their husband, their children," and only sometimes taking care of their own health.

Some women mentioned that when they challenged the submissive role, they encountered violence. One Maryland participant from the 35 – 49 year-old group said, "Many problems in the family begin when a woman refuses to have sex with her husband, so he'll hurt her." The women also stated that at times their partners refused to allow them to use contraception because their partner viewed it as a threat to their virility.

Again, lack of education was mentioned as a barrier. The women confirmed that there was an enormous need to educate men. As one New York participant from the 35 – 49 year-old group put it, "Even to experience pleasure, you have to be educated. You can enjoy it more if you receive education." Another Maryland participant stated, "Men need a lot of education. In our culture, they do not receive education." Interestingly, one participant from the 18- to 34-year-old group in New York discussed domestic violence as it related to reproductive health. She felt that if a person was not educated on how to be a part of a couple or relationship there was a possibility for abuse to occur.

Additionally, shame emerged as a factor which prohibits sexual and reproductive health. Shame was associated with behaviors that could hinder their sexual and reproductive health such as not speaking to their partner, not seeking assistance, having their thoughts translated by an interpreter, and having reproductive health examinations.

The women mentioned that prostitution, alcohol, and drugs were also barriers to being able to maintain optimal sexual and reproductive health. These three issues were viewed as common to Latino low-income communities. When these issues were brought up, the women appeared to feel powerless to change them.

While overall the women at the sites agreed on the barriers they face, the 35- to 49-year-old women from New York also felt that the lack of preventive behaviors of Latinas impeded them from having a healthy sexual and reproductive life. As one 35- to 49-year-old participant stated, "We, Latinos, because of our culture, are passionate, and we do not take care of ourselves much. We do not carry protection at the time of intercourse, and if we are very interested in the person, we do not think of their sexual history. We are not very responsible when it comes to seeking our health care."

Men

Men at all sites felt that a barrier to a healthy sexual and reproductive life is the intimate relationships they have with other women without protection. However, the men from Maryland and New York did not view their promiscuity as an issue; instead, they viewed having unprotected sex as the problem. In contrast, the men from California and Florida felt they had to avoid promiscuity to avoid diseases. Men felt that avoiding diseases was important, but never mentioned preventing pregnancy. For women, fidelity and monogamy are factors that contribute to a healthy sexual and reproductive life, but for men, having protected sex is primary. Men also viewed their desire to protect their primary partners as a barrier because if they were to suggest the use of condoms during intercourse, their partner would become upset.

Other barriers mentioned were immigration status; poverty; and lack of health insurance, Spanish-speaking providers, and available translators. Immigration status was important because they stated that if they got their partner pregnant and she did not have "papers," she would not be able to access prenatal services or services for the baby. Language was mentioned as a barrier in relation to accessing family planning information and the lack of available Spanish-speaking providers and translators when trying to access services. The men from Florida, Maryland, and New York also included drugs as an obstacle since it prevents them from protecting themselves because it lowers their inhibitions and results in not being careful when they have intimate relations.

Promotores

Promotores felt that Latinos and Latinas cannot easily achieve a healthy sexual and reproductive life because of all the barriers they face. These barriers were similar to those mentioned by community members. For example:

- **Immigration status** was a big concern for community members, according to the *promotores*, as Latinos are fearful of deportation if they access services. In addition, the lack of legal status creates an issue because they may not have the documents requested by clinics before they are given services.

- *Promotores* also connected **lack of access to services** to the lack of information about sexual and reproductive health. It is their belief that lack of access to services also impedes access to information.

- *Promotores* believed that **language** was a significant barrier. The lack of Spanish-speaking providers and Spanish information presents an obstacle when the community seeks out services. In addition, the length of time between appointments, the hours of operation, and the location of the services prevents the community from accessing services since they often work long and late hours.

- *Promotores* also believed that **lack of education** also presents a barrier to achieving a healthy sexual and reproductive life. The community does not have information about resources and services that are available to them.

- Another barrier identified was **Latino cultural values**. *Promotores* felt that Latino culture does not allow for open communication about sexual and reproductive health. Women are forced to find services and utilize contraception behind their husbands' backs. Latino families do not discuss these topics in the home, and this leads to women not knowing about the risks they face when engaging in sexual intercourse.

Additional factors mentioned included poverty, low wages, lack of health insurance, discrimination, and the high costs of services.

Promotores in Florida and California also mentioned a lack of time as a barrier. Time was perceived as a barrier since it prevents individuals from taking care of their own health and providing education to their children. One *promotor* from Florida stated that, "There are parents who have two or three jobs, and they do not have time to educate their children." Therefore, this fosters the myths concerning sex.

Additionally, while both the Florida and California *promotores* mentioned religion during the discussion of barriers, neither group felt it was truly a barrier. While the *promotores* discussed that the use of contraception is a sin in the eyes of the Catholic Church, they believed that Latinos do not succumb to viewing their use of contraception as making them any less religious. *Promotores* felt that Latinos do not conform to this belief of the church since they would have to deal with the consequences of unwanted pregnancies.

Decision-making about Contraception

Women

Women across all groups were in agreement that couples have a responsibility to be honest, make an effort to communicate, and be respectful of each other. In addition, they felt it was both partners' responsibility to educate themselves about family-planning issues.

In general, women stated that their partners were involved in the family-planning process. However, when probed further, it was revealed that this involvement was limited to the partner giving permission for the use of contraception, paying for the services, taking them to the doctor's office to get contraception, or making a unilateral decision that the woman will use contraception.

Given the limited involvement of their partners, women felt they held the most responsibility as it related to family-planning and made the effort to protect themselves from unwanted pregnancies by using contraception. FGDs revealed that women typically initiate the family planning process and make the decision (with or without health providers' participation) about what method to use, as "men only think about the pleasure of sex and not the consequences or responsibility," according to one interviewee. It was only when health reasons prevented women from using contraception did the men assume responsibility for preventing pregnancy by using condoms.

Women in the 35- to 49-year-old group appeared to have more decision-making power in relation to the family-planning process, as many of them made the decision not to have children or to have their partner use condoms. They exercised this authority when they were tired of using contraception, wanted to protect themselves from STIs, and for various other health reasons. Women in the 18- to 34-year-old groups who do not have a stable partner also insist on their partners using condoms to prevent pregnancy and STIs. The younger women also indicated that physicians play a key role in the contraception decision-making process. In addition, if the decision was made not to have children, most women made the decision on their own without any input from men and chose sterilization.

Only three participants said that they "made the decision together." In these cases, the men participated by discussing, researching, listening, learning, and accompanying women to the provider's office.

While women did want men to participate in the family-planning process, a number of women felt that men attempted to interfere with their use of contraception. One woman stated that she uses contraception without her husband's knowledge because of his accusations that her use of contraception is a mechanism to have an affair with other men [without becoming pregnant]. However, despite their belief that men interefere with their use of contraception, the women continue using contraception. The women from Maryland and New York continue their use of contraception without their partners' knowledge or consent, while the women from California and Florida continue their use of contraception with the knowledge of their partner regardless of whether or not he agrees, as they felt it was a decision that "they could not leave in the hands of anyone else."

Men

In general, discussions with men revealed that they have similar perspectives as the women in that men do not participate in the decision to select what method of contraception their partner would use. Although many men stated they were involved in the process, upon further probing the involvement of men was limited to giving the woman permission to use contraception. Additionally, the younger men tended to validate what the younger women expressed regarding women making decisions about their bodies. One young man stated that his partner made the decision to have "the surgery" and he learned of it afterward.

Men felt it was their responsibility to use a condom. However, the use of a condom was related to protecting themselves rather than preventing pregnancy. Only a few men from Maryland said that they assumed the responsibility of contraception in their primary relationship because they had to. Men became responsible for contraception only when women, for various reasons, cannot use contraception.

The only exception to this was when men engaged in casual sex. In this case, men assume the responsibility for contraception. With their primary partners, they allow the women to be responsible for protecting themselves from both STDs and unwanted pregnancies. They believe that protection and contraception is the woman's responsibility even if the man is promiscuous.

It is important to note that the men do not initiate these conversations and will not discuss contraception unless it is with their primary partner.

The men in Maryland tended to assume more responsibility for family planning when compared to the New York men. However, this appeared to be the case because they were not generally involved in what they considered stable relationships. Many of the men stated that they had a partner in this country who may or may not be considered their primary partner. When this relationship becomes the primary relationship, then the woman assumes responsibility for family planning. In the case of men from Florida and California who are involved in stable relationships, doctors also played a key role in the decision of what contraceptive method to use.

Promotores

Promotores also confirmed that decisions about family planning lie primarily with women. Women carry the responsibility of family planning and, according to the *promotores*, they will do whatever it takes to prevent pregnancy, including obtaining contraceptives from their home countries, finding help in their neighborhood, or visiting community clinics without their partner's knowledge. Men only thought about protecting themselves from diseases and not about pregnancy.

Promotores underscore that Latino couples tend to discuss contraception with their primary partners. The *promotores* felt that single people do not remember to use condoms. According to one Maryland *promotor*, "There are some that may remember but they are few." However, another *promotora* from Maryland felt that many Latino couples do not view themselves as being in long-term, committed relationships. She felt that Latinos would tend to get together for a short period until one of their spouses emigrates to the U.S. from their home country. In these cases, the belief is that they do not speak very much about sexual and reproductive health.

The *promotores* from California felt that men do not participate in the process because they do not want to be viewed as being told what to do by their wives. Additionally, the Florida *promotores* felt that Puerto Rican men do not participate in the family planning process because they believe that children are an accepted part of life and that the "more children you have, the more of a man you are."

Known Contraceptive Methods

Women

Although women participants were aware and knowledgeable of the different contraceptive methods available to them, they did not necessarily know how they worked to prevent contraception or their effectiveness.

They named the following contraceptive methods: rhythm method, IUDs, condoms, birth control pills, sterilization, Norplant, the patch, withdrawal, morning after pill, diaphragm, female condom, vasectomy, injection, sponge, and Nuvaring. When asked to name long-term methods, the women named Norplant, sterilization, vasectomy, the patch, pills, injection, "Depo," rhythm

method, withdrawal, and the IUD. The women in Florida felt that no method was permanent because "even the tubes can grow back." See Attachment J for the methods named by site and age group.

The knowledge women had about the methods they named was limited to how the methods were used or the appearance of the method actually looked. Please see Attachment R for the full listing of contraceptive methods mentioned by city and age group.

Men

Overall, men did not have as much knowledge of the different types of contraception available and were less likely than the women to know how the methods work. Men mentioned the following: [birth control] pills, a thing she ties to herself like a ring [Nuvaring], the patch, condoms, rhythm method, gels and foams, vasectomy, withdrawal, injection, IUD, morning after pill, "*la operación*" ["the operation" – sterilization], and "tying the tubes." When asked to name long-term methods, the men named: "*la operación*" ["the operation" – sterilization] and "tying the tubes." In California, the men felt that no method is permanent. See Attachment S for the methods named by site and age group.

Promotores

Promotores were able to name a range of or multiple contraceptive methods. However, much like the community members, they were unable to explain how these methods were used and their effectiveness.

Methods named by the *promotores* were rhythm method, IUD, *rayitas* (Norplant), the patch, condoms, pills, injections, sterilization, "tying the tubes," gels, female condoms, foam, vasectomy, and the morning after pill. When asked to name long-term contraception, *promotores* identified Norplant, sterilization, IUD, injections, vasectomy, abstinence, diapraghm, and pills. See Attachment T for the methods named by site and age group.

Although these *promotores* had received training on a variety of health issues, they had not been trained on sexual and reproductive health, which helps to explain their vague or incomplete responses.

Methods that Latinos are Reluctant to Use

Women

Women participants had strong opinions regarding the methods of contraception they were reluctant to use, which included 1) methods that required inserting something into the body because they were considered dangerous and unnatural; 2) surgical interventions such as "tying the tubes" because it was considered a mutilation of the body; 3) condoms because of vaginal irritation; 4) the rhythm method and withdrawal because they were not effective; 5) the method in which your menstrual cycle comes only four times a year because it contaminates the body; 6)

injection, the patch, and pill because of side effects; and 7) the IUD because of its invasiveness and the belief that it presents a risk to the woman, the couple, and a potential baby.

Men

Men did not like to use condoms for various reasons, such as condoms being a distraction or interruption and not having the same sensations during intercourse. The men in Maryland also made a distinction between "deluxe" condoms and "regular" condoms. "Deluxe" condoms are the ones they buy and believe to be of better quality. "Deluxe" condoms "are soft and thin," while free condoms provided are "coarse and thick."

When vasectomy was mentioned, it provoked nervous laughter among the men. They would not do it because they believed it was painful "to be cut there," as one Maryland participant stated. One participant from California would not undergo a vasectomy because it was "like losing your manhood." Yet another stated: "In that case, I rather use condoms." Many men agreed with him although they did not like condoms. A participant from Maryland did advocate for the method by saying: "Nobody would do that, but is one of the methods that you know nothing would happen. It is more secure than condoms and pills. Why do women always have to do it [sterilization]? Why can't we do it?"

The men in Maryland mentioned injections, pills, and hormones as being undesirable. They did not like these methods because of the side effects their partners experienced. Additionally, the men from Florida would not use the rhythm method because they felt it was unreliable.

Promotores

Promotores mentioned condoms, the IUD, the rhythm method, and vasectomy as methods Latinos are reluctant to use. The IUD was the subject of many myths and thus that was the reason for it not being used. The rhythm method was not used, in their opinion, because men do not respect the days that women are not to engage in intercourse. *Promotores* felt that men would not undergo a vasectomy because of fear and lack of information about the method. *Promotores* from California felt that women would not use a diaphragm "because they do not like to touch their vagina."

Misperceptions about Contraceptives

Women

Numerous misperceptions about contraception were shared by participants in Maryland and New York. The method that elicited the most confusion across all groups was the IUD. Misconceptions about the IUD centered on the IUD causing harm to the woman, her partner, and an unborn child. Specifically, the women stated that a child can be born with the IUD embedded in its head, it could become lost in the body, it could bother a partner's penis, and the IUD can become attached to the partner's penis and keep the partner attached to the woman.

There were also misperceptions about condoms which were relatively commonplace. For example, the women stated that men do not experience intercourse or orgasms the same way when using condoms and they produce vaginal infections.

Two other misperceptions were expressed by women. They believed that birth control pills cause sterility after prolonged use and that intercourse during your menstrual cycle causes cancer.

Unlike in Maryland and New York, women in California and Florida did not know of, were not aware of, or did not express any common misperceptions relating to contraception. The only misperception related by women of all ages in both locations and among the *promotores* in California was that after undergoing a hysterectomy a "woman remains empty and is of no use." The women felt that men believe this, although no men in either location echoed this statement. The 18- to 34-year-old women from California expressed a similar misperception for men in that men who undergo a vasectomy "are not men." The lack of misperceptions among the women in California and Florida can be attributed to the fact that they have been in the United States longer than the women who participated in the Maryland and New York FGDs.

Men

The men at all four sites did not express as many misperceptions about contraception as the women did. Misconceptions expressed focused on the loss of sensation that is experienced when a condom is used during intercourse or the periods of time a woman can become pregnant. For example, the men in Maryland and New York stated that it was a myth when women would tell them that they could not get pregnant when they are menstruating, while the men from California and Florida expressed the misperception a woman could not get pregnant the first time she had intercourse. All men's groups stated that they believed that condoms reduce sensation during intercourse. However, some men disagreed with that statement.

Promotores

As previously mentioned, the IUD was the subject of many myths among women in Maryland and New York, as well as among the *promotores* in those locations. *Promotores* from Maryland and New York reiterated many of the same myths about the IUD as women did. The *promotores* also held the same beliefs as the community members concerning condoms; many believed that males cannot feel the same way, they cannot have a pleasant orgasm, and that condoms break.

Promotores in both California and Florida, much like the women from these locations, did not express as many misperceptions about contraceptive methods as did their counterparts in Maryland and New York. The *promotores* from Los Angeles mentioned that having sex standing up prevents pregnancy and that drinking tea after sex prevents pregnancy, among other "old wives tales."

Hormones

Women

Overall, Latina participants preferred not to use hormone prescriptions, primarily citing concerns with side effects. These ranged from physical beauty concerns to serious health concerns, including weight gain, acne, skin discoloration, anxiety, mood changes, blood clots, high blood pressure, hunger, bodily pains, breast tenderness and growth, enlargement of hips, hair loss or increased hair growth on undesirable places, headaches, endocrine problems, and that hormones kill red blood cells.

Hormones are generally associated with pills, injections, and the patch. The patch was the method most likely to be linked with the dangerous side effects of hormones. The women also associated it with menopause.

Despite the side effects mentioned, the young women from New York and some older women from California and Florida stated that not all women react to the use of hormones in the same way. In addition, all women agreed that it was up to each woman to decide for herself whether or not to take hormones.

Men

Men did not like hormones because of the side effects experienced by their partners. The side effects were not directly tied to health concerns, but more to the changes they saw in their partner which affected their relationship, such as their partners' weight gain, changes in mood, and their lack of sexual desire. One Maryland participant stated, "Hormones make them (women) moody, angry."

For men, hormones were associated with pills, injections, the patch, and menopause. During the discussion, some men said that they do not allow their partners to use these methods.

Promotores

Promotores generally echoed the comments made by community members. They felt that Latinos do not like to use them because of the side effects. In general, side effects from hormones made Latinos not "like them nor use them." *Promotores* mentioned side effects such as itchiness, weight gain, weight loss, acne, vein constriction, cancer, heart palpitations, dizziness, nausea, and stroke. *Promotores* from California mentioned that hormones "could cause cancer."

Where Do Latinos get Contraceptives?

Women

Given limited access to the health care system and, in particular, to reproductive health services, women are forced to get their contraceptives and services in nontraditional places and through nontraditional ways depending on where they are located.

While numerous women obtain their contraceptives from doctors, pharmacies, community centers, and clinics, several women from Maryland and New York obtain their contraceptives from local Latino stores. Community clinics and centers were mentioned as the primary providers of condoms which are given free. In addition, at these sites, women can access low-cost services that are based on their ability to pay. Moreover, the services are provided in their preferred language. Women also mentioned pharmacies such as Rite-Aid and CVS, or supermarkets or convenience stores, such as Giant or 7-11, where they obtain condoms and other contraception.

Many women from both New York and Maryland, because of their inability to access health services, turn to their home country networks to obtain contraceptives. Participants stated that they have birth control pills and injections sent to them from abroad, or they buy them at local Latino stores since they can buy them without having to see a doctor and without a prescription. They inject themselves or pay a neighborhood woman or store personnel to inject them, saving the expense of a trip to the doctor or clinic. In contrast, the women from California and Florida did not mention local Latino stores or their home countries as a source of contraception. All stated that they find their contraceptives at the doctor's office and community clinics by prescription.

Men

Men from Maryland and New York acquired their contraceptives at many of the same places that the women did. Participants named pharmacies, local Latino stores, their countries of origin, community centers, HIV prevention programs, and hospitals. When asked where their partner obtains her method, they stated their countries of origin. Condoms were primarily acquired at community organizations for free. However, when they wanted thinner condoms, they went to the pharmacy to purchase them. Men from California and Florida mentioned doctors' offices as well as gas stations and pharmacies as locations to obtain contraceptives.

Promotores

Latinos, according to the *promotores,* find their contraceptives at doctors' offices, pharmacies, local Latino stores, in their countries of origin, community centers, and community clinics.

The Maryland *promotores* felt that women were more likely to use contraceptives they bring, or ask others to bring, from their countries of origin. *Promotores* from California felt that many women they see also do the same thing despite the women from California not stating this. Another common source is a local Latino store, where women might receive injections. It was

also noted that women find a person in their neighborhood to give them the injection, confirming what the women in the community said. The men and women obtain condoms from local community clinics and organizations such as Casa de Maryland.

Where do Women Obtain Information about Sexual and Reproductive Health?

The women's answers differed when asked about where they obtain sexual and health-related information when they have a problem. Most of the women from New York turn to the Internet and their gynecologist. Some of the women from the New York groups turned to a friend. Participants from Maryland primarily turned to a friend. This friend usually is another woman. In Florida, the 35- to 49-year-old women turned to gynecologists while the 18- to 35-year-old women turned to the Internet and their mothers as well as to gynecologists.

Participants from New York and Maryland also mentioned hospitals and clinics as sources of information. However, they preferred accessing private services rather than going to a public clinic because of the impersonal service they receive at public facilities. Overall, the women also preferred women providers because they feel more comfortable; however, some women expressed no preference or a preference for men because, as one Monterey Park young woman stated, male physicians "speak a little more."

The use of the Internet to obtain information about sexual and reproductive health was mentioned by two women in the 35- to 49-year-old group in Florida. The 18- and 34-year-old men in California also used the Internet to obtain sexual and reproductive health information. *Promotores* did not feel that Latinos use the Internet frequently because of lack of knowledge, since awareness of the Internet is related to a person's educational level. However, they felt that adolescents definitely use the Internet more frequently than adults.

Do Latinos Have All of the Information They Need to Make Good Decisions?

Women

All participants were in agreement that they do not have enough information necessary for maintaining good sexual and reproductive health. While they felt they do not have enough information, the women felt men have even less. The women want more and better information and education on sexual and reproductive health, especially on specific topics. For example, they noted the need to educate Latinas about the control they have over their own bodies, to teach men about sexual and reproductive health, how to communicate with your partner, information on STIs, pregnancy, available sexual and reproductive health services, gender-specific information, and the different contraceptive methods available and their side effects. Women in California and Florida felt that their partners need more information and requested that information regarding sexual and reproductive health be produced for men specifically.

Men

When asked about having enough information, the men from Maryland unanimously stated that they do not have enough information to make good decisions about their sexual and reproductive

health. They felt the information they have is limited, and they felt ignorant about the subject. These men would like to know more about vasectomies, hormones, STIs, and more generally about protection. However, two participants from New York stated that they know everything that they can possibly know about sex and how to behave. After this comment was made, the rest of the men in the group did not provide any opinions. Additionally, both men and women in California and Florida felt that women generally have more information than men about the topic of sexual and reproductive health.

Promotores

The *promotores* from Maryland felt that Latinos do not have the information they need to make good decisions about their sexual and reproductive health. This was similar to the sentiments of the community groups. However, the *promotores* from New York felt differently. They felt that there is a lot of information and numerous programs, but they believed that Latinos do not seek these out. "There is an abundance of information on the Internet," was the sentiment expressed by one *promotora*. Another stated that their center has "lots of information, brochures, and pamphlets. The rooms are full of people every night, but the information is still there." *Promotores* from California and Florida agreed but added that information in Spanish cannot always be found, and when it is found it is not very understandable. They expressed the need to have information presented clearly and in simple terms.

Trusted Sources of Information

Women

Doctors, *promotores*, friends, gynecologists, neighbors, counselors, mentors, community centers, and someone trained on sexual and reproductive health were all named by women as trusted individuals who would be good sources for information on sexual and reproductive health. However, the caveat was that the individuals belong to "our community," meaning that they speak Spanish and understand Latino culture.

While participants named many individuals they felt were trustworthy sources of information, doctors/gynecologists and *promotores* were the individuals most frequently mentioned. Women prefer that doctors be women because women have a better understanding of the subject. *Promotores* were trusted because *promotores* worry about them as individuals. In addition, *promotores* were described as unconditional in the help and attention they give to the women they serve. Surprisingly, the women in California and Florida as well as the men in Florida felt that mothers are a trusted source of information. The 18- to 34-year-old group of women in California also viewed the Internet as a trusted source of information.

As mentioned earlier, face-to-face interaction is extremely important, and while doctors were mentioned frequently as a source of sexual and reproductive health information, it became apparent that the source need not be a physician. What is important is that the information provided be precise and that they have access to referrals. In addition, the person providing the information must have the trust of the community. Trust was conceptualized as the person having and being able to provide the correct information.

Participants from the New York and Florida groups do not trust the information they receive from pharmaceutical companies. They were in agreement that "the pharmaceutical companies only want to sell their products." In addition, they felt that the companies "do not care for them (consumers) or the side effects of their products."

Participants from the groups in Maryland and California were confused by the question. They understood the question as asking about pharmacists (an individual) and the pharmacy (a store), rather than the pharmaceutical company (the industry). Despite attempts to clarify the question, the women still did not answer the question asked. Instead, they repeatedly stated that they do not trust pharmacists because they could give them the wrong prescription, and the pharmacists do not directly sell them contraceptives. It appears that there is a lack of knowledge of a pharmacist's role.

Men

Similar to the women, the men mentioned doctors, friends, a counselor, teachers, and trained individuals as those they trust to give them information about sexual and reproductive health. A key difference between the men and the women was that the men did not care about the gender of the person who provided them with information. The only time gender mattered for men was when they sought out information from their friends. In that case, they would seek out a male friend. As with the women's groups, the men felt that the individuals providing information needed to understand Latino culture.

Men felt that doctors were the best source of information on sexual and reproductive health as they would feel most comfortable speaking to a doctor. However, any person trained on the topic would be adequate. In either case, they would prefer to receive this information face-to-face with a person who has their trust so they can speak honestly and openly.

Men, like women, do not have much confidence in the information provided by pharmaceutical companies. They agreed that pharmaceutical companies' primary interest was to sell their products. As one New York participant stated, "It's all about money, big money. They control you by selling you things that you do not need." In addition, they felt that while information on side effects is provided, it is never complete. One participant in Maryland also mentioned that he lacked confidence in pharmacists since they can make errors that can harm your health.

Promotores

Similar to the views expressed by community members, *promotores* viewed doctors, *promotores*, and persons trained on the subject matter as trusted sources of information on sexual and reproductive health. However, the *promotores* recognized that doctors usually do not have the time to explain things to patients.

Promotores at all sites felt that pharmaceutical companies were more interested in money and selling their products than in providing information. In general, they do not trust the information provided by pharmaceutical companies.

Delivery of Information

Women

Women in New York and Maryland expressed a strong desire for more information in Spanish. They want information to be presented in terms that were free of jargon and universal so that all Latinos understand it. The young women in New York suggested that information aimed at them be in "Spanglish," since it is what they communicate in, or use a very simple Spanish. The 18- to 34-year-old groups of women and men in both California and Florida expressed a desire to receive information in English.

In addition, women in New York and Maryland had a strong preference for receiving information face-to-face ideally through *charlas* (community workshops) or meetings. They preferred *charlas* as they have the opportunity to speak directly with a person, have an interactive dialogue, and receive information immediately. Additionally, *charlas* are a culturally-appropriate mechanism for providing information since there is an emphasis placed on the interpersonal interaction. Some suggested having videos as part of *charlas* as a tool to initiate conversation and to increase their appeal to potential attendees.

While face-to-face interaction was viewed as important, the Internet was viewed as a desirable mechanism to receive sexual and reproductive health information by the 18- to 34-year-old men in California. They felt it was a great medium for this information as one could obtain the information in a private environment. In addition, the 35- to 49-year-old women in Florida also mentioned their desire to obtain information from the Internet, despite not currently having access to this source.

All groups cited mass media as a mechanism to disseminate health information to Latinos. Television was viewed as a good way to reach Latinos since you can watch a show in between breaks at work or housework. They suggested a talk show format in which real situations can be discussed. The show should not rely on doctors to do the educating, but rather use plausible situations as a means to pass along the information. In addition, they felt that documentaries and dramatizations (*novellas*) are also useful to disseminate information on television.

Radio is another form of media that participants thought could be useful for disseminating information to Latinos. The radio is heard by Latinos on their way to work and in their cars. Again, women preferred a talk-show format in which the audience can call in and participate in the discussion. This format is already being used by Spanish-language radio to discuss other topics.

Written information was also requested by participants. They desired brochures, pamphlets, even magazines or newspapers. Magazines were viewed as especially attractive by the women's groups in California and Florida. Nevertheless, printed materials have to be attractive, contain illustrations, pictures, statistics, and if possible be interactive by containing tests or questions for them to answer. The text needs to be large and clearly written to capture their attention. Additionally, the information needs to be in a format that can be used repeatedly. Written

information can be disseminated at bus and metro/train stops, as the women mentioned sometimes they have to wait 20 minutes for the next bus or train.

While written information was viewed as useful, participants also recognized the difficulties inherent in using it. First, the issue of time was presented as a barrier to Latinos obtaining this information. Second, and most importantly, the participants from Maryland mentioned the high rates of illiteracy in the Central American community due to low levels of education. In their opinion, creating written information that they would be able to access would be quite difficult.

Other mechanisms to disseminate information to Latinos included churches, the Internet, and schools. Churches were viewed by the young women from New York and the older women from Maryland as good places to provide information since Latinos congregate there and they are viewed as trusted sources. The Internet was mentioned by several young women in New York because they are already using the Internet to conduct research and find information on topics of interest to them. Schools were viewed as a good mechanism to reach parents through meetings. In addition, some women viewed schools as a good mechanism to reach men as they will not attend any other type of event.

Men

For the men's groups, there was no agreement among the sites as to the most effective language for sexual and reproductive health information. The men in Maryland had a preference for Spanish that was simple. However, four out of the five men in the New York group did believe it mattered whether the information was in English or Spanish. This is not surprising since the men in New York are older, have lived in the country longer, know English, and overall appear more acculturated to American culture than those from Maryland who are younger and have been in the country for a shorter duration.

Despite the differences in preferred language, both groups indicated an interest in getting information through *charlas*. However, one participant did mention that there needs to be initiative on the part of the man to actually come to the *charla*. Both groups felt that television and radio were also good mechanisms to disseminate information as they reach a large portion of the Latino community. In addition, men from California and Florida felt that it would be useful to disseminate information to men through the use of sports channels or during sporting events like soccer games as well as the classified section of the newspaper.

Promotores

Promotores felt that the information needs to be in a universal Spanish that was understood by all Latinos, regardless of their country of origin. Furthermore, they felt that information needs to be clear and simple.

Charlas were seen by *promotores* as a good way to deliver sexual and reproductive health information. *Promotores* would like videos to use in the *charlas*. The Maryland *promotores* want "information that explained the different contraceptive methods, the side effects of each one, and the consequences of long-term use."

Promotores felt that television, radio, and Spanish-language magazines and newpapers are good mechanisms to reach Latinos. Television was seen as a good mechanism as the *promotores* felt that Latinos could watch it while doing chores. Additionally, *promotores* felt that radio stations could have shows that discuss these topics.

Informative brochures at bus stops and the metro/subway were also viewed as useful for the same reason mentioned by the women's groups – people have free time when they are waiting for the bus or train.

One *promotor* felt that a campaign is needed to provide this information to the Latino community. The campaign would involve different media so there would be repetition and saturation of the messages for effectiveness.

Three additional mechanisms mentioned by *promotores* but not mentioned by community members were at baseball games (on the big screens), at street fairs, and via a hotline. The baseball games and street fairs were viewed as good places because Latinos congregate there. The hotline was suggested because of the sensitivity of the subject. A hotline would provide anonymity, but the information would have to be in Spanish.

Preparation for a Doctor's Visit

Overall, neither Latina women nor Latino men prepare for doctor visits. Reasons for not preparing for visits varied but, overall, Latinos do not view a doctor's visit as a preventive measure due to lack of health insurance. Thus, when they do visit the doctor, it is because they are sick and their primary concern is taking care of whatever ails them. In addition, it appeared that they did not view preparing a list in preparation for the doctor's visit as important. Only one young woman from Maryland mentioned sometimes writing a list because she tends to be forgetful.

The men were less likely to think about preparing for a doctor's visit, as they generally do not visit the doctor; they only see a doctor when they are very ill. Much like the women, they did not see the importance of creating a list prior to going to the doctor's office. As one stated, "When I arrive (at the appointment) I tell him what is wrong, then he asks questions and I tell him what I feel. It is simple."

IV. Implications and Recommendations

NCLR believes that the findings of the FGDs from Monterey Park, California; New York, New York; Orlando, Florida; and Silver Spring, Maryland have several implications:

- **Community-based health education and prevention programs for Latinos related to reproductive health should seek to develop and integrate the following components:**
    - Culturally-appropriate and relevant information in Spanish
    - Materials on a number of topics, including facts about different contraceptive methods, their efficacy, safety, and side effects; and factors to consider in deciding how to choose a birth control method
    - Strategies to promote and enhance communication and trust between couples related to sexual health
    - Strategies aimed at men to foster their knowledge of and responsibility for family planning, contraception, and overall sexual health
    - Instruction on how to be active in monitoring their own health, including how to prepare for doctor's visits
    - Education for Latinos on how to navigate the health care system so they may receive quality services

- **The following factors would increase the effectiveness of public information and community outreach efforts for Latinos on issues related to reproductive health:**
    - A specific strategy should be developed to address the concerns for which Latinos seek information and contraception from local stores and *bodegas*, which could include methods that are not regulated or dangerous.
    - Pharmaceutical companies should partner with respected Latino organizations, providing information to the community to be viewed as a more trustworthy source of information.
    - Radio and television, as opposed to print materials, are considered the most useful vehicles to disseminate information on sexual and reproductive health aimed at Latinos.
    - The Internet should be used to disseminate information to Latinos who have been in this country longer and may be more adapted to American mainstream culture.
    - The information presented should be tailored to specific subgroups and by gender.

- **Additional research on this issue should**:
    - Focus on topics related to the myths surrounding hormonal contraceptive methods.

Appendix A: Methodology

Sixteen focus group discussions (FGDs) were conducted between November 17, 2005 and May 6, 2006. A total of 160 individuals (113 women and 47 men) of Latino origin participated in the FGDs. The FGDs were coordinated by and took place at four NCLR community-based Affiliate organizations: Dominican Women's Development Center (DWDC) in New York, New York; Casa de Maryland in Silver Spring, Maryland; Latino Leadership in Orlando, Florida; and the Multicultural Area Health Education Center in Monterey Park, California.

Each discussion lasted approximately 90 minutes.

Participant profiles and characteristics did not always follow the agreed-upon protocol. While the sites did not always follow the research protocol, the deviations from the protocol were minimal and did not affect the interaction between participants in the focus groups. Overall, there were three deviations from the protocol. The first deviation was in recruiting the requisite number of individuals for each group. The second deviation occured when one site did not recruit an adequate mix of participants from the prescribed national origins. Lastly, there was one instance in which a woman who was not sexually active was recruited for a group and it did not become apparent to the focus group moderator until more than halfway through the discussion. The first and second deviations were addressed by the addition of more focus group discussions in Los Angeles and Orlando. The third deviation occurred only once and did not affect the discussion within the group. Based on these considerations and despite the fact that all FGDs have limitations, NCLR believes that given the number of participants and the geographic and subgroup diversity, these findings do provide a better understanding of the needs, concerns, and preferences of Hispanics with respect to reproductive health issues. Please see Attachments A-P for more detailed demographic data.

The FGDs were conducted in Spanish, and the moderator's discussion guide was developed and used to guarantee uniformity within each group. Each session was recorded to ensure accuracy in the analysis and facilitate the preparation of the report. Notetakers were also employed in each session. On a technical note, while six of the eight groups were completely recorded, the *promotores* group in New York was not recorded and the female 18- to 34-year-old group was partially recorded due to human error. Notes taken by the notetakers present were used to complete the analysis and report. Additionally, after the first round of focus groups in New York and Maryland, the moderator's guide was revised to reflect information learned which the researchers believed would strengthen the subsequent FGDs (e.g., reordering, adding, or deleting questions to allow for probing of opinions and deeper discussion).

Before beginning each FGD, participants were asked to complete the registration form. These forms were used to gather the additional demographic data in Attachment Q. Each participant signed the consent form, which concedes all rights to use the information collected in this report. At the end of each session, participants received a monetary incentive for their participation.

Attachment A: ***Promotores*** **– New York, NY**

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	38	Single	0	Outreach worker/ Psychologist	University	NR	24	Pill
Female	40	Living together	4 (1 girl and 3 boys) 13, 10, 20, 4	State house coordinator	University	NR	20	Condom
Female	36	Married	3 (2 girls and 1 boy) 10, 5, 14	Outreach worker/ Interior designer	University	$13.86 an hour	20	Pill
Female	40	Married	2 (1 girl and 1 boy) 14, 9	Community health worker /Asthma educator	University	NR	20	Pill
Female	45	Married	6 (3 girls and 3 boys) 20, 21, 25 9, 22, 24	Enrollment counselor	University	$2,200 a month	NR	Pill
Female	NR*	Separated	3 (1 girl and 2 boys) 30, 36, 13	Social worker	University	NR	22	Rhythm

All Dominican *NR = not reported

Attachment B: Women (18-34 age group) – New York, NY

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	25	Single	0	Secretary	University	NR	16	Pill
Female	19	Single	0	Student	University	NR	16	Condom
Female	28	Married	0	Hotline coordinator	University	$800 a week	27	Patch
Female	34	Divorced	1 (1 boy) 19	Social worker	University	$14.98 an hour	18	Pill
Female	26	Single	0	Administrative assistant	University	$363 every two weeks	21	Pill and condom
Female	NR*	NR	NR	NR	NR	NR	NR	NR

4 Dominicans and 1 Puerto Rican *NR = Not reported

Attachment C: Women (35-49 age group) – New York, NY

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	38	Separated	4 (4 boys) 20, 16, 14, 5	Escort for school bus	University	Not currently working	24	Pill
Female	40	Living together	2 (2 boys) 22, 24	Case worker/sociologist	University	NR	16	Pill and IUD
Female	46	Divorced	2 (1 girl and 1 boy) 18, 20	Housekeeper	8th grade	NR	20	Unnamed device
Female	45	Separated/ living together	5 (4 girls and 1 boy) 8, 11, 25, 26, 22	Housewife	11th grade	NR	15	Pill and condom
Female	45	Single	3 (1 girl and 1 boy) 13, 14	Home attendant/ accountant	University	$8.00 an hour	20	Condom
Female	46	Separated	1 (1 girl) 20	Case manager	7th grade	$2,000 (period not specified)	18	Pill
Female	47	Divorced	0	Housewife	NR	$675 (period not specified)	21	Condom
Female	43	Married	3 (2 girls and 1 boys) 16, 10, 18	Counselor/ advocate	University	$18.00 an hour	23	IUD
Female	35	Separated	3 (3 girls) 9, 2, 10	Home attendant	University	$6.85 an hour	19	Pill
Female	42	Single	2 (1 girl and 1 boy) 16, 15	Home aid	University	$10.00 an hour	20	Condom
Female	40	Single	3 (2 girls and 1 boy) 10, 16, 13	Housewife	8th grade	NR	19	Condom

4 Dominicans, 4 Puerto Ricans, 1 Ecuadorian, and 2 Cubans *NR = Not reported

Attachment D: Men (35-49 age group) – New York, NY

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Male	35	Single	0	Broadcast producer	University	$2,400 a month	18	Condom
Male	41	Single	0	NR	12th grade	$6.75 an hour	15	Condom
Male	43	Divorced	2 (1 girl and 1 boy) 14, 24	NR	10th grade	$10.00 an hour	25	Condom
Male	39	Single	1 (1 girl) 2	Mechanic	12th grade	$200 a day	16	Condom
Male	49	NR	8 (4 girls and 4 boys)** 8, 10, 12, 12 16, 18, 24	General vendor	12th grade	$10.00 an hour	17	Condom

2 Puerto Ricans, 1 Colombian, 1 Peruvian, and 1 Dominican *NR = Not reported. **Age of one child not reported.

Attachment E: *Promotores* – Silver Spring, MD

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	30	Married	2 (2 girls) 4, 4 months	*Promotora*/ Accounting assistant	University	$200 a month	Never used	None
Female	56	Separated	1 (1 boy) 18	*Promotora*/ Patient interviewer	12th grade	$650 a month	Never used	None
Female	53	Married	2 (2 boys) 22, 27	*Promotora*/ Housecleaner	8th grade	NR	Never used	None
Female	51	Married	3 (2 girls and 1 boy) 20, 25, 28	*Promotora*/ Housecleaner	9th grade	$800 a month	22	IUD
Female	60	Widow	6 (2 girls and 4 boys)** 40, 30, 38, 30, 13	*Promotora*/ Housecleaner/ Nurse Assistant.	8th grade	$8.00 an hour	19	Pill
Female	32	Living together	2 (2 boys) 6, 8 months	*Promotora*/ Housecleaning/ Pharmacy	11th grade	$300 a week	18	Pill and Injection
Female	37	Single	3 (3 boys) 12, 9, 8	*Promotora*/Teller	12th grade	$7.50 an hour	25	Condom
Female	55	Divorced	3 (1 girl and 2 boys) 26, 21, 22	*Promotora*/ Housecleaning/ Insurance business	University	$384 a month	28	Pill
Female	38	Single	0	*Promotora*/Dental assistant/ Nurse	Technical	$1,200 a month	Never used	None
Female	39	Married	1 (1 girl) 11	*Promotora*/Education paraprofessional/ Teacher	University	$14.00 an hour	27	Pill
Female	39	Married	1 (1 girl) 20	*Promotora*/Cleaning/ Nurse Technician	12th grade	$80 a day	Never used	None
Female	36	Married	4 (2 girls and 2 boys) 18, 5, 11, 3	*Promotora*/ Beauty consultant/ Clinic lab	University	$600 a week	25	IUD

3 Mexicans, 1 Colombian, 2 Salvadorans, 1 Guatemalan, 2 Nicaraguans, 1 Honduran, and 2 Peruvians *NR = Not reported. **Age of one child not reported.

Attachment F: Women (18-34 age group) – Silver Spring, MD

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	24	Single	0	Student/teacher	University	$15.00 an hour	Never	None
Female	19	Separated	0	Unemployed/student	8th grade	NR*	16	Pill
Female	24	Living together	2 (2 boys) 8, 5	Housewife	9th grade	N/A**	16	Pill
Female	20	Single	0	Cleaning	7th grade	$300 a week	16	Pill
Female	26	Married	2 (2 boys) 6, 1	Housewife	11th grade	N/A	26	Pill
Female	26	Married	2 (2 girls) 7, 4	Housewife	University	N/A	19	Injection
Female	29	Married	2 (2 girls) 14, 10	Housewife	8th grade	N/A	16	Pill
Female	33	Divorced	3 (2 girls and 1 boy) 16, 6, 15	Housewife	11th grade	N/A	20	Injection
Female	34	Separated	2 (1 girl and 1 boy) 14, 6	Housewife	8th grade	N/A	Never	Rhythm
Female	34	Living together	4 (2 girls and 2 boys) 16, 13, 17, 9	Housewife	University	N/A	22	Pill
Female	25	Living together	1 (1 boy) 2	Dry clean	5th grade	$1,400 a month	24	Pill

1 Peruvian, 5 Guatemalans, 4 Salvadorans, and 1 Mexican *NR = Not reported **N/A = Not applicable

Attachment G: Women (35-49 age group) – Silver Spring, MD

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	35	Married	2 (1 girl and 1 boy) 1 ½ , 4	Parking lot attendant/secretary	University	$720 a month	28	Injection
Female	35	Married	3 (3 boys) 7, 3, 3	Housewife	9th grade	N/A**	16	Pill
Female	35	Single	1 (1 girl) 5	Cleaning	12th grade	$180 a week	16	Pill
Female	36	Separated	4 (2 girls and 2 boys) 3 ½, 11, 5	Housewife/Teacher	University	N/A	26	Injection
Female	40	Divorced	0	Cleaning/Waitress	6th grade	$500 a week	21	Pill
Female	42	Living together	3 (2 girls and 1 boy) 19, 16, 13	Cleaning in a museum	9th g	$10.00 an hour	18	Pill
Female	49	Married	2 (1 girl and 1 boy) 32, 30	Factory	8th grade	$7.50 an hour	21	IUD
Female	49	Divorced	0	Cleaning/Housewife	5th grade	NR*	32	Pill
Female	45	Divorced	6 (2 girls and 4 boys) 28, 2, 26, 24, 18, 6	Cleaning/Housewife	5th grade	$450 a month	22	Pill

1 Bolivian, 5 Salvadorans, 1 Chilean, 1 Guatemalan, and 1 Mexican *NR = Not reported **N/A = Not applicable

Attachment H: Men (18-34 age group) – Silver Spring, MD

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Male	20	Separated	0	Painter/student	5th grade	$250 a week	18	Condom
Male	21	Living together	0	Construction/farm worker	7th grade	$300 a week	18	Condom
Male	24	Separated	2 (1 girl and 1 boy) 4, 6	Construction	5th grade	NR	16	Condom
Male	22	Single	0	Carwash	8th grade	NR	15	Condom
Male	23	Single	0	Printing	12th grade	$800 a month	18	Condom
Male	23	Single	2 (2 boys) 7, 4	Employ	6th grade	$300 a week	16	Condom
Male	25	Living together	0	Carpenter	7th grade	$12.00 an hour	15	Condom
Male	25	Married	1 (1 girl and 1 boy) 4, 8 months	Carwash/car mechanic	12th grade	$7.75 an hour	14	Condom
Male	29	Married	2 (2 girls) 8, 3	Driver	University	$16.00 an hour	16	Condom
Male	26	Separated	2 (2 girls) 9, 5	*NR	5th grade	$400 a week	15	Condom
Male	30	Married	2 (2 girls) 4, 4 Mos.	Painter	12th grade	$15.00 an hour	18	Condom
Male	29	Married	4 (3 girls and 1 boy) 13, 6, 5, 12	Unemployed/ construction	11th grade	NR	17	Condom
Male	30	Single	0	Cleaning	9th grade	$1,000 a month	18	Condom

Male	34	Separated	3 (2 girls and 1 boy) 12, 6, 14	Carpeting	8th grade	$100 a day	17	Condom
Male	32	Living together	4 (2 girls and 2 boys) 14, 17, 9, 20	Plumber	5th grade	$10.00 an hour	17	Condom

8 Guatemalans, 6 Mexicans, and 1 Salvadoran *NR = Not reported

Attachment I: *Promotores* – Los Angeles, CA

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	48	Married	2 (2 girls) 20, 17	*Promotora*	University	NR	NR	N/A
Female	40	Married	2 (1girl and 1 boy) 13, 12	*Promotora*	12th grade	$10 an hour	24	Pill
Female	20	Single	1 (1 girl) 1	*Promotora*	12th grade	NR	18	Pill
Female	43	Married	5 (2 girls and 3 boys) 17, 21, 13, 19, 22	*Promotora*	12th grade	Variable	19	Pill
Female	29	Married	0	*Promotera*/ Receptionist	University	$10 an hour	18	Pill
Female	42	Separated	3 (3 girls) 25, 17, 14	Community Rep/ *Promotora*	University	$12.95 an hour	19	Pill

4 Mexicans and 2 of Mexican Descent *NR = Not reported

Attachment J: Women (18-34 age group) – Los Angeles, CA

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	34	Married	4 (2 girls and 2 boys) 5, 4, 17, 8	Housewife	12th Grade	N/A**	25	IUD
Female	34	Married	3 (1 girl and 2 boys) 4, 10, 9 mos.	Housewife/ travel agency	12th Grade	N/A	28	Pill
Female	35	Single	3 (2 girls and 1 boy) 14, 1 ½, 16	Housewife	5th Grade	N/A	NR	NR
Female	34	Married	4 (2 girls and 2 boys) 13, 6 mos., 17, 7	Housewife	12th Grade	N/A	22	Pill
Female	30	Married	2 (2 boys) 6, 9	Sales Person	12th Grade	$9.60 an hour	20	Pill
Female	28	Married	2 (1 girl and 1 boy) 5, 8	Housewife	12th Grade / Vocational	NR*	21	Pill
Female	28	Married	2 (1 girl and 1 boy) 8, 4	Student/ Housewife	University	0	16	Condom, Monthly Injection (Patector)
Female	26	Married	1 (1 girl) 6	Student	University	0	17	Condom
Female	33	Married	4 (2 girls and 2 boys) 13, 18, 16, 8	Housewife	12th Grade	NR	18	Pill
Female	25	Single	0	Student/working	University	$1,500 a month	24	Depo Provera
Female	28	Single	0	Babysitter/ teacher	University	NR	21	Condom
Female	26	Separated	1 (1 girl) 7	Housewife	12th Grade	NR	N/A	None

12 Mexicans *NR = Not reported **N/A = Not aplicable

Attachment K: Women (35-49 age group) – Los Angeles, CA

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	44	Married	4 (2 girls and 2 boys) 19, 10, 22,12	Student Aid/ Child care	3rd Grade	$6.75	28	Pill
Female	40	Married	4 (2 girls and 2 boys) 11, 15, 20, 13	Housewife	5th Grade	NR*	None	Never
Female	49	Separated	5 (3 girls and 2 boys) 27, 22, 17, 35, 32	None	NR	$1,000 a month	28	Pill
Female	48	Divorced	3 (3 girls) 25, 27, 31	Housewife	8th Grade / Secretarial	NR	19	Pill
Female	43	Married	4 (3 girls and 1 boy) 18,11, 5, 19	Recreation	NR	$7.25	26	Pill
Female	46	Separated	3 (3 girls) 32, 25, 23	Housewife	5th Grade	N/A**	None	None
Female	35	Married	3 (1 girl and 2 boys) 5, 10, 4	Housewife	5th Grade	NR	25	IUD
Female	42	Married	3 (3 girls) 25, 17, 14	Community Representative	University	$1,100	18	Pill
Female	36	Married	2 (1 girl and 1 boy) 12, 16	Housewife	5th Grade	N/A	20	Injection
Female	37	Married	3 (2 girls and 1 boy) 13, 5, 10	Housewife	8th Grade	N/A	20	Pill
Female	35	Single	0	Child care	University	0	None	None
Female	35	Married	2 (1 girl and 1 boy) 15, 8	Housewife	University	NR	22	Injection

12 Mexican *NR = Not reported. **N/A = Not applicable

Attachment L: Men (18 - 34 age group) –Los Angeles, CA

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Male	18	Single	0	Receptionist	12th grade	NR	NR*	NR
Male	18	Single	0	Medicare, Claims detector	University	$10.50 an hour	N/A**	N/A
Male	34	Married	2 (1 girl and 1 boy) 7, 10	Labor	3rd grade	$10.00 an hour	15	Condom
Male	34	Married	3 (3 boys) 13, 8, 3	Manufacturer	12th grade	$10.00 an hour	17	None
Male	20	Single	0	NR	University	$11.00 an hour	16	Condom
Male	20	Single	0	Student	University	$0	18	Condom
Male	34	Married	4 (2 girls and 2 boys) 19,10, 22,12	Driver	6th grade	NR	17	Condom
Male	19	Single	0	Student	University	$0	16	Condom
Male	20	Single	0	Student	University	$0	19	Condom
Male	21	Living together	0	Student	University	$0	17	Condom
Male	18	Living together	0	Tutor, Boys & Girls Club	University	$850 a month	No	None
Male	25	Single	0	Student	University	NR	0	NR

12 Mexicans. *NR = Not reported. **N/A = Not applicable

Attachment M: *Promotores* –Orlando, FL

Gender	Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	68	Married	2 (2 boys) 35, 49	Retired	12th grade	NR	NR	NR
Male	69	Married	3 (2 boys and 1 girl) 46,47, 43	Retired	12th grade	$1,169 a month	18	Condom
Male	38	Married	2 (1 girl and 1 boy) 17, 13	Real state agent/ University's teacher	Master's	Commission	17	Condom
Female	42	NR	2 (1 girl and 1 boy) 10, 5	NR	12th grade	$7.50 an hour	31	IUD
Female	44	Widow	3 (3 girls) 25, 23, 15	Nurse	9th grade	NR	19	Pill
Female	62	Single	2 (1 girl and 1 boy)	AARP Clerical	12th grade	$6.40 an hour	20	Pill
Female	40	Divorce	4 (3 girls and 1 boy) 22, 13, 10, 4	Commerce	University	$6.15 an hour	Never	None
Female	18	Single	0	Student	12th grade	NR	15	NR
Female	34	Divorce	3 (2 girls and 1 boy) 15, 10, 1	Construction	8th grade	$10 an hour	20	Pill
Male	33	Separated	1 (1 boy) 5	Public Notary	University	$600 a month	16	Condom
Female	45	Married	2 (2 boys) 12, 15	Travel agent	University	NR	18	Condom

Male	68	Married	6 (3 girls and 3 boys) NR	NR	University	NR	NR	NR
Male	49	Living together	2 (1 girl and 1 boy) 10, 5	Technician	University	$12 an hour	NR	NR

2 Ecuadorians, 1 U.S. Citizen of Hispanic Descent, 2 Nicaraguans, 5 Puerto Ricans, 1 Dominican, 1 Mexican, and 1 Colombian * NR = Not reported

Attachment N: Women (18-34 age group) – Orlando, FL

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	26	Single	0	Secretary	University	$13 an hour	19	Condom
Female	25	Living together	4 (4 girls) 6, 3, 2, 1	Nurse	University	$16 an hour	17	Injection/ Depo Provera
Female	42	Separated	2 (1 girl & 1 boy) 9, 21	Community Officer	University	$12 an hour	NR	Condom
Female	20	Living together	1 (1 boy) 22 mo	Clothing Store	11th Grade	$6.50 an hour	19	Depo Provera
Female	21	Single	0	Student	12th Grade	NR	NR	NR
Female	18	Single	0	Student	12th Grade	$7 an hour	17	Condom
Female	19	Married	1 (1 boy) 2	Housewife	12th Grade	NR	18	Pill
Female	33	Divorced	1 (1 girl) 8	Office Work - Front Desk	University	$13 an hour	24	Condom
Female	30	Single	0	Accountant	University	$30 an hour	NR	NR

8 Puerto Ricans and 1 Mexican *NR = Not reported

Attachment O: Women (35-49 age group) – Orlando, FL

Gender	Current Age	Marital Status	Number of Children/ Gender & Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Female	49	Married	5 (1 girl and 4 boys)**	Para-professional	4th Grade	NR	20	Pill
Female	28	Single	0	Student	University	$1,600 month	19	Pill
Female	46	Married	3 (3 boys) 25, 13, 10	Correspondent Company	7th Grade	$11 an hour	21	Pill
Female	26	Single	1 (1 boy) 9	Housewife/ Autism assistant teacher	12th Grade	N/A	17	Pill
Female	45	Married	4 (2 girls and 2 boys) 14, 9, 12, 7	Housewife	University	N/A	27	Pill
Female	43	Single	0	Accountant	MBA	$40,000 a year	21	Condom
Female	49	Widow	1 (1 girl) 24	Disabled	University	$574	Never	None
Female	33	Divorced	1 (1 girl) 4	Customer Service	University	NR	18	Pill
Female	48	Married	5 (3 girls and 2 boys) 20, 16, 14, 12, 19	Housewife/ manufacturing	6th Grade	Unemployed	15	Pill

8 Puerto Ricans and 1 Mexican *NR = Not reported. **Age of children not reported.

Attachment P: Men (35-49 age group) – Orlando, Florida

Gender	Current Age	Marital Status	Number of Children/ Gender and Ages	Occupation	Education	Salary	Age at Initial Use of Contraception	First Method of Contraception
Male	44	Married	4 (4 boys) 23, 19, 19,18	Unemployed	Technical	NR	NR	NR
Male	50	Single	6 (4 girls and 2 boys) NR	Social Security	7th grade	$513	NR	NR
Male	35	Living together	4 (4 girls) 5, 3, 2, 1	Fiberglass laminator	9th grade	$9.50	16	Condom
Male	39	Married	1 (1 boy) 5	Self-employed (Health)	University	Variable	14	Condom
Male	42	Married	3 (2 girls and 1 boy) 18, 14, 21	Construction	8th grade	$600 a week	27	Condom
Male	44	Separated	3 (3 girls) 15, 14, 14	Electricity	University	$13 an hour	No	None
Male	30	Single	1 (1 boy) 3	Cook	12th grade	$8.25 an hour	16	Condom
Male	37	Married	2 (1 girl and 1 boy) 7, 5	Construction/ Baker	8th grade	$600 a week	17	Condom
Male	44	Single	2 (2 boys) 17, 22	Construction	4th grade	NR	NR	Condom
Male	34	Living together	2 (2 boys) 6, 8	Unemployed	University	Variable	18	Condom

7 Puerto Ricans and 3 Mexicans * NR = Not reported

Attachment Q: Demographic Profiles by City

New York, NY Participants

Gender	Nationality	Age at Initial Use of Contraception		First Method of Contraception
24 Women	15 Dominicans 5 Puerto Ricans 1 Ecuadorian 2 Cubans 1 NR	1 - 15 3 - 16 2 - 18 2 - 19 6 - 20 2 - 21	1 - 22 1 - 23 2 - 24 1 - 27 2 - NR	12 - Pill 6 - Condom 1 - Rhythm 1 - Patch 2 - IUD 1 - NR
5 Men	2 Puerto Ricans 1 Colombian 1 Peruvian 1 Dominican	1 - 15 1 - 16 1 - 17 1 - 18 1 - 25		5 - Condom

Silver Spring, Maryland Participants

Gender	Nationality	Age at Initial Use of Contraception		First Method of Contraception
32 Women	3 Peruvians 7 Guatemalans 11 Salvadorans 5 Mexicans 1 Bolivian 1 Chilean 1 Colombian 2 Nicaraguans 1 Honduran	7 - 0 6 -16 2 - 18 2 -19 1 -20 2 - 21 3 - 22	1 - 24 2 - 25 2 - 26 1 - 27 2 - 28 1 - 32	6 - None 3 - IUD 17 - Pill 1 - Condom 4 - Injection 1 - Rhythm
15 Men	8 Guatemalans 6 Mexicans 1 Salvadoran	1 - 14 3 - 15 3 - 16 3 - 17 5 - 18		15 - Condom

Monterey Park, California Participants

Gender	Nationality	Age at Initial Use of Contraception		First Method of Contraception
30 Women	28 Mexicans 2 of Mexican Descent	1 - 16 1 - 17 4 - 18 3 - 19 3 - 20 2 - 21 2 - 22	2 - 24 2 - 25 1 - 26 3 - 28 2 - NR 5 - No/0	16 - Pill 2 - Condom (Obs: 1 preservative) 3 - Injection (Depo) 2 - IUD 1 - Combination (condom and injection) 3 - None 1 - Never 1 - NR 1 - N/A
12 Men	12 Mexicans	1 - 15 2 - 16 3 - 17 1 - 18 1 - 19 1 - No 1 - NR 1 - N/A		7 - Condom 2 - NR 2 - None 1 - N/A

* NR = Not reported

Orlando, Florida Participants

Gender	**Nationality**	**Age at Initial Use of Contraception**		**First Method of Contraception**
26 Women	19 Puerto Ricans 3 Mexicans 1 Dominican 1 Colombian 1 Nicaraguan	1 - 15 3 - 17 3 - 18 4 - 19 3 - 20 2 - 21	1 - 24 1 - 27 1 - 31 2- Never 4 - NR	11 - Pill 5 - Condom 2 - Depo Provera 1 - IUD 1- Preservative (Condom) 2 - None 3 - NR
15 Men	9 Puerto Ricans 3 Mexicans 1 Nicaraguans 1 Ecuadorian 1 American (U.S.A.)	1- 14 3- 16 2- 17 2- 18 1- 27 1- Never 5- NR		9 - Condom 1 - Preservative (Condom) 4 - NR 1 - None

* NR = No response

Attachment R: Women – Methods of Contraception Mentioned by Age and City

Age Group	City	Known Methods of Contraception	Long-term Contraception
18-34	New York	Pill, condom, the patch, injection, Nuvaring, female condom, celibacy, withdrawal method, "tying the tubes," *la operación* (surgery), morning after pill, rhythm method, diaphragm, IUD	"Tying the tubes," vasecotmy
35-49	New York	Rhythm method, IUD, pill, condom, the patch, sterilization, Norplant, abstinence, withdrawal method	Norplant, *la operación* (surgery), IUD, "tying the tubes"
18-34	Silver Spring	Patch, vasectomy, injection, rhythm method, *planificación en el brazo* (Norplant), *la T de cobre* (IUD), *la operación* (sterilization), pill	*La operación* (surgery)
35-49	Silver Spring	Condom, pill, injection, IUD, rhythm method, withdrawal method, the patch, *uno como un abanico* (like a fan – Norplant), "tying the tubes"	Sterilization, vasectomy, IUD
18-34	Monterey Park	Pill, injection, "*Aparatito*" (IUD), "Ring" (Nuvaring), the patch, foam, condom	IUD, injection, pill, "Depo," "natural methods" such as withdrawal and rhythm method
35-49	Monterey Park	IUD, pill, condom, female condom	the patch, IUD, "tie your tubes"
18-34	Orlando	Condom, pill, injection, sponge, the patch, female condom, rhythm method, abstinence, IUD	Injection, IUD
35-49	Orlando	Pill, condom, IUD, injection, the patch, the "ring" (Nuvaring), rhythm method, "*la operación*" (sterilization)	IUD, pill, injection

Attachment S: Men – Methods of Contraception Mentioned by Age and City

Age Group	City	Known Methods of Contraception	Long-term Contraception
18-34	Silver Spring	Pill, "a thing that she ties to herself like a ring" (Nuvaring), the patch, condom, vasectomy, withdrawal method	"Tying the tubes"
18-34	Monterey Park	Pill, injection, "tie their tubes," vasectomy, the patch, "not finishing inside of her" (withdrawal)	"No method is permanent"
35-49	New York	Condom, pill, the patch, injection, "the menstruation method" (rhythm method), morning after pill, "*T de cobre*" (Cooper T – IUD), withdrawal method	*la operación* (surgery), "tying the tubes"
35-49	Orlando	Pill, the patch, injection, IUD, gel, foam, rhythm method	IUD, injection, the patch, "tying the tubes"

Attachment T: *Promotores* – Methods of Contraception Mentioned by City

City	Known Methods of Contraception	Long-term Contraception
Silver Spring	Rhythm method, IUD, Norplant, pill, condom, the patch, injection, sterilization, "tying the tubes," morning after pill	Norplant, sterilization, IUD
New York	Rhythm method, gel, foam, IUD, Norplant, pill, condom, the patch, injection	IUD, injection, pills
Monterey Park	Pill, injection, condom, rhythm method	"tying the tubes," IUD
Orlando	Condom, female condom, pill, vasectomy, "tying the tubes," injection, IUD	"*la operación*" (sterilization), vasectomy, abstinence, diaphragm, IUD

[1] U.S. Census Bureau, Population by Race and Hispanic or Latino Origin for the United States: 1990 - 2000, http://www.census.gov/population/cen2000/phc-t1/tab04.pdf.

[2] U.S. Census Bureau, American Community Survey 2004, http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=&geo_id=01000US&_geoContext=01000US&_street=&_county=&_cityTown=&_state=&_zip=&_lang=en&_sse=on&ActiveGeoDiv=&_useEV=&pctxt=fph&pgsl=010

[3] U.S. Census Bureau, Census 2000 Demographic Profile Highlights, http://factfinder.census.gov/servlet/SAFFIteratedFacts?_event=&geo_id=01000US&_geoContext=01000US&_street=&_county=&_cityTown=&_state=&_zip=&_lang=en&_sse=on&ActiveGeoDiv=&_useEV=&pctxt=fph&pgsl=010&_submenuId=factsheet_2&ds_name=DEC_2000_SAFF&_ci_nbr=400&qr_name=DEC_2000_SAFF_R1010&reg=DEC_2000_SAFF_R1010%3A400&_keyword=&_industry=.

[4] U.S. Census Bureau, Population by Age, Sex, Race, and Hispanic or Latino Origin for the United States: 2000, http://www.census.gov/population/cen2000/phc-t9/tab01.pdf. Percentages calculated by NCLR.