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Framing Colombian Women's Beliefs, Values and Attitude Towards Sex and Sexual High-Risk Behaviors

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Framing Colombian Women's Beliefs, Values and Attitude Towards Sex and Sexual
High-Risk Behaviors

by

Rosa Ore

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Latin American Caribbean Studies
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Table Of Contents

List of Figures	iii
Abstract	iv
Chapter One: Introduction	1
Latin Diversity in the United States.....	1
Latin Demographics.....	1
Hispanic Health Outcomes	2
Acculturation And Latinos.....	4
Latin Women in American Media	5
Chapter Two: Literature Review	8
Latin Demographics In The United States.....	8
Statistics and Latin Health Outcomes In The United States	9
High-Risk Behaviors.....	11
Assimilation And Acculturation Contribute To Hispanic Health Deterioration	12
Exploring Latin America’s History and Culture and Its Influence on Women.....	15
Latin America and the Indigenous.....	15
Latin America Colonized And Christianized By Spain.....	17
The New Castilian Law	17
The Latin American Woman And The Patriarchal System	18
Machismo.....	18
Marianismo	19
Latin Subgroup: The Shaping of Colombian Women’s Values, Beliefs and Attitudes	20
Colombian Women: Gender Inequalities.....	20
Colombian Women and Education	21
Sex Health Education.....	22
The Colombian Woman and Marriage	23
Today’s Colombian Women	24
Chapter Three: Methods	26
Conceptual Model	26
Identifying the Sample Size.....	28
Recommended Instrument	29
Measures	30

Comparing the Instruments	37
Procedures for Obtaining Participants	40
Chapter Four: Results	43
Chapter Five: Discussion	46
Policy Implications	46
Potential Limitations	48
References	50
Appendices	57
Appendix 1: Behavioral Health Survey	58
Appendix 2: Behavioral Health Survey – Translated in Spanish	70

List Of Figures

Figure 1.1: Cervical Cancer Incidence Rates By Race and Ethnicity, U.S., 1999-2008	3
Figure 2.1: HPV – associated cervical cancer rates by race and ethnicity, United States, 2004-2008.....	10
Figure 3.1: Model of Sexual High-Risk Behaviors	27

Abstract

Hispanic immigrants constitute the largest and fastest growing groups of minorities in the United States. According to the 2010 Census, there are 50.5 million Hispanics in the United States, making up 16.3% of the total population (Passel, Cohn & Lopez, 2011). Furthermore, the state of Florida is home to 4,223,806 Hispanics (U.S. Census Bureau, 2010). Because the Hispanic population continues to grow, it is important to study their sexual health behaviors because diseases linked to risky sexual behaviors account for approximately 20,000 U.S. deaths each year, and are linked to a number of adverse reproductive outcomes (Abraido-Lanza, Chao, & Florez, 2005; Hussey, Hallfors, Waller, Iritani, Halpern & Bauer, 2006; Mokdad, Marks, Stroup & Geberding, 2004). Much of the research on risky sexual behaviors has included women of Mexican, Cuban and Puerto Rican descent (Weiss & Tillman, 2009). Therefore, to fill a gap in the current research further investigations should be conducted among other Latin subgroups such as Colombians. Conducting studies of Colombian women will contribute to the relatively unknown attitudes, beliefs and values towards sex and sexual high-risk behaviors of South American women.

This study systematically examines literature in order to build a conceptual model, which will explain the sexual behaviors of Colombian women. The study will provide a survey instrument to be used in future research.

Chapter One:

Introduction

Latin Diversity in the United States

Latin America is full of so many different cultures and languages, yet American society continues to fuse all Latinas into one group. According to Denner and Guzman (2006), Latinas have diverse migration and cultural histories as well as different levels of education and income. Because Latin women come from Latin America and the Caribbean, they represent diverse nationalities, political and economic circumstances of migration. Therefore, these women should be researched and investigated, not as females of one category or unit, but as individuals with different voices and characteristics (Shapiro, 2005). It is important not to ignore the growing population of Latinos in the United States, and each of the Latino subgroups and nationalities such as Colombians, for the future health of this nation depends on understanding their health, habits and culture. If the goal of the public health researchers is to enhance population health, then further research of Latinos is urgent and necessary.

Latin Demographics

The United States' (US) Latino population, which was 35.3 million in 2000, has grown by 43% over the last decade and also accounts for most of the nation's population growth (56%) from 2000 to 2010 (Passel et al., 2011). These numbers show that the Latin population of the United States can no longer be ignored, as was the case prior to

the 1980's. It was not until 1980, that the US Census Bureau added a question on Spanish or Hispanic origin or descent to the 100-percent sample (total population) survey for the first time. In 1970 this question was asked of only 5 percent of the population (U.S. Census Bureau, 1980). In addition, since Hispanics are the largest minority population in the United States, their children account for large portions of the American young adult and child populations. Although 40% of the Hispanic population is foreign-born, 56% of those foreign-born are younger than 30 years old (Weiss & Tillman, 2009). Consequently, it is predicted that in the upcoming years, the number of first-generation Latin immigrants will shrink and the second generation will more than double in the United States (Oropesa & Landale, 2004; Pew Research Hispanic Center, 2009). The numbers of Latin Americans in United States are expected to grow and the demographic composition of this population is expected to change over the next ten years making the importance of addressing Hispanic American health and health disparities obligatory (Office of Minority and Health Department [OMHD], 2007).

Hispanic Health Outcomes

Since the Hispanic population is expected to grow, the future health of the US as a whole will be affected negatively, if their poor health outcomes do not improve (OMHD, 2007). For instance, Figure 1.1 below, shows that Hispanic women had the highest incidence rate for cervical cancer in comparison to White, Black and Asian women.

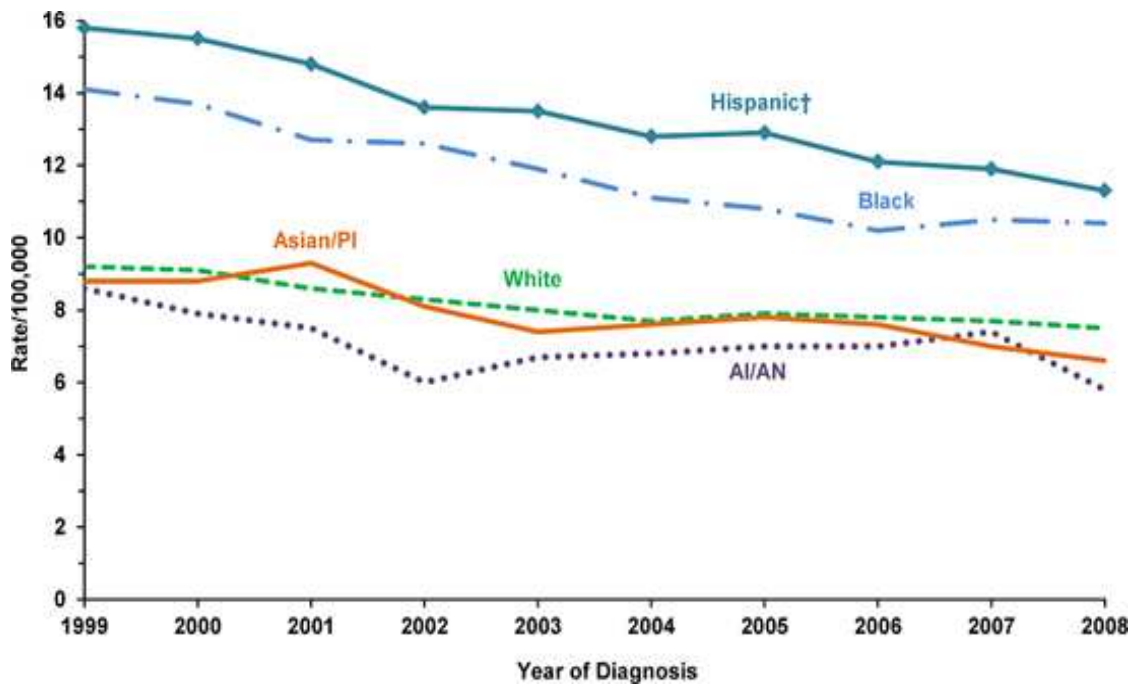


Figure 1.1: Cervical Cancer Incidence Rates* by Race and Ethnicity, U.S., 1999–2008

Combined data from the National Program of Cancer Registries as submitted to CDC and from the Surveillance, Epidemiology and End Results program as submitted to the National Cancer Institute in November 2010. □ *Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25-1130). Incidence rates cover approximately 100% of the U.S. population. □ †Hispanic origin is not mutually exclusive from race categories (white, black, Asian/Pacific Islander, American Indian/Alaska Native). Retrieved from:

<http://www.cdc.gov/cancer/cervical/statistics/race.htm>.

Research has also shown that Hispanics in the United States experience higher rates of sexually transmitted diseases (STDs), HIV infection and cervical cancer than non-Hispanic whites. One in five Latina adolescents have sexually transmitted infections (STIs) (Edwards, Haglund, Fehring, Pruszynski, 2011). However, the risk of such negative sex-related outcomes may fluctuate by country of origin, i.e., U.S. vs. foreign birth (Edwards et al., 2011; Weiss & Tillman, 2009).

These alarming poor sex-related health outcomes among Hispanic women could be the consequence of participation in high-risk sexual behaviors. For instance, the

Centers for Disease Control and Prevention (CDC) and other authors such as MacKay et al. (2000) report that negative health outcomes linked to risky sexual behaviors are more common among Hispanic youth (as cited in Trejos-Castillo & Vazsonyi, 2009).

Furthermore, studies on Latinos and the process of adapting to the United States indicate that sexual risk-taking behaviors increase with greater acculturation (Afable-Munsuz & Brindis, 2006). In addition, a report by the National Alliance for Hispanic Health on the state of Hispanic girls reviewed multiple studies across the United States and found that “contrary to popular stereotypes, greater acculturation among Hispanic girls is tied to poorer health and educational outcomes” (as cited in Asencio, 2002, p. 29). Thus, it is imperative that the repercussions of Latin immigrants’ adjustment to the United States be researched further in order to enable the design of public health interventions to improve their health status (Weiss & Tillman, 2009).

Acculturation And Latinos

Acculturation is the process of adopting the attitudes, beliefs, customs and values of a new culture (Abraida-Lanza et al., 2005). Part of the acculturation process for Latin women includes negotiating of their sexual behaviors between their Latino background and the American cultural expectations. A study conducted in California proved that Latin adolescent girls aggressively obtained and exchanged information to help them make decisions about their sexual behaviors (Guzman, Arruda & Feria, 2006). Yet, little is known on the individual cultural values and their association to sexual high-risk behaviors. Therefore, it is crucial that further inquiry be conducted on the values and beliefs that help shape Latina adolescents’ views on sexual activity and how they develop their decision making process (Edwards et al., 2011). In American society, most of the

information readily available to young individuals is provided by the mass media and various other information technology platforms. Unfortunately, the American media does not always provide the American people with a positive example of appropriate sexual behaviors. Instead the media continues to reinforce male chauvinistic attitudes towards women in society. Hence, Latin women are relentlessly challenged by their portrayal on the American media as sexual objects and as seducers.

Latin Women in American Media

Although, there are many Latin women that are famous actresses, it is the South American Latin population in the United States, that are not as readily recognized. However, the media has begun exposing the American people to Latin women from other countries beyond Puerto Rico, Mexico and Cuba, via new television shows such as “Modern Family” and “The Voice”. The main actresses from these two shows are Colombian female named Sofia Vergara and Ecuadorian popular music singer, Christina Aguilera. Unfortunately, in these particular television shows, the South American celebrity women are portrayed in a sexual, provocative and seductive manner, once again reinforcing the stereotype that Latin women are sexual objects and seducers. During the 2013 Screen Actors Guild Awards show, Sofia Vergarra openly joked of how her father warned her not to get into acting because her big breasts and curves would cause her to be mistaken for a “hooker” (Nudd, 2013). Lately, Christina Aguilera has been highly criticized in the media for gaining weight because she has abandoned the “skinny white girl” look and embraced her “Latin curvaceous body” (Chen, 2012). As a result, it has been reported that Christina Aguilera has felt pressure from her music label to lose the weight or compromise her career (Chen, 2012). While one South American Latin woman

is being threatened of losing her career for embracing her Latin curvaceous body, another Puerto Rican celebrity, Jennifer Lopez, is enjoying the fame her huge buttocks have brought her. In addition, it is known that Jennifer Lopez protects her fame and fortune that her buttocks have brought her by insuring her butt for \$1 billion (Guzman & Valdivia, 2004). Anytime Jennifer Lopez is portrayed in the media, she is photographed from the rear, glamourizing her butt at all times (Guzman & Valdivia, 2004). Although, this kind of attention may not bother Jennifer Lopez, it doesn't necessarily mean that all Latin women want to be admired or recognized solely for their sexuality. For example, Salma Hayek, a famous Mexican actress, grew tired of being offered roles that stereotype her as a Latin sexual object; therefore, she decided to start her own production company that produced movies that focused on Latin history (Guzman & Valdivia, 2004). If more Latin-American women don't stand up to the media and come against societal sexual stereotypes, then what can be said about the future of other young Latin immigrant women that want an opportunity to be successful actresses.

Overall, Latin American women, continue to be stereotyped as sexual objects and are consistently experiencing marginalization in US society (Guzman & Valdivia, 2004). Attitudes and behaviors towards Latin women have cast a shadow over their true identities as women (Guzman & Valdivia, 2004). Furthermore, these erroneous perceptions of women have served as a smoke screen that hides who a woman really is and have served as a barrier to addressing issues that are relevant to the health and wellbeing of Latin woman. It is important to explore these incorrect perceptions and get a more accurate insight into other Latin American subgroups such as Colombian woman's beliefs, attitudes, and values towards sex and their participation in sexual high-risk

behaviors. As this Colombian subgroup of Latin people continues to migrate and get established in the United States, it is essential to study their health behaviors because they have their own distinctive Spanish language, culture and history that is comparatively unfamiliar to American researchers.

Chapter Two:

Literature Review

Latin Demographics in United States

The Latin population within the United States continues to grow. Currently, 53 million Hispanics make up 17% of the total U.S. population (Taylor, Gonzalez-Barrera, Passel & Lopez, 2012). Even though the 2010 Census indicates that Hispanics of Mexican, Puerto Rican, and Cuban origin or descent remain the nation's three largest Hispanic country-of-origin groups, it also confirms that the next four Hispanic subgroups—Salvadorians, Dominicans, Guatemalans and Colombians—increased quicker in the past ten years (Lopez & Dockterman, 2011). In 2010, Colombians were the seventh-largest group of Hispanics living in the United States, and 1.9% of the U.S. Hispanic population (Pew Hispanic Center, 2012). Despite the fact that Mexicans remain the largest group of Hispanics in the United States, they are not the dominant group; therefore, research on Latin health outcomes must begin to include more data from these subgroups such as Colombians (Lopez & Dockterman, 2011).

Further examination of articles on Latin sexual health-related outcomes and behaviors, exposed that most of the studies were based on Latinos of Mexican origin, Puerto Ricans, Dominican and some Central American. In a literature review of 17 studies on the relationship between acculturation and the sexual and reproductive health of Latino youth in the United States conducted by Aimee Afable-Munsuz and Claire

Brindis, disclosed that the studies included only participants from Mexican, Puerto Ricans, Dominicans, Cubans and Central Americans populations (2006). Other sexual behavioral studies have focused on Mexicans and Puerto Ricans because they are largest Hispanic populations in the United States while ignoring Hispanics from other countries (Weiss & Tillman, 2009). In addition, much of the literature on acculturation and health behaviors either focuses specifically on Mexican Americans, or on the West and Southwest regions of the US where the Latino population is predominantly of Mexican origin [ie. Cantero et al., 1999; Crespo et al., 2000, 2001; Markides, Krause & Mendes de Leon, 1988, 1990; Perez-Stable et al., 1994] (as cited in Abraido-Lanza, Chao, & Florez, 2005). Therefore, it should be noted that these studies are not complete indicators of the sexual behaviors and health of the whole Latin immigrant population in the United States.

Statistics and Latin Health Outcomes in the United States

According to the Centers for Disease Control and Prevention (CDC, 2010a) one of the leading causes of morbidity and mortality among youth and adults in the United States is related to high-risk sexual behaviors, which result in STDs such as HPV. It is estimated that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24 (Weinstock, Berman & Cates, 2004). Since many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV), may not be reported to the CDC at all; therefore, the reported cases represent only a fraction of the true burden of STDs in the United States (HealthyPeople.gov, 2010). STDs that go untreated can lead to serious long-term health consequences, especially for adolescents and young women (HealthyPeople.gov, 2010). For example, Genital human papillomavirus (HPV) is the most common sexually

transmitted disease in the United States, which can infect the genital areas of women, including the vulva (area outside the vagina), and anus, and the linings of the vagina, cervix, and rectum (CDC, 2011). Unfortunately, the CDC also reports that the human papillomavirus (HPV) can result in cervical cancer (CDC, 2010b).

The Office of Minority Health, reports that the number of new cases of invasive cervical cancer among Hispanic American/Latino women (age 30 years and older) is about twice the number of non-Hispanic women (2005). It is also reported that due to the lack of access to Pap testing or preventive treatment, more Hispanic women get cervical cancer and are diagnosed at later stages of the disease than women of other races or ethnicities (CDC, 2012). The data gathered by the CDC indicated on Figure 1.2. shows that Hispanics have the highest rates of HPV related cervical cancer (2012). It is also very disturbing to know that statistically, Hispanic American/Latino women are 40 percent more likely to die from cervical cancer, than non-Hispanic women (OMH, 2005)

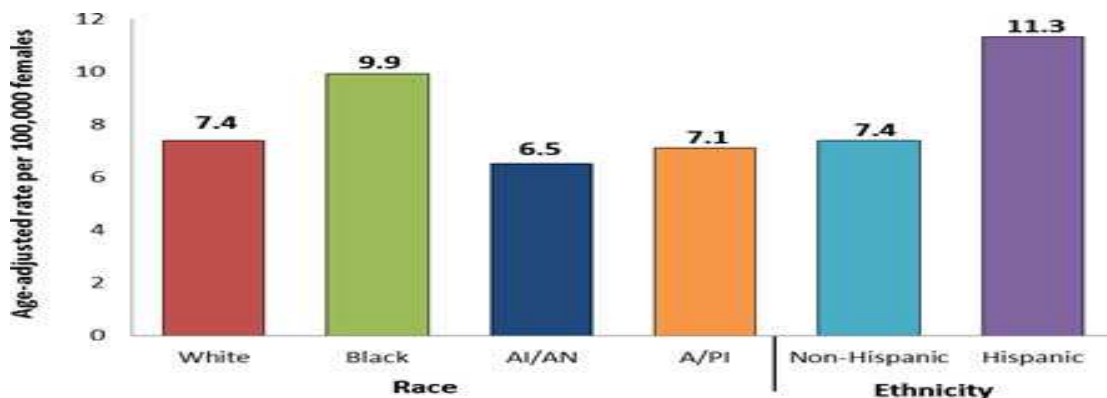


Figure 2.1: HPV-associated cervical cancer rates by race and ethnicity, United States, 2004–2008

The graph above shows age-adjusted incidence rates for cervical cancer in the United States during 2004–2008. "AI/AN" means American Indian/Alaska Native, and "A/PI" means Asian/Pacific Islander. The rates shown are the number of women who were diagnosed with cervical cancer for every 100,000 women. About 10 black women, 7 white women, 7 American Indian/Alaska Native women, and 7 Asian/Pacific Islander women were diagnosed with cervical cancer per 100,000 women. About 11 Hispanic women were diagnosed with cervical cancer per 100,000 women, compared to 7 non-

Hispanic women. This graph was adapted from Centers for Disease Control and Prevention (CDC). [Human papillomavirus–associated cancers—United States, 2004–2008](#). *MMWR* 2012;61(15):258–261.

Overall, there are significant disparities in outcomes among racial and ethnic groups. Adolescents and young adults who are Hispanic, especially those living in poverty, experience worse health outcomes compared to adolescents and young adults who are white (Adolescent Health, 2012).

High-Risk Behaviors

High-risk health behaviors are identified in Healthy People 2020, as one of the leading behavioral causes of premature morbidity and mortality (Kilmer et al., 2006; Mokdad et al., 2004; Scott-Sheldon, Carey & Carey, 2008; U.S. Department of Health and Human Services, Center for Disease Control and Prevention, 2008). For the purpose of this type of research on Latin women, health-related protective behaviors (e.g., condom use) are actions that preserve or improve health status; however, health-related risk behaviors (e.g., unprotected sex and excessive drinking) are actions that may result in immediate or long-term negative health outcomes (Henson, Carey, Carey & Maisto, 2006). From a psychological perspective, risk taking behaviors can be theorized as adaptive and exploratory, however, too much exploration can lead to repetitive negative behaviors that represent a risk for the well being of youth (Trejos-Castillo & Vaszonyi, 2009). Although these exploratory behaviors are usually initiated during adolescence, many of the adverse consequences of drug use and sexual risk-taking do not appear until adulthood (Abraido-Lanza, et al., 2005).

Extensive research has shown that there is an association between becoming sexually active at an early age and a higher frequency of sexually transmitted diseases (STD) in women (Greenberg, Magder & Aral, 1992). Studies have also identified age at

first intercourse as a significant risk factor for STDs such as herpes simplex virus type 2, cervical cancer, and the presence of HPV in invasive cervical cancer (Greenberg et al., 1992). The Youth Risk Behavior Survey (2004) shows that Hispanics are 15.7% more likely to have sex before the age of 13 and have four or more sexual partners in comparison to 10.8% in European American adolescents (as cited in Trejos-Castillo & Vazsonyi, 2009). These statistics are a clear indication that Hispanic youth are engaging in high-risk sexual behavior at a very early age, therefore, increasing the prevalence of STDs among the Latin population. Hence, it is only logical that behavioral interventions are necessary to decrease health risks associated with early sexual activity for this young population (Villarruel, 1998). In order to develop effective strategies and culturally appropriate interventions for Latin adolescents, important and relevant factors such as cultural values, attitudes and expectations should be included in these approaches (Villarruel, 1998).

Assimilation and Acculturation Contribute to Hispanic Health Deterioration

Due to the lack of research on specific subgroups of Latinos, very little is known about the health habits of Latin immigrants such as Colombians. However, according to Rumbaut, it is assumed that when groups of newcomers arrive to the United States they are destitute, underprivileged and poor in health because they are not yet “Americanized”; but the contrary is true (1997). In an article by David Hayes-Bautista, results from data collected on Latino health statistics revealed a Latino Epidemiological Paradox, which indicated that even though Latinos had fewer access to healthcare, they also had better health outcomes such as 35% fewer heart attacks, 43% fewer cancers, 45% fewer strokes, 5 years longer life expectancy and less infant mortality (2008). These

studies have shown that immigrants arrive in good health and that their health begins to deteriorate as assimilation and acculturation to the American lifestyle takes place. These two concepts, assimilation and acculturation, are used in the majority of these studies and are best described by Schneider, Comer and Berry in this statement:

“Acculturation has been viewed as a linear progression, whereby immigrants gradually adopt the values, behaviors and traits of their host culture and discard those of their country of origin. Studies of “integration” or “assimilation” have focused on immigrants’ educational and employment status as compared with that of the native population” (as cited in Afable-Munsuz & Brindis, 2006).

According to Weiss and Tillman, it is substantiated that conforming to the American lifestyles and behaviors may lead to immigrants’ deterioration of their physical and emotional health (2009). “It is also implied that the health of foreign-born Hispanics may be “protected” by their native cultural tendencies, which does not allow permissive parenting styles nor does it allow experimentation with sexual activity and substance abuse” (Weiss & Tillman, 2009). Scribner (1994), Markides and Coreil, (1986) refer to the health behavior hypothesis and they proposition that Latinos are less likely to participate in high-risk behaviors such as drinking alcohol and smoking than non-Latino whites, resulting in favorable health behaviors and better health outcomes (as cited in Abraido-Lanza et al., 2005). However, since these positive health behaviors are believed to be associated with Latino cultural norms, the acculturation hypothesis predicts that health behaviors become riskier with greater acculturation (Abraido-Lanza et al., 2005). Therefore, acculturation can lead to non-healthy and high-risk behaviors, resulting in the downward slope of an immigrant’s health.

Patterns of acculturation can usually be identified by looking at the age at time of migration, time in the United States, language spoken at home, and adherence to the culture of the country of origin (Afable-Munsuz & Brindis, 2006). In order for immigrants to navigate their way around their new society, they must learn the new language. This is the beginning of becoming acculturated to the United States because it means learning English as a second language. Even though immigrants may have to learn English in the United States, many Latin immigrants use their native language as a way of staying in touch with their culture. Latin immigrant parents often reinforce their culture on their children by forcing them to speak only Spanish at home. Being bilingual is important and valuable, especially to the 1.5 generation because they are children who straddle the old and the new worlds but according to Rumbaut, are fully part of neither” (Zhou, 1997). When the parents of the U.S. born children or 2nd generation, do not reinforce the need to be bilingual, they end up being monolingual and become even more acculturated. On the other hand, 2nd generation Latin immigrant children illustrate selective acculturation by not abandoning their parents’ language and key elements of their culture through parental guidance and support. (Portes & Rumbaut, 2006) When families experience selective acculturation the language nor the culture is fully discarded and great efforts are made to hold on to their values and beliefs by cooking cultural foods, listening to music from their home country and traveling often to their country of origin. Even though Latin immigrants may not totally renounce their cultural background, they must become accustomed to the American way of life in order to assimilate and attain upward mobility.

Exploring Latin America's History and Culture and Its Influence on Women

Migrating from one country to another has to be one of the most difficult life decisions human beings can make. In addition, transitioning from one culture to another can also be traumatizing for some more than others. For women, in particular, this can mean leaving behind not only your country, but also your family and culture. Although immigrants are forced to adapt to their new country and culture, they are not always willing to let go of their old way of life. Consequently, although Latin immigrant women may have access to medical care in the United States, they still tend to deal with illness according to their old traditional homeland methods (Vaughn, Jacquez & Baker, 2009). In order to understand why Latin immigrant women may not want to follow an American Doctor's recommendations, it is crucial that Medical Providers learn about their patients cultural background and beliefs about illness (Vaughn et al., 2009). Overall, if the Medical Healthcare Providers and the Public Health sector intend to successfully improve the health of all the Latin population, then it is important that they create culturally competent programs that acknowledge all patient's cultural differences (Vaughn et al., 2009). Furthermore, in order to earn a patients' trust and obtain cooperative patients, it is crucial to know their cultural background and the history of their homeland. For example, it is only after further study of the history of Colombia that one can begin to understand that these women come from a patriarchal society that has highly influenced and shaped their values, beliefs and attitudes towards sex and sexual high-risk behaviors.

Latin America and the Indigenous

The history of South America reveals that it was originally occupied by a diversity of indigenous people, such as the Muiscas, Tayronas, Chibchas, Caribs, and

Arawaks (Dugas, 2009; Hudson, 2010). Prior to colonization by any countries outside South America and before they were influenced by any external forces, the indigenous people lived a very different and liberated life. They practiced sex freely and considered it very special because they used sex as a means for delight in regards to their sexuality (Garces, 2008). According to Restrepo (1995) “matrimony was considered an obligation for the maintenance of the family, which was the social and economic nucleus of the State” (as cited in Garces, 2008, p.91). Even though marriage was well respected and desired, Restrepo (1995) and Gutierrez de Pineda (1997), emphasize that changing partners at will was not frowned upon (as cited in Garces, 2008). The man was responsible for the woman and the children and women were respected and appreciated. In addition, Indian laws were in place to protect women against physical or sexual violence (Garces, 2008). Because women were respected and appreciated by the leaders of the community, they were paid benefits during different stages of their lives such as pregnancy, widowhood, and old age (Garces, 2008). Virginity did not bring respect for a woman, but instead it represented a shortcoming because this meant she was neither desired nor good enough for a man to want to be with her (Garces, 2008). Restrepo (1995) specifies that purity and virginity were not concepts that were part of the indigenous worldview; moreover, a woman’s sexual life began at puberty and sex was practiced with no restriction (as cited in Elena Garces, 2008). But not all sexual practices were favorable for a woman. Women were offered sexually as a sign of friendship to visitors or foreigners and refusing to offer the visitor a female for sex was considered rude and offensive to the visitor (Garces, 2008).

Latin America Colonized And Christianized By Spain

When the Spaniards first colonized South America, the conquistadores felt their sexual practices were savage and immoral, but the Spaniards had no problem taking advantage of this practice and slept with their women (Garces, 2008). Not only did the Spaniards take advantage of their women, but they also invaded their lands and put them under the control of Spain's government. After the Spaniards arrived in Latin America, they believed that they were to conquer the new world and "Christianize the heathen because the Catholic Church needed to convert these lost souls for the kingdom of heaven" (Garces, 2008; Hudson, 2010). The priests were not only concerned with saving the souls of the indigenous people, but were also fascinated with acquiring their land and wealth for their church (Hudson, 2010). Furthermore, Restrepo (1995) clarifies that the Spanish empire and its catholic monarchs saw converting Latin America to Christianity as their main objective (as cited in Garces, 2008). However, the Spanish ideologies were difficult for the Indians to understand because they could not grasp the foreigner's laws and mythologies (Garces, 2008). As a result, many of the indigenous culture and languages were exterminated and many died from illnesses (Dugas, 2009, Garces, 2008).

The New Castilian Law

In the effort to convert the New World into Christianity according to the catholic beliefs, new ideas were brought by the Spaniards regarding women and their status in society. According to Segura Graino (1995), Castilian law was more favorable for men than for women because it gave men many privileges and left women disadvantaged by its decrees (as cited in Garces, 2008). Women were expected to deny their sexuality; nevertheless, their sole purpose for sex was to please their husband and reproduce to

create a big family (Keen, 1992). According to the Castilian laws and religious beliefs, women were considered to be weak beings because they were inheritors of Eve's impure and sinful nature, having malicious and evil personality traits and inclined to sin (Dore & Molyneuz, 2000; Garces, 2008). These beliefs originated from the biblical story of Adam and Eve, where it told that human beings were thrown out of Paradise because they were no longer perfect and were of a sinful nature (Garces, 2008). Further Catholic Christian interpretations of the Bible associated sex with disobedience and sin, making Mary the symbol of the ideal woman and Eve the symbol of evil and temptation (Garces, 2008). Unfortunately, "five hundred years later in Colombia, the idea that a woman is responsible for the "fall" of man and the human race continues to be a firm belief for this society" (Garces, 2008, p. 88).

According to Pablo Rodriguez (1995) during the colonial times, "the ideal woman was constructed by masculine fantasy, therefore, feminine virtues were chastity, modesty, piety, discretion, obedience, prudence, and an affable nature" (as cited in Garces, 2008, p. 87). Jaime Humberto Borja (1995) also mentions that although, the essence of a good woman was to be a good administrator of her home, ultimately her virginity was proof of her suppressing her uncontrolled nature (as cited in Garces, 2008). Therefore, virginity epitomized the model Christian woman and a marriage was the only outlet for her to express her sexuality, while advancing procreation (Garces, 2008).

The Latin Woman And The Patriarchal System

Machismo

From the moment the indigenous people of Colombia encountered the Spaniards, Colombian cultural norms became influenced and firmly established on patriarchal

ideology (Garces, 2008). Mitchell (1973) defines patriarchal ideology as the domination patterns of men over women, which not only enforces “the rule of father,” but also authorizes men to use force when necessary to maintain dominance (as cited in Garces, 2008, p.14). Pitt Rivers (1966) explains that Machismo is a legacy brought to Latin America by the conquistadores, originating over eight hundred years ago from the Moorish cultural influence in Spain and remains very strong in Colombia (as cited in Garces, 2008; Plata, 1988). Spaniard Machismo is defined as “exaggerated aggressiveness and intransigence in male-to-male interpersonal relationships and arrogance and sexual aggression in male-to-female relationships” (Garces, 2008, p.151). Chris Kramarae and Paula A. Treichler (1985), authors of a feminist dictionary, define Machismo as the Latin word for the mystic of manliness, which represents a range of attitudes, values and behaviors that include contempt for women (as cited in Garces, 2008). Men who are machistas base their self-value, honor and pride on how they see themselves and how society sees them as well (Garces, 2008).

Marianismo

On the other hand, Evelyn Stevens (1973) explains that marianismo, which is the complement to machismo, is a cult of feminine spiritual superiority, that tries to demonstrate that women are semi-divine, therefore, morally superior and spiritually stronger than men (as cited in Garces, 2008). Furthermore, Maurice Hamington (1995) writes that the idea of women being semi-divine has contributed to society’s beliefs that women are either good or bad, Mary or Eve; therefore, allowing for women to be objectified as the “other” or less human (as cited in Garces, 2008). Consequently, perceiving women in this manner increases sexism and has contributed to the physical

abuse of women by men (Garces, 2008). When men are unable to financially support their wife and children, they forbid their wife from working outside of the home because they do not want to be perceived as incapable of fulfilling his manly duties (Plata, 1988). Consequently, the men grow frustrated with their financial situation and eventually take out their frustrations on their wife by beating on them (Plata, 1988).

Latin Subgroups: The shaping of Colombian Women's Values, Beliefs and Attitudes

Colombian Women: Gender Inequalities

Today's Colombian family still accentuates and reinforces many of the gender inequalities and its Castilian Law brought over to Latin America from Spain. In Colombian society women are not valued and are considered a burden. Unfortunately, there still exist many differences between boys and girls, through games, household chores, and freedom to socialize without supervision outside of the home (Garces, 2008). From an early age, children's gender and identity are established and shaped through subtle patterns of behaviors prescribed by the parents and society (Garces, 2008). Colombian men who were machistas have been known to refer to their daughters and granddaughters as a "house slipper," meaning another woman had arrived into the family or someone warm and cozy to scuff around the house only good enough for cooking, cleaning, getting married and producing more grandchildren (Garces, 2008). Nonetheless, women were considered special and delicate as porcelain; therefore, needed constant protection because they could get easily harmed (Dore & Molyneux, 2000, Garces, 2008; Plata, 1988). Graino (1995) further emphasizes that men were to care for and protect women and they were not to be left alone and should be accompanied by the father, brother or husband at all times (as cited in Garces, 2008; Plata, 1988). They were

treated differently and were forbidden from participating in many activities that boys would do such as climbing trees, playing rough games, and going to parties and the movies without chaperones (Garces, 2008; Plata, 1988). This kind of treatment towards women only devalues them and can contribute to women seeing themselves as weaklings. This kind of society only causes women to treat men as kings and see themselves as second-class citizens.

Colombian Woman and Education

For many years, females in Colombia were expected to attend school but getting an academic education was not considered a priority. Instead girls were geared towards behaving properly and becoming a dutiful wife (Garces, 2008; Plata, 1988). Because Colombia is 90% Roman Catholic, the schools employed nuns and priests as their teachers; therefore, the most common topics covered in school were religious instruction and anything that would prevent any distraction from God (Garces, 2008; Hudson, 2010; CIA World Factbook, 2013). The girls were taught that, “silence was the golden rule and obedience of the highest value”; therefore, girls were to express their thoughts and concerns through an internal dialogue with God (Garces, 2008, p.3). This early cultural instruction has caused Colombian girls not to express their thoughts and to lose their sense of identity (Garces, 2008). Feminine behavior was reinforced at all times and behaving like a tomboy was not allowed nor tolerated (For example, pushing, shouting and playing kick ball was considered vulgar and inappropriate for a young lady (Garces, 2008). Being a proper lady meant sitting with legs crossed at all times, remaining calm, controlled and gracious at all times (Garces, 2008). The nuns were very diligent in teaching the girls that virginity was valuable and their bodies were “temples of the

Holy Ghost” (Garces, 2008, p. 4). There were certain expectations that came with this idea: hence, nothing was allowed to soil the minds of young girls because freedom, impurity and insubordination could lead to prostitution (Garces, 2008). By adolescence, girls were taught how they could tempt boys and how they were responsible for causing a man to commit sin (Garces, 2008). The guilt that was placed on these young girls was substantial because they were constantly reminded that, “Eve’s misbehavior caused all humanity to lose paradise forever and that such ungrateful human beings were condemned to cultivate the earth by the sweat of their brows and give birth to children in pain” (Garces, 2008, p.4). Consequently, there is a heavy expectation and obligation on Latin women to correct the harm done by Eve by becoming good women. Additionally, women were expected to abide by the patriarchal definition of a good woman, which was being obedient, submissive, silent, pure and virginal (Garces, 2008).

Sex Health Education

In addition to all these limitations and restrictions, mothers were very reluctant to discuss a women’s sexuality or even basic biology with their daughters (Garces, 2008). However, Colombia has made some progress since the late 1980s and 1990s in addressing the sexual health education for young people (Ali, Cleland & Iqbal, 2003). Colombia has actively implemented new policies making sure that sex education and family planning services are made available to teenagers and young adults; therefore, generating a promising future for a healthier society (Ali et al., 2003). Profamilia, an affiliate of the International Planned Parenthood Federation, became the main provider of sex education and reproductive health services in the country (Ali et al., 2003). The Colombian Ministry of Health (MOH) department in a decree that was issued in the year

2000, recognized that there was a need sexual and reproductive health education making sex education obligatory in primary and secondary schools (Ali et al., 2003). These kind of policies and actions are necessary and crucial to producing a healthy society, but sometimes not enough for a patriarchal society like Colombia.

The Colombian Woman and Marriage

Marriage in Colombia is an institution that is fiercely dominated by the Roman Catholic Church because it is one of the few remaining Latin American countries in which the Church and the State are closely linked (Hudson, 2010; Plata, 1988). The Roman Catholic Church has very strong guidelines for marriage and sex, in which they use the bible to declare that the wife is to obey the husband and the husband was to rule his household as he pleased. (Garces, 2008; Thornton & Camburn, 1989). In addition, the nuclear family lived under strict laws and regulations that were not only dictated by Catholicism but also approved and supported by the judiciary (Garces, 2008). Divorce is only possible by means of marriage annulment, which can only be granted by Church authorities under canonical law (Plata, 1988). Unfortunately, after so many decades of change in government and change in the make-up of Colombia's society, the nuclear family unit, continues to be dominated by the authoritarian and patriarchal system (Hudson, 2010). Although, as of 1974 there have been legal reforms that extend equal civil and property rights to women, traditional male–female relations are primarily followed and obeyed (Hudson, 2010; Plata, 1988). Because divorce and separation is so difficult to obtain through the Catholic Church and Canonical lawyers, many couples are choosing to live in consensual unions (Plata, 1988). A perfect example of why couples may not want to get married anymore was reported on June 4th of 2001, *El*

Tiempo, a Colombian newspaper, reported that the government awarded a man's pension to his wife and to his lover (2008). It also reported that because of this ruling of the courts, bigamy may no longer be seen as an illegal act, but as an accepted practice by Colombian culture; consequently, allowing men to experience their sexuality freely (Garces, 2008). Surprisingly, even after all the gender inequalities, marriage through the Catholic Church continues to be highly preferred and seen as the ideal foundation for the legal, social and sexual basis of the family (Hudson, 2010).

Today's Colombian Women

According to Garces (2008), Latin women have been silenced and repressed for many years due to the influence of the European western culture and ideologies of the Roman Catholic Church. The legacy of machismo and marianismo, which are attitudes, values and behaviors of condescension towards a woman amongst the Latino population, are very much alive and still practiced by men in Latin America and in our American society (Garces, 2008). However, some South American countries like Colombia have undergone extensive changes in their government and culture that have dramatically influenced the role of women in their society. The country of Colombia has endured years of violence and peace, which have affected women negatively and causing them to be "internally displaced persons (IDPs)" (Rojas, Anderlini & Conaway, 2004, p.7). Throughout these times of violence and peace, women have taken on roles as armed combatants and peacemakers. It is reported that 17% of the peace leaders and activists in Colombia that have disappeared or been killed, were women (Rojas, Anderlini & Conaway, 2004). Nonetheless, Colombian women have successfully evolved as leaders in their homes and leaders in their community. However, due to the history of violence

and danger in Colombia, many families have left Colombia and migrated to the United States (Keen, 1992). In 2010, it was reported that 972,000 Colombians live in the United States, making them the 7th largest Hispanic population in America (Pew Hispanic Center, 2012). Of those Colombians living in the United States, 59% claim to speak English very well and the other 41% claim they speak English but they are not very proficient (Pew Hispanic Center, 2012). Compared to other Hispanics, 47% of the Colombian population is married and 32% have obtained a Bachelor's degree or higher level of education (Pew Hispanic Center, 2012). In 2010, it was also reported that the median income of Colombians was \$25,000 and 13% were living in poverty (Pew Hispanic Center, 2012).

As time passes, the Colombian population will continue to increase and become more acculturated to the American way of life. Of all the Colombians that have migrated to the United States, 34% live in the state of Florida (Pew Hispanic Center, 2012). Therefore, it is important to study this growing population as their health behaviors may give the Public Health researchers better insight into developing effective preventive measures that will benefit all Hispanics.

Chapter Three:

Methods

The purpose of this study is to build a conceptual model, which will explain the sexual behaviors of Colombian women and provide a survey instrument to be used in future research. This section provides a description of how a sampling frame for this type of study can be determined and presents a survey containing questions tailored specifically for Latin subgroups such as the Colombian population that will give greater insight to South American women's health habits.

Conceptual Model

Building a conceptual model to facilitate the analysis of Latin women's high-risk behaviors is a new approach that is crucial and relevant. Because there is so much diversity within the Latin community, it is important to be able to identify those factors and variables that affect health behaviors. For example, the socio-ecological model is used to provide a visual explanation of how an individual's behavior is affected by their social environment, and how that behavior is shaped by multi-levels of influence (Daley, Alio, Anstey, Chandler, Dyer, & Helmy, 2011). Therefore, this new conceptual model intends to provide an illustration, which will facilitate the analysis of how family and friends, socioeconomic status, religious beliefs, culture, sexual encounters and history, use of drugs and alcohol are all interconnected and contributors to an individual's participation in sexual high-risk behaviors. When developing effective health preventive

and intervention programs, knowing the population is primary and essential. The level of effectiveness of any program can be increased, by the exchange of information and sharing of knowledge, between the Provider of the service and the individual receiving the service (Vaughn, Jacquez & Baker, 2009). If the issue being addressed is sexual high-risk behaviors, then it is only logical that all the relevant information be gathered about the individual's background, which includes asking questions about family and friends, socioeconomic status, religious beliefs, culture, sexual encounters and history, and use of drugs and alcohol. Taking a closer look into each of these factors about an individual, will give better insight as to why one might choose to participate in these sexual high-risk behaviors. At the same time, this kind of in-depth investigation about a population will produce public health researchers that are culturally competent.

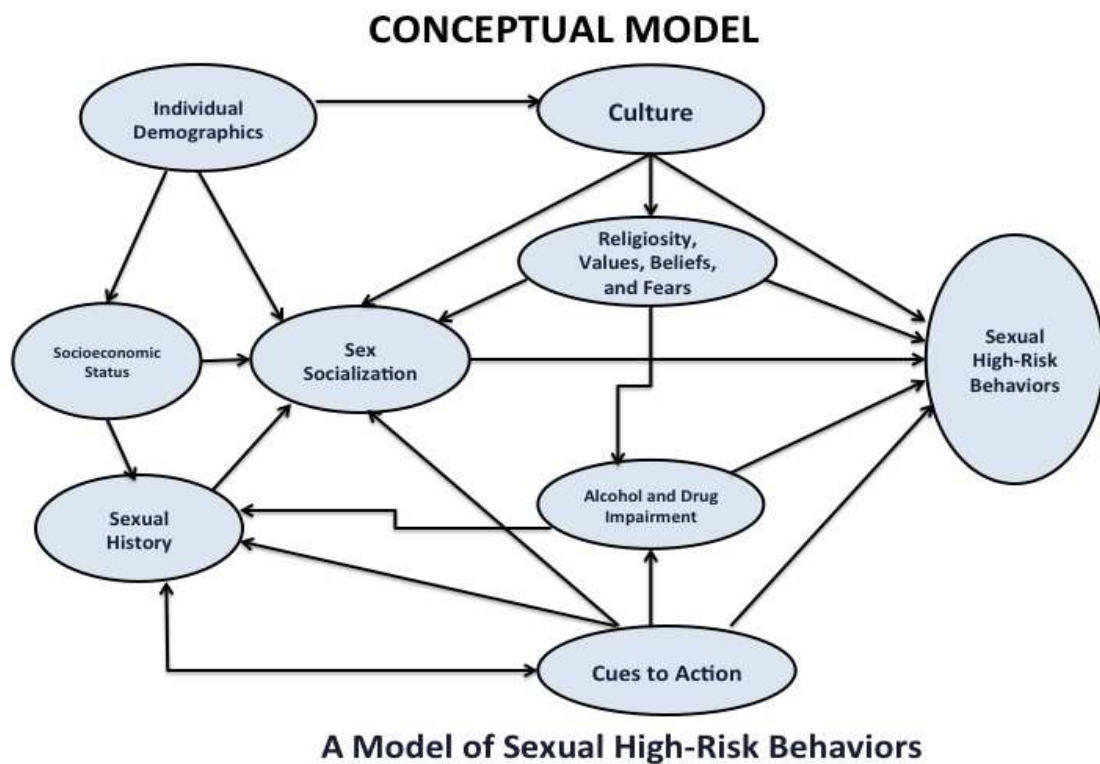


Figure 3.1 A Model of Sexual High-Risk Behaviors

Identifying the Sample Size

The U.S. Census Bureau shows that there is a large Colombian population in Miami-Dade. The study sample size of this Latin subgroup can be calculated using the age pyramid obtained from the CIA World Factbook website and the NationMaster.com website. In this study, it is assumed that the migrant Colombian population in Florida has a similar age pyramid as that of their native country, therefore, allowing the safe construction of a sampling frame and determination of a study sample.

The age pyramid of Colombia shows an overall sex ratio of approximately 49% males to 51% females (CIA World Factbook, 2013), and that approximately 8% of all females are between the ages of 20 and 44 (see NationMaster.com, n.d.). In order to obtain the best possible results, the age group recommended for this study is 21 to 44 because it allows for investigation across generations. This age group also allows for women who are old enough and mature to answer the survey questions without parental consent and excludes women who are in menopause.

According to the US Census Bureau, in 2010 the Colombian population in Miami-Dade County, Florida, was 114,701 (U.S. Census Bureau, 2010b). It is estimated that 51% of the Miami-Dade counties' Colombian population are female. This puts the number of Colombian females in the Miami-Dade County at 58,497. If 8% of these females are between the ages of 20 and 44, then this puts the number of this age group for the Miami-Dade County at 4,679. In order to produce valid study results, the appropriate sample size should be determined by the investigating team.

Recommended Instrument

The instrument recommended for this type of study was designed to help identify those variables not addressed by other surveys used previously in national or large-scale studies. Although many of the questions on the survey are adapted from the YRBS 2011, National College Health Risk Behaviors Survey (CDC, 1995), and from two health behavior studies by Scott-Sheldon, Carey and Carey (2008), and Henson, Carey, Carey and Maisto (2006), new questions were added to the survey to ascertain if different levels of acculturation, such as age at time of migration, time in the United States, language spoken at home, culture and communication with parents, and religion are associated to Latin women's participation in high-risk sexual behaviors. Because Latin immigrants struggle with maintaining their identities and being true to their culture and adapting to their new country of residence, these factors are essential to the study. Since research has shown that high-risk behaviors increase with the acculturation process, it is important to include questions that may show differences in participation of high-risk behaviors between the 1st generation, 1.5 generation and 2nd generation Latin immigrants (Afable-Munsuz & Brindis, 2006). Since not all Latin women are fluent in English, accommodations need to be made to be able to reach the rest of population that is not fluent in English. Therefore, a Professional Translator has translated the survey designed for this study into Spanish. The 2nd generation of Latin immigrants, which are the most acculturated, are most likely to be proficient in English.

For the purpose of this study, the 1st generation and 2nd generation definitions are taken from Pew Research Hispanic and Center and will be defined as follows:

First generation: Same as foreign born above. The terms “foreign born,” “first generation”(Pew Research Hispanic Center, 2009).

Second generation: Born in the United States, with at least one first-generation parent (Pew Research Hispanic Center, 2009.)

In addition, the 1.5 generation is important and relevant to study because their behavior and social development is usually different in comparison to the 2nd generation children. (Zhou, 1997) Therefore, the 1.5 generation is best described as the children who straddle the old and the new worlds but are fully part of neither (Zhou, 1997) These are children that were born in their country of origin, but arrived at a very young age. They are usually between the ages of 6 and 13 years of age. (Zhou, 1997)

Measures

The recommended survey consists of 66 questions, which were adapted from the following studies:

1. Health behavior and college students: Does Greek affiliation matter? Written by Scott-Sheldon, L. J., Carey, K. B., & Carey, M. P. in 2008.

This study surveyed 1595 college students from Syracuse University and investigated their participation in high-risk behaviors such as alcohol and drug use, smoking, sexual behavior, eating, physical activity, and sleeping. The purpose of this study was to explore if affiliation with Greek organizations increased a college student’s participation in high-risk behaviors in comparison to non-Greek affiliated college students. The study results showed that college students who were Greek members engaged in more risky health behaviors (e.g.,

alcohol use, sexual partners, and sex under the influence of alcohol or drugs) than those students that were not members of any Greek student organizations.

Since the study achieved great results, a few questions from this study were adapted into the new instrument for this study. The questions from this study were used to address the following topics:

- a. Sexual Behaviors - (1) number of lifetime sexual partners (where sex is defined as oral, anal, or vaginal sex). Sexual intercourse was defined as “any physical contact between two individuals involving stimulation of the genital organs of at least one of the individuals involved in the sexual act” (Dorland’s Medical Dictionary for Health Consumers, 2007). (2) number of sexual partners in the past 3 months and in the previous year (3) unprotected sex in the past 3 months (4) condom use in the past 3 months (5) ever been diagnosed with sexually transmitted diseases (yes/no) in lifetime and past 3 months (6) Condom use norms and perception of high-risk behaviors are assessed using three measures (a) “my friends think it's necessary to use condoms even if the women is taking the pill,” (b) “my friends use condoms regularly,” and (c) “my partner would agree if I wanted to use condoms”, where the participant gets to respond with disagree, somewhat disagree, somewhat agree and agree.
- b. Alcohol Use - The definition for a drink was obtained from this study and defined as a “Standard drink described as 12oz of beer, 4oz of wine, or 1oz shot of liquor straight or in a mixed drink”.

2. Associations Among Health Behaviors and Time Perspective in Young Adults: Model Testing with Boot-Strapping Replication. Written by James M. Henson,

Michael P. Carey, Kate B. Carey, and Stephen A. Maisto in 2006.

This study surveyed 1568 college students and investigated both risky and protective health behaviors from future, hedonistic, and fatalistic time perspective.

The health behaviors examined in this study were alcohol, drug, tobacco, and seat belt use, sex behaviors, and exercise. The purpose of this study was to examine the relationship between time perspective and health behaviors. Since this study addressed the same high-risk health behavior topics that are being researched, it was used as a reference for the following questions for the new survey:

- a. Condom use during the past three months with answer choices: “never,” “rarely,” “sometimes,” “often,” “most of the time,” “always,” and “have not had sex”.
- b. Sexual Behaviors - number of lifetime sexual partners (where sex is defined as oral, anal, or vaginal sex), number of partners during the previous year.
- c. Birth Control use in the past three months with answers: “never had sex”, “never”, “rarely”, “sometimes”, “often”, “most of the time”, “always”
- d. Alcohol Use - The definition for a drink was used from this study where it is defined as 12oz beer, 4oz wine, or 1oz liquor.

3. Youth Risk Behavior Surveillance - United States, 2011(MMWR 2012 June 8, 2012 Volume 61 No. 4).

The CDC conducts an investigation on a national level as well as in local school-based education and health agencies. This Youth Risk Behavior Surveillance System (YRBSS) maintains watch on leading causes of morbidity and mortality among youth and young adults in the United States. The CDC uses the Youth Risk Behavior Survey (YRBS), which is a standard questionnaire containing 86 questions to investigate the following six categories of health-risk behaviors among youth and young adults: 1) behaviors that contribute to unintentional injuries and violence; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection; 5) unhealthy dietary behaviors; and 6) physical inactivity. The purpose of the data collected by the YRBS data is used to measure progress toward achieving 20 national health objectives for Healthy People 2020. The questions from this study were used to address the following topics:

- a. Demographics – age, ethnicity
- b. Sexual Behaviors – ever had sexual intercourse, age of first coitus, # of sexual partners
- c. Condoms use - Last time had sexual intercourse, was condom used by participant or partner, with answers: yes or no.
- d. Birth Control – Method of birth control used last time had sex:
(Answers: Never had sex, No birth control method used, birth control

pills, condoms, Depo-Provera, Nuva Ring, Implanon, Withdrawal,
other method, Not sure if method was used)

- e. Alcohol or Drug use – Did participant ever drink alcohol or use drugs before having sex with answers: yes or no.
- f. Sex Health Education: Modified HIV question and replaced it with HPV (Human Papillomavirus). Asked participant if they ever learned about HPV in school.
- g. Violence Related Behaviors – Asked participant if during the past year they had ever been hit, slapped or physically hurt by sexual partner.
Also, asked if they were ever forced to have sexual intercourse.

- 4. The National College Health Risk Behavior Survey (NCHRBBS) was conducted in 1995 among undergraduate college students. Results from the survey were published in the MMWR, Volume 46, Number SS-6, November 14, 1997. The survey monitors priority health risk behaviors that contribute to the leading causes of death, illness, and social problems among young adults in the United States. Questions were adapted from this survey into this new instrument because it facilitated for the following topics to be addressed:

- a. Demographics – Marital Status, # of people living in the same home.
- b. Education – Level of education of parents.
- c. Violence Related Behaviors – If participant was ever forced to have sexual intercourse, at what age was the last time this may have occurred.

- d. Condom use in the past 30 days with answers: no sex in the past 30 days, “never”, “rarely”, “sometimes”, “most of the time”, “always”
- e. Sex Health Education – Modified HIV question and replaced it with HPV (Human Papillomavirus). Asked if participant ever learned about HPV in school and where on college campus did they receive information on HPV preventive measures, with answers: college classes, residence hall, student clubs/organizations, student health services, never attended college.

5. New questions added to New Instrument: These questions were added to provide further insight and revelation of the possible existence of any associations between acculturation and participation in sexual high-risk behaviors. The questions that were added are intended to address the following topics:

- a. Demographics – Birthplace, age at time of migration to the US, county of present residence and self –identification.
- b. Culture – Language spoken at home, type of music listened to, type of ethnic food cooked at home, frequency of travel to home country, celebration of cultural holidays, celebration of American holidays
- c. Socioeconomic Status - # of people living in the home, income of participant.
- d. Education – Level of education obtained by participant.
- e. Sexual Behavior - Age of first coitus. Question if participant ever participated in ménage a trois and frequency of such practice. Also questioned level of sexual satisfaction with answers: Very satisfied = I

reach orgasm and I feel loved, Somewhat satisfied = I reach orgasm but do not feel any emotional reciprocation, Somewhat dissatisfied = I feel loved and emotionally reciprocated but I do not reach orgasm, Not satisfied at all = I feel forced to have sex and do not reach orgasm.

- f. Unprotected Sex – Use of condom while having oral sex, anal sex, vaginal sex immediately after anal sex.
- g. Birth Control – Methods used and frequency use of birth control.
- h. Alcohol and Drugs – Frequency of sexual intercourse after drinking alcohol or using drugs with answers: “never”, “infrequently”, “habitually”, “frequency”, “always”.
- i. Sex Health Education – Parental communication about sex and STDs.
Questioned if participant ever learned about HPV in school.
Questioned if participant ever had Pap Smear test for HPV.
- j. Sexually Transmitted Diseases – Questioned if participant ever had a pap smear test done, ever had a pap smear test done in the past year, last time had a pap smear test done, ever been diagnosed in their lifetime with HPV or STDs, and if they had ever been diagnosed with HPV or STDs in the past 3 months.
- k. Additional Measures – Included questions that asked the participant where they sought medical attention after being diagnosed with HPV (with answers: Primary Care Provider, college campus health services, Health Department, Emergency room, free community health services,

other, never been diagnosed, never sought medical care), and # of pregnancies.

1. Religion – Rank from 1 to 10 level of religiosity with 1 representing not religious and 10 representing very religious. Frequency of church attendance.

Comparing the Instruments

The YRBS and NCHBRS surveys are instrument that have shown high internal consistency and are validated instruments that produced usable results. For this reason many of the questions were adapted into the new survey. However, the new survey has questions not normally asked of people or by the nationally approved surveys used in previous health behavior studies such as the YRBS and NCHBRS. This new instrument investigates in depth the importance of culture accompanied by the number of years living in the United States to establish level of acculturation as well as identifying generational immigrant status. Previous studies and surveys have questioned the Hispanic population's participation in high-risk behaviors, acculturation, and frequency of high-risk behaviors producing results and statistics; however, it is recommended that further in depth research be conducted of the possible association of high-risk behaviors to a specific culture or the religious background of a person (Vaughn et al., 2009).

Questions regarding the participant's socioeconomic status were important to ask because studies have shown that being a Latino usually means having low socioeconomic status (Villaruel, 1998). They are also less likely to have health insurance than non-Latino whites, which means that they are likely to have very high morbidity and mortality rates (as cited in Abraido-Lanza et al., 2005). However, studies have also shown that

Latinos have lower mortality rates and higher life expectancy than non-Latino whites regardless of their socioeconomic status (as cited in Abraido-Lanza et al., 2005).

Therefore, including questions in the new survey that help identify the socioeconomic status of a population that may or may not participate in sexual high-risk behaviors is imperative.

Lower mortality rates and higher life expectancy indicate that Hispanics can have positive health behaviors, therefore, it is only logical to investigate where these favorable health behaviors originate. One article emphasized that these advantageous health behaviors are associated with cultural norms (Abraido-Lanza et al., 2005). Hence, questions regarding culture were included. Questions used in the national surveys such as the YRBS and NCHRBS only inquire about the language spoken at home and years in the United States, but they have not asked the age at time migration to the United States. Therefore, it is essential to know the age of at time of migration to help identify the level of acculturation. In addition, the new survey contains questions that specifically ask the type of music that is listened to the most, type of food eaten at home and celebration of Colombian holidays in comparison to the celebration of American holidays, which gives further insight into the process of acculturation and its effects on the participant's behaviors.

Studies have shown that people use religion as their source for values and morality; consequently, church philosophies and doctrines play a role in the formation of an individual's attitudes, values and character (Thornton & Camburn, 1989; Villaruel, 1998). Every culture exercises different health and healing practices that are very well linked to religion, which can incorporate supernatural factors including God, destiny, and

indigenous beliefs such as witchcraft (Vaughn et al., 2009). It is known that, in general, the Latin culture believes that illness and diseases can be a result of bad behavior and are more likely to use home remedies and spiritual healing than seek medical help (Vaughn et al., 2009). There are even some illnesses or mental afflictions that are considered culture-bound syndromes because they are unique to the culture and influenced directly by cultural beliefs (Vaughn et al., 2009). Some common culture-bound syndromes within the Latin community are “mal de ojo” (evil eye) and “susto” (magical fright), which are treated only with home remedies (Vaughn et al., 2009). In conclusion, questioning Latin women on their cultural practices as well as their level of religiosity can definitely give a greater revelation and understanding to their health behaviors and expose any possible associations to high-risk behaviors. Once again, the YRBS and the NCHRBS used in previous health behavior studies have not questioned a Hispanic woman’s level of religiosity or importance of religion, therefore, omitting important and relevant information that may provide crucial information relating to Latin women’s participation in high-risk behaviors.

Questions related to parental communication about sex were also included because parents are very influential in a child’s upbringing and play a very important role in educating their children as well as provide moral guidance for good behaviors. Communication between parent and child about sex is crucial and can be a predictor of risky sexual behaviors (Trejos-Castillo & Vazsonyi, 2009; Villaruel, 1998). Children shape their beliefs and values around their parent’s own beliefs and values. Research has shown that Hispanics have strong family values, beliefs and positive parent-child relationships that counteract and protect a child from participating in high-risk behaviors

(as cited in Trejos-Castillo & Vazsonyi, 2009; Villaruel, 1998). Therefore, it is important to ask if there has been adequate parental communication in their lifetime especially about sex and sexual health. Although students are receiving some health education courses in a school setting, parental guidance is more influential and can help shape future health behaviors of a child.

Additional measures were addressed in the new survey such as HPV, violence related behaviors, pregnancy and sexual satisfaction. Since cervical cancer is one of the leading causes of death for Latin women, questions regarding HPV, education received on HPV, preventive behaviors (condom use), ever been diagnosed with HPV and treatment were included. Since this South American country, Colombia, has a long history of violence, questions on violence related behaviors are relevant and necessary. Colombian women have suffered under a patriarchal society for years and continue to be treated subservient to men; therefore, it is only logical to ask about their level of sexual satisfaction. It is assumed that a woman that is mistreated by her partner or spouse, may not be a willing participant in a sexual act, therefore, resulting in sexual dissatisfaction. Since the media portrays Latin women as promiscuous, asking about a women's sexual satisfaction might show if women actually enjoy sex with their partner. If sexual satisfaction is accompanied by a high number of partners, then this might support the media's assumption that Latin women are hot and promiscuous.

Procedures for Obtaining Participants

Recruiting participants for this study can be conducted in several ways. Participants can be recruited by word of mouth, email, Internet, contacting local Hispanic organizations, contacting local colleges and universities and recruiting one on one at

Latin restaurants and Hispanic hair salons for women. When studying a specific Latin population such as the Colombian female population, recruiting from specific Colombian locations is necessary and helpful. It will require that the Principal Investigator contact local Hispanic organizations that would be willing to support the research. In the Miami-Dade County, there are local Hispanic non-profit organizations and non-governmental Latin organizations, such as Colombian American Coalition of Florida and Colombian American Service Association (C.A.S.A.). Since participants are from the age of 21, they can also be recruited from college campuses such as the Florida International University, Miami-Dade College, and the University of Miami. Within each of these college campuses in the Miami-Dade area, there are student organizations that are Colombian such as “Por Colombia” and the Colombian Student Association “COL.S.A”. The Florida International University, in particular, has a Latin American and Caribbean Center as well as a Colombian Institute. There are also many Colombian restaurants and hair salons within the county that would be great places to recruit Hispanic female participants for the study.

Since technology is available everywhere and most people use the Internet, recruiting via the Internet on “Facebook” is definitely very advantageous. All student organizations have Facebook pages, making it easy to post an announcement and the survey on the webpages. Therefore, making the survey available online in English and Spanish, by using the Survey Monkey or Checkbox programs, is highly beneficial in reaching the intended Latin population. However, the survey can be administered on paper, one on one, as well as by attending student organization meetings and events.

Not only should the survey be translated into Spanish, but the flyers and emails announcing the study should be translated as well. The key to successfully recruiting participants for such an important study, is gaining their trust. Trust can be obtained by providing a complete explanation of the purpose of the study and explaining that there is a huge gap in the research for a subgroup such as Colombian's women sexual behavior. Making the survey available in both languages allows the participant to feel comfortable and fully understand what they are reading in their own language. Hispanics take great pride in knowing that they are being acknowledged and that they are important and should not be ignored.

Chapter Four:

Results

Data gathered from the surveys can be used to compare the number of sexual partners in a woman's lifetime, the use of condoms, whether a woman has had sex under the influence of drugs or alcohol, frequency of unprotected sex, frequency of anal sex, number of diagnoses of STDs and HPV awareness. The questions that focused on culture, parental communication and religion will help identify associations between these factors and participation in high-risk behaviors.

Acculturation is measured by time living in the United States, language spoken at home, and importance of holding onto their culture from their country of origin. Questions on culture will show how important to each Latin subgroup, such as Colombian culture is to the participant. For example, if the results show that the participant is more attached to their Colombian culture and traditions, then they are probably less likely to participate in high-risk behaviors because religiosity, church attendance, importance of family and valuing religion has been associated with less permissive attitudes about sex and low number of sexual partners (Durant, Pendergrast & Seymore, 1990; Thornton & Camburn, 1989; Villaruel, 1998). Research has shown that religiosity is significant in building beliefs and values within Latinas' cultural context and influences their sexual behavior (Edwards et al., 2011). In addition, research has shown

that acceptance of sexual intercourse and early sexual initiation is greater among those with low involvement in religious institutions (Thornton & Camburn, 1989).

Differences of high-risk sexual behaviors are expected across generations, especially when family pressures to conform to cultural values may prevent sexual intercourse across 1st generation youth but not 2nd generation adolescents (Trejos-Castillo & Vazsonyi, 2009). Immigrant teenagers experience high levels of stress when they are forced to negotiate values and norms of different cultures, therefore, making them vulnerable to high-risk behaviors (Afable-Munsuz & Brindis, 2006). Part of the stress immigrant teenagers may experience, could be related to religion and the pressure of maintaining their virginity. These religious restrictions against pre-marital sex may actually force the individual to be sexually innovative, therefore, resulting in an increase in oral and anal sex. Although, acculturated teenagers usually have sex at a younger age, the less acculturated teenagers do their best not to violate their cultural norms and do not engage in high-risk sexual behaviors (Afable-Munsuz & Brindis, 2006).

A study was conducted on “Risky Behaviors Among Hispanic Young Adults In South Florida: Nativity, Age And Gender Differences,” in which 709 Hispanic individuals aged 18-23 were interviewed (Weiss & Tillman, 2009). The results showed that “among women, sexual behavior did not differ between those born in the United States and those who had immigrated before age six; it also did not differ between the two foreign-born groups (Weiss & Tillman, 2009). However, compared with women born in the United States, those who had immigrated at age six or older had had fewer sexual partners (2.0 vs. 3.7); among sexually experienced women, late arrivers were less likely to have had oral sex in the past year (66% vs. 86%) (Weiss & Tillman, 2009). In

addition, “78% Seventy-eight percent of foreign-born youth who had immigrated at age six or older had ever had sex, compared with 87% of those who had immigrated earlier” (Weiss & Tillman, 2009, p. 205).

Weiss and Tillman state that,

“Several empirical studies suggest that the emotional well-being and risk-taking behaviors (specifically, drug use and dependence) of Hispanic youth who immigrated before age six do not differ significantly from those of their U.S. born peers, whereas youth who immigrated at age six or older tend to report greater emotional well-being and fewer risk-taking behaviors” (2009, p 203.).

Based on this evidence, it can be expected that 1st and 1.5 generation youth are less likely to engage in high-risk sexual behaviors in comparison to the more acculturated 2nd generation youth. Consequently, the 2nd generation that are U.S. born children and are usually the most Americanized are expected to increase in sexual risk-taking behaviors. (Afable-Munsuz & Brindis, 2006).

Chapter Five:

Discussion

Policy Implications

According to Healthy People 2020 it is a priority to develop prevention programs that address the relationship between health status, individual behavior, health services, social factors, and policies (HealthyPeople.gov, 2012). It is believed that being able to help a person modify their health behaviors in a positive manner, can reduce the incidence rates of chronic diseases in this country (HealthyPeople.gov, 2012). In order, to be effective and produce long-term positive results in this country, interventions must begin with the Hispanic young adults because this population is expected to increase in the next few years (Lawrence, R. S., Gootman, J.A., Sim, L. J., 2009). Creating effective prevention health behavior programs for young adults is essential because adolescence is a time of major transitions, when young people acquire behavioral patterns and relational behaviors that will transmit through into their adult lives (Lawrence et al., 2009).

However, these interventions should be able to meet the needs of all Hispanics and not just some subgroups of Latinos in the United States. Consequently, there needs to be more cultural knowledge and sensitivity towards all immigrant populations of the United States. Although, this may seem like an arduous task for the Public Health sector and the Medical Healthcare Providers, it is completely indispensable for the future health of America.

Although this study was not actually administered on real participants, the results of the data collected from this study, once analyzed, will produce vital information about Latin subgroups such as Colombian women and their beliefs, values and attitudes towards sex and sexual high-risk behaviors. The study will help discover any association between high-risk behaviors and a Latin woman's beliefs, attitudes and values absorbed from their cultural and religious background. The data can be used to support or disrepute theories and stereotypes about Latin women presented by the general American media. Overall, the results of the data will contribute to the limited amount of research available on sexual high-risk behaviors for Latin subgroups such as Colombian women in the state of Florida. Finally, the results from this study will give better insight to the importance of improving sexual health education programs for Latin women and making those interventions culturally competent.

Medical Educators can also benefit from the results of this study because research has shown that cultural differences affect treatment decisions and Doctors need to know how to obtain this information from patients (Vaughn et al., 2009). There is an urgent need in the medical field for improvement in the Patient – Doctor relationship (Vaughn et al., 2009). In order to deliver an accurate diagnosis and treatment of the diseases, Doctors need to learn to be more personal and communicate with their patients because this is key to gaining a patient's trust and getting them to cooperate (Vaughn et al., 2009). When patients trust their medical providers they are more willing to accept and follow the medical advice that will restore or maintain their health (Vaughn et al., 2009).

Potential Limitations

Although, this study was designed to fill a gap in the research on Latin women's participation in sexual high-risk behaviors, there are some limitations that should be addressed in future studies. First, when studying the Colombian population, it is important to note that they are very scattered throughout the Miami-Dade County making the recruitment process very difficult and expensive. In order to make the study valid, a huge number of participants must be recruited, therefore, the recruitment process may take longer if the population is scattered all over the county. Since there is no public transportation in Florida, the study investigators must travel everywhere by car to find participants, making it expensive on gasoline and time consuming.

Also, gaining the trust of the Latin population is not always an easy process, therefore, it is recommended that the Investigators be Hispanic and fluent in Spanish. It is crucial that the purpose of the study be communicated clearly so that the participant understands why the survey asks intimate questions about their sex habits. For example, the Colombian culture frowns upon women expressing their sexuality openly; therefore, answering the questions on a sex behavior study survey may seem offensive and too intrusive for some women. This is why clarifying the study's purpose and goals is crucial in gaining a participants' trust and successfully getting them to participate in the study.

The Principal Investigator should be bilingual and all documents should be translated. Although the Investigators may be bilingual, funding is necessary to hire a Professional Translator to translate all the documents. The IRB requires that a Professional Translator translate the survey, the consent forms, the flyers and emails. Hiring a professional translator can become very expensive, but it will ensure accurate

communication between the participant and the Investigator and reduce the amount of risk for the participant.

Another limitation that may be encountered in the recruiting process by the Study Investigators is that the older generation does not use technology very often. For example, the local Colombian organization, C.A.S.A., had a database with a list of emails of Hispanics that attended the organization, but the staff was sure that their clients would not read their emails on a regular basis. Therefore, recruiting participants via the Internet is not always effective or successful. In this situation, the best way to recruit the older Colombian women is by communicating one on one and administering the survey in paper. Administering the survey in paper form is definitely more time consuming but it ensures participation.

Overall, this kind of research is deemed necessary and urgent for the future health of Latin American women in the United States. Administering this survey will definitely open the door for more questions to be asked in future studies about people from other cultures and nationalities. Grouping people into one huge category and then developing health preventive measures that are generic, is neither ideal nor effective. If the Public Health researchers want to improve population health, then acknowledgement that subgroups exists within these populations is essential for populace health.

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Appendices

Appendix 1: Behavioral Health Survey

PURPOSE OF THIS STUDY: To study Latin women's beliefs, attitudes and values towards sex and sexual high-risk behaviors.

1. How old are you?
 - a. 21-25 years old
 - b. 26-29 years old
 - c. 30-33 years old
 - d. 34-37 years old
 - e. 38-41 years old
2. Are you Hispanic?
 - a. Yes
 - b. No
3. Where were you born?
 - a. Colombia
 - b. New York City
 - c. United States
 - d. Other part of the world
 - e. Decline to answer
4. Why do you consider yourself Colombian?
 - a. I was born in Colombia
 - b. Both of my parents are Colombian
 - c. My mother is Colombian
 - d. My father is Colombian
 - e. I am not Colombian, but I am very familiar with the culture
5. If you were not born in the United States, how old were you when you came to the United States?
 - a. under the age of 6
 - b. 6 – 10 years old
 - c. 11 – 14 years old
 - d. 15 – 19 years old
 - e. 20 – 25 years old
 - f. 26 or older
6. Do you live or work or go to school in Miami-Dade County in Florida?
 - a. Yes
 - b. No

7. What language do you speak at home?
 - a. Spanish
 - b. English
 - c. Both
 - d. Other
8. What kind of music do you mostly listen to?
 - a. Colombian music – vallenatos, y cumbia
 - b. Spanish music – salsa, bachata, reggaeton
 - c. American pop music
 - d. Hip-Hop
 - e. Rock n Roll
9. What type of food do you or your family mostly cook at home?
 - a. Colombian food
 - b. Spanish food from different Latin countries
 - c. American food
 - d. Italian food
 - e. Other
10. How often do you travel to Colombia?
 - a. Once a year
 - b. Every to 2 to 3 years
 - c. Every 5 or 7 years.
 - d. I haven't traveled to Colombia for 8 years or more.
 - e. Its not important to me to travel to Colombia
 - f. I do not want to return to Colombia.
11. Do you or your family celebrate Colombian holidays, such as Colombian independence day?
 - a. Yes
 - b. No
12. Do you or your family celebrate American Holidays, such as Thanksgiving?
 - a. Yes
 - b. No
13. What is your marital status?
 - a. Never been married
 - b. Married
 - c. Separated
 - d. Divorced
 - e. Widowed

14. With whom do you currently live?
- a. I live alone
 - b. Spouse/domestic partner
 - c. Roommate(s)/friend(s)
 - d. Parent(s)/Guardian(s)
 - e. Other relatives
 - f. Your children
 - g. Other
15. How many people live in your household?
- a. 1
 - b. 2
 - c. 3
 - d. 4
 - e. 5
 - f. 6 or more
16. What is your total household income?
- a. \$11,000 - \$18,999
 - b. \$19,000 – \$33,999
 - c. \$34,000 - \$45,999
 - d. \$46,000 - \$75,999
 - e. \$76,000 - \$149,999
 - f. \$150,000 +
17. What is the highest degree or level of school you have completed?
- a. No schooling completed
 - b. Less than 9th grade
 - c. 9^h to 12 grade no diploma
 - d. High School Graduate OR GED
 - e. Some College No degree
 - f. Associate's degree
 - g. Bachelor's Degree
 - h. Master +
18. How much education did your mother complete?
- a. She completed somewhere between 1st and 8th grade
 - b. She did not finish high school
 - c. She graduated from high school or attained a GED
 - d. She completed some college
 - e. She completed her Bachelor's Degree
 - f. She completed her Master's Degree
 - g. She completed her PhD
 - h. Not Sure

19. How much education did your father complete?
- a. He completed somewhere between 1st and 8th grade
 - b. He did not finish high school
 - c. He graduated from high school or attained a GED
 - d. He completed some college
 - e. He completed his Bachelor's Degree
 - f. He completed his Master's Degree
 - g. He completed his PhD
 - h. Not Sure

Now I would like to ask you some questions about your sexual behaviors:

Sexual intercourse is defined as “any physical contact between two individuals involving stimulation of the genital organs of at least one of the individuals involved in the sexual act (Farlex, (n.d.).”

20. Have you ever had sexual intercourse?
- a. Yes
 - b. No
21. How old were you when you had sexual intercourse for the first time?
- a. I have never had sexual intercourse
 - b. 11 years old or younger
 - c. 12 - 14 years old
 - d. 15 – 17 years old
 - e. 18 – 20 years old
 - f. 21 – 23 years old
 - g. 24 – 26 years old
 - h. 27 years old or older
22. During your life, with how many people have you had sexual intercourse?
- a. I have never had sexual intercourse
 - b. 1 to 2 people
 - c. 3 to 5 people
 - d. 6 to 8 people
 - e. 9 to 11 people
 - f. 12 to 14 people
 - g. 15 to 20 people
 - h. 21 or more people

23. During the past 3 months, with how many people did you have sexual intercourse?
- a. I have never had sexual intercourse
 - b. I have had sexual intercourse, but not during the past 3 months
 - c. 1 person
 - d. 2 people
 - e. 3 people
 - f. 4 people
 - g. 5 people
 - h. 6 or more people
24. During the past year, with how many people did you have sexual intercourse?
- a. I have never had sexual intercourse
 - b. I have had sexual intercourse, but not during the past year
 - c. 1 person
 - d. 2 people
 - e. 3 people
 - f. 4 people
 - g. 5 people
 - h. 6 or more people
25. Have you ever had sex with more than one person at the same time?
- a. Yes
 - b. No
26. If you answered yes to question #18, which statement would you agree with: (If no, then skip this question)
- a. Once
 - b. A few times
 - c. Frequently
 - d. Regularly
 - e. All the time
27. If you answered yes to question #18, approximately how many times in your lifetime have you had sex with more than 1 person at a time? (If no, then skip this question)
- a. 1 time
 - b. 2 times
 - c. 3 times
 - d. 4 times
 - e. 5 times
 - f. 6 or more times

28. Every time you have sex with your husband or partner, how satisfied are you?
- a. I have never had sexual intercourse
 - b. Very satisfied = I reach orgasm and I feel loved
 - c. Somewhat satisfied = I reach orgasm but do not feel any emotional reciprocation
 - d. Somewhat dissatisfied = I feel loved and emotionally reciprocated but I do not reach orgasm
 - e. Not satisfied at all = I feel forced to have sex and do not reach orgasm

According to the Merriam- Webster Dictionary Oral Sex is defined as oral stimulation of the genitals.

29. Have you ever had Anal sex?
- ☐ Yes, Unprotected
 - ☐ Yes, Protected
 - ☐ No, I have never had anal sex
30. Have you ever had vaginal sex after you had anal sex?
- ☐ Yes
 - ☐ No
 - ☐ No, I have never had anal sex
 - ☐ No, I have never had sex
31. Have you ever received Oral sex?
- ☐ Yes, Unprotected
 - ☐ Yes, Protected
 - ☐ No, I have never had oral sex
32. Have you ever given Oral sex?
- ☐ Yes, Unprotected
 - ☐ Yes, Protected
 - ☐ No, I have never had oral sex

Now I'd like to ask you some questions about condom use.

33. The last time you had sexual intercourse, did you or your partner use a condom?
- a. I have never had sexual intercourse
 - b. Yes
 - c. No
34. During the past 30 days, how often did you or your partner use a condom?
- a. I have not had sexual intercourse during the past 30 days
 - b. Never used a condom
 - c. Rarely used a condom
 - d. Sometimes used a condom
 - e. Most of the time used a condom
 - f. Always used a condom

35. In the past 3 months, about how many times did you have unprotected sex **in one week?**
- a. I have never had sexual intercourse
 - b. Didn't have unprotected sex in the 3 months
 - c. 1 time
 - d. 2 times
 - e. 3 times
 - f. 4 to 5 times
 - g. 6 to 8 times
 - h. 10 or more times
36. In the past 3 months, how frequently have you used a condom?
- a. I have never had sexual intercourse
 - b. Never
 - c. Rarely
 - d. Sometimes
 - e. Often
 - f. Most of the time
 - g. Always
37. The last time you had sexual intercourse, what method did you or your partner use to prevent pregnancy? (Select all that apply)
- a. I have never had sexual intercourse
 - b. No method was used to prevent pregnancy
 - c. Birth control pills
 - d. Condoms
 - e. Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), Implanon (or any implant) or any IUD
 - f. Withdrawal
 - g. Some other method
 - h. Not Sure
38. In the past 3 months, how often have you used any birth control?
- a. I have never had sexual intercourse
 - b. Never
 - c. Rarely
 - d. Sometimes
 - e. Often
 - f. Most of the time
 - g. Always

Now I'd like to ask you some questions about your Alcohol use.

*Standard drink described as 12oz of beer, 4oz of wine, or 1oz shot of liquor straight or in a mixed drink.

39. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
- a. I have never had sexual intercourse
 - b. Yes
 - c. No
40. If yes, how often do you have sex after you use drugs or drink alcohol?
- a. Never
 - b. Infrequently
 - c. Habitually
 - d. Frequently
 - e. Always

Now I'd like to ask you some questions about Sex health education.

41. Did your parents ever talk to you or teach you about sex?
- a. Yes
 - b. No
42. Did your parents ever talk to you or teach you about STDs?
- a. Yes
 - b. No
43. Have you ever been taught about STDs in school?
- a. Yes
 - b. No
 - c. Not Sure

Human papillomavirus (HPV) a virus that is the cause of common warts of the hands and feet, as well as lesions of the mucous membranes of the oral, anal, and genital cavities. More than 50 types of HPV have been identified, some of which are associated with cancerous and precancerous conditions (CDC, 2011).

44. Have you ever been taught about HPV in school?
- a. Yes
 - b. No
 - c. Not sure
45. Have you ever been taught about HPV in your college classes?
- a. Yes
 - b. No
 - c. Not Sure
 - d. Never attended college

46. During this school year, where on your college campus did you receive information about avoiding HPV?
- a. College classes
 - b. Residence Hall or other campus housing
 - c. Student clubs or organizations
 - d. Student Health Services
 - e. Never attended college
47. Have you ever had a Pap Smear test done for HPV?
- a. Yes
 - b. No
 - c. Not Sure
48. In your lifetime have you ever been diagnosed with HPV?
- a. Yes
 - b. No
 - c. Not Sure
49. Have you been diagnosed with HPV in the past 3 months?
- a. Yes
 - b. No
 - c. Not Sure
50. Have you ever been diagnosed with a Sexually Transmitted Disease or Infection in your Lifetime?
- a. Yes
 - b. No
 - c. Not Sure
51. Have you ever been diagnosed with a Sexually Transmitted Disease or infections in the past 3 months?
- a. Yes
 - b. No
 - c. Not Sure
52. During the last time that you were diagnosed with HPV, where did you seek medical attention: (check all that apply)
- a. Primary Care Provider
 - b. Campus Student Health Services
 - c. Health Department
 - d. Emergency room
 - e. Free Community Health Services
 - f. Other
 - g. Never been diagnosed
 - h. Never sought medical care

53. During the last time that you were diagnosed with a Sexually Transmitted Disease or infections, where did you seek medical attention: (check all that apply)
- a. Primary Care Provider
 - b. Campus Student Health Services
 - c. Health Department
 - d. Emergency room
 - e. Free Community Health Services
 - f. Other
 - g. Never been diagnosed
 - h. Never sought medical care
54. Have you ever had a Pap Smear?
- a. Yes
 - b. No
 - c. Not sure
55. If Yes, have you had a Pap Smear in the past year?
- a. Yes
 - b. No
 - c. Not Sure
56. If not, when was the last time you had one?
- a. A year ago
 - b. 2 years ago
 - c. 3 years ago
 - d. 4 years ago
 - e. 5 years ago or more
 - f. Never had a Pap Smear
57. Based on your past year's sexual behavior, what is your perception of HPV risk?
- a. No risk
 - b. Low risk
 - c. Medium risk
 - d. High risk
58. "My friends think it's necessary to use condoms even if the woman is taking the pill"
- a. Disagree
 - b. Somewhat disagree
 - c. Somewhat agree
 - d. Agree

59. "My friends use condoms regularly"
- a. Disagree
 - b. Somewhat disagree
 - c. Somewhat agree
 - d. Agree
60. "My partner would agree if I wanted to use condoms"
- a. Disagree
 - b. Somewhat disagree
 - c. Somewhat agree
 - d. Agree
61. How many times have you been pregnant?
- a. 0 times
 - b. 1 time
 - c. 2 or more times
 - d. Not Sure
62. During the past 12 months, did your sexual partner ever hit, slap, or physically hurt you on purpose?
- a. Yes
 - b. No
63. Have you ever been physically forced to have sexual intercourse when you did not want to?
- a. Yes
 - b. No
64. How old were you the last time you were forced to have sexual intercourse against your will?
- a. Never been forced
 - b. 4 years old or younger
 - c. 5 to 12 years old
 - d. 13 or 14 years old
 - e. 15 or 16 years old
 - f. 17 or 18 years old
 - g. 19 or 20 years old
 - h. 21 to 24 years old
 - i. 25 years old to older

65. From a scale of 1 through 10, how religious are you? (Please Circle ONE)
1, 2, 3, 4, 5, 6, 7, 8, 9, 10

66. How often do you attend a religious service?
a. Once a week
b. More than once a week
c. 1 to 3 times a month
d. Less than once a month
e. Never

Appendix 2: Spanish Translated Survey:

Encuesta de Salud de Comportamientos

PROPÓSITO DE ESTE ESTUDIO: Un estudio de las creencias, actitudes y valores hacia el sexo y los comportamientos sexuales de alto riesgo de la mujer Latina

1. ¿Cuántos años tienes?
 - a. 21-25 años
 - b. 26-29 años
 - c. 30-33 años
 - d. 34-37 años
 - e. 38-41 años
2. ¿Eres hispano?
 - a. Sí
 - b. No
3. ¿Dónde naciste?
 - a. Colombia
 - b. Sur América
 - c. Nueva York
 - d. Estados Unidos
 - e. Otra parte del mundo
4. ¿Por qué te consideras colombiano?
 - a. Nací en Colombia
 - b. Mis padres son Colombianos
 - c. Mi madre es Colombiana
 - d. Mi padre es Colombiano
 - e. Yo no soy Colombiano, pero estoy muy familiarizado con la cultura
5. Si usted no nació en los Estados Unidos, ¿cuántos años tenías cuando llegaste a
 - a. los Estados Unidos?
 - b. Menor de 6 años
 - c. 6 – 10 años
 - d. 11-14 años
 - e. 15-19 años
 - f. 20-25 años
 - g. 26 años o mayor

6. Usted vive o trabaja o estudia en el condado de Miami-Dade en Florida?
 - a. Si
 - b. No
7. Qué idioma habla en su casa?
 - a. Español
 - b. Inglés
 - c. Los dos lenguajes, Ingles y Espanol
 - d. Otro lenguaje
8. ¿Qué tipo de música te gusta escuchar la mayoría del tiempo?
 - a. Musica Colombiano – vallenatos y cumbia
 - b. Música Hispana - salsa, bachata, reggaeton
 - c. Música pop
 - d. Hip-Hop
 - e. Rock n Roll
9. ¿Qué clase de comida típica usted o su familia generalmente cocina en casa?
 - a. La comida colombiana
 - b. Comida Hispana de diferentes países
 - c. Comida Americana
 - d. Comida Italiana
 - e. Otro
10. ¿Con qué frecuencia viaja a Colombia?
 - a. Una vez cada año
 - b. Cada 2 a 3 años
 - c. Cada 5 a 7 años.
 - d. No he viajado a Colombia hace 8 años o más.
 - e. Viajar a Colombia no es importante para mí
 - f. No quiero regresar a Colombia
11. ¿Usted o su familia celebran los días festivos de Colombia, como el día de la independencia Colombiana?
 - a. Si
 - b. No
12. ¿Usted o su familia celebran los días festivos Americanos, como el día de “Acción de Gracias”?
 - a. Si
 - b. No

13. ¿Cuál es su estado civil?
- a. Nunca se ha casado
 - b. Casada
 - c. Separada
 - d. Divorciada
 - e. Viuda
14. Actualmente con quien usted vive?
- a. Vivo sola
 - b. Esposo o cónyuge/companero doméstico
 - c. Roommate(s) / Amigo
 - d. Padre(s) / Guardianes
 - e. Otros parientes
 - f. Tus hijos
 - g. Otros
15. ¿Cuántas personas viven en su hogar?
- a. 1
 - b. 2
 - c. 3
 - d. 4
 - e. 5
 - f. 6 o más
16. ¿Cuál es el ingreso total de su hogar?
- a. \$11,000 - \$18,999
 - b. \$19,000 – \$33,999
 - c. \$34,000 - \$45,999
 - d. \$46,000 - \$75,999
 - e. \$76,000 - \$149,999
 - f. \$150,000 +
17. ¿Cuántos años de educación has completando?
- a. Nunca fui a la escuela
 - b. Complete menos de el 9 grado.
 - c. Complete del 9 al 12 grado, pero no tengo el Diploma de Escuela Secundaria
 - d. Tengo mi Diploma de Escuela Secundaria o tengo el GED
 - e. Algunos estudios universitarios pero sin titulo
 - f. Titulo Asociado del colegio
 - g. Bachillerato
 - h. Masters

18. ¿Que nivel de educacion completo su madre?
- a. Entre 1 a 8 grado
 - b. Ella no terminó la escuela secundaria
 - c. Ella se graduó de la escuela secundaria o completo el GED
 - d. Completó algunos creditos o clases universitarias
 - e. Completó su bachillerato
 - f. Completó su maestría
 - g. Completó su doctorado
 - h. No estoy seguro
19. ¿Que nivel de educacion completo su padre?
- a. Entre 1 a 8 grado
 - b. El no terminó la escuela secundaria
 - c. El se graduó de la escuela secundaria o complete el GED
 - d. Completó algunos creditos o clases universitarias
 - e. Completó su bachillerato
 - f. Completó su maestría
 - g. Completó su doctorado
 - h. No estoy segura

Ahora me gustaría hacerle algunas preguntas sobre sus habitos sexuales: Relaciones sexuales se define como "cualquier contacto físico entre dos individuos relacionados con la estimulación de los órganos genitales en la cual uno de los individuos es involucrado en el acto sexual (Farlex, (n.d.)."

20. ¿Durante su vida, ha tenido relaciones sexuales?
- a. Sí
 - b. No
21. ¿Cuántos años tenias cuando tuvo relaciones sexuales por primera vez?
- a. Nunca he tenido relaciones sexuales
 - b. 11 años o menos
 - c. 12-14 años
 - d. 15-17 años
 - e. 18-20 años
 - f. 21- 23 años
 - g. 24-26 años
 - h. 27 años o mayor

22. ¿Durante su vida, con cuántas personas ha tenido relaciones sexuales?
- a. Nunca he tenido relaciones sexuales
 - b. 1 a 2 personas
 - c. 3 a 5 personas
 - d. 6 a 8 personas
 - e. 9 a 11 personas
 - f. 12 a 14 personas
 - g. 15 a 20 personas
 - h. 21 o más personas
23. Durante los últimos 3 meses, con cuántas personas has tenido relaciones sexuales?
- a. Nunca he tenido relaciones sexuales
 - b. He tenido relaciones sexuales, pero no durante los últimos 3 meses
 - c. 1 persona
 - d. 2 personas
 - e. 3 personas
 - f. 4 personas
 - g. 5 personas
 - h. 6 o más personas
24. Durante este año pasado, con cuántas personas has tenido relaciones sexuales?
- a. Nunca he tenido relaciones sexuales
 - b. He tenido relaciones sexuales, pero no durante el año pasado
 - c. 1 persona
 - d. 2 personas
 - e. 3 personas
 - f. 4 personas
 - g. 5 personas
 - h. 6 o más personas
25. Alguna vez en su vida a tenido relaciones sexuales con mas de una persona a la misma vez?
- a. Si
 - b. No
26. Si usted contesto Si a la pregunta #18, indique cual declaracion usted esta de acuerdo con: (Si no, omita esta pregunta)
- a. Una vez
 - b. Un par de veces
 - c. Frecuentemente
 - d. Regularmente
 - e. Todo el tiempo

27. Si usted contesto Si a la pregunta #18, aproximadamente cuantas veces en su vida ha tenido sexo con mas de una persona?

- a. Una vez
- b. 2 veces
- c. 3 veces
- d. 4 veces
- e. 5 veces
- f. 6 veces o mas

28. Cada vez que tiene relaciones sexuales con su esposo o compañero, ¿usted queda satisfecha?

- a. Nunca he tenido relaciones sexuales
- b. Muy satisfecha = tiene un orgasmo y me siento amada
- c. Un poco satisfecha = tiene un orgasmo, pero no siento ninguna reciprocidad emocional
- d. Un poco insatisfecha = me siento amado y emocionalmente correspondida pero no tiene un orgasmo
- e. No me satisface en absoluto = me siento forzada a tener relaciones sexuales y no tiene un orgasmo

Según el Diccionario Merriam-Webster Sexo Oral se define como la estimulación oral de los organos genitales.

29. ¿Alguna vez ha tenido sexo Anal? (marque todo lo que corresponda)

- a. ☐ Sí, y no he usado proteccion sexual
- b. ☐ Sí, y he usado proteccion sexual
- c. ☐ No, nunca he tenido sexo anal

30. ¿Alguna vez ha tenido sexo vaginal despues de haber tenido sexo anal?

- a. ☐ Si
- b. ☐ No
- c. ☐ Nunca he tenido sexo anal
- d. ☐ Nunca he tenido relaciones sexuales

31. ¿Alguna vez ha recibido Sexo Oral? (marque todo lo que corresponda)

- a. ☐ Sí, y no he usado proteccion sexual
- b. ☐ Sí, y he usado proteccion sexual
- c. ☐ No, nunca he tenido sexo oral

32. ¿Usted nunca ha dado Sexo Oral? (marque todo lo que corresponda)

- a. ☐ Sí, y no he usado proteccion sexual
- b. ☐ Sí, y he usado proteccion sexual
- c. ☐ No, nunca he tenido sexo oral

Ahora me gustaría hacerle algunas preguntas sobre el uso del Condón.

33. ¿La última vez que tuviste relaciones sexuales, tu o tu pareja usaron un Condón?
- a. Nunca he tenido relaciones sexuales
 - b. Sí
 - c. No
34. Durante los últimos 30 días, ¿cuántas veces usted o su compañero usaron un Condon?
- a. No he tenido relaciones sexuales durante los últimos 30 días
 - b. Nunca usó el Condón
 - c. Rara vez utilizo un Condón
 - d. A veces utilizo un Condon
 - e. La mayor parte del tiempo he usado un Condon
 - f. Siempre uso un condón
35. En los últimos 3 meses, en una semana cuantas veces tuviste relaciones sexuales sin
- a. protección?
 - b. Nunca he tenido relaciones sexuales
 - c. No tuve relaciones sexuales sin protección en los ultimos 3 meses
 - d. 1 vez
 - e. 2 veces
 - f. 3 veces
 - g. 4 a 5 veces
 - h. 6 a 8 veces
 - i. 10 o más veces
36. Durante los últimos 3 meses, ¿con qué frecuencia has utilizado un condón?
- a. Nunca he tenido relaciones sexuales
 - b. Nunca
 - c. Rara vez
 - d. A veces
 - e. Con frecuencia
 - f. La mayoría del tiempo
 - g. Siempre

37. ¿La última vez que tuvo relaciones sexuales, que método anticonceptivo usaste para prevenir el embarazo? (Seleccione todas las que correspondan)
- a. Nunca he tenido relaciones sexuales
 - b. No utilice ningún método para prevenir el embarazo
 - c. Pastillas anticonceptivas
 - d. Condones
 - e. Depo-Provera (o cualquier control anticonceptivo), Anillo de Breaker (o cualquier anillo anticonceptivo), Implanon (o cualquier implante) o cualquier IUD
 - f. Withdrawal
 - g. Algún otro método
 - h. No estoy segura
38. En los últimos 3 meses, ¿cuántas veces ha utilizado cualquier anticonceptivos?
- a. Nunca he tenido relaciones sexuales
 - b. Nunca
 - c. Rara vez
 - d. A veces
 - e. Con frecuencia
 - f. La mayoría del tiempo
 - g. Siempre

Ahora me gustaría hacerle unas preguntas sobre su uso de Alcohol. * Una Bebida estándar es descrita como 1 oz de licor, 4 onzas de vino o 12 onzas de cerveza.

39. ¿La ultima vez que tuviste relaciones sexuales, bebiste alcohol o usaste drogas?
- a. Nunca he tenido relaciones sexuales
 - b. Sí
 - c. No
40. Si contestaste Si, a la pregunta #32, con que frecuencia tienes sexo despues de tomar alcohol or usar drogas?
- a. Nunca
 - b. Con poca frecuencia
 - c. Habitualmente
 - d. Frecuentemente
 - e. Siempre

Ahora me gustaría hacerle unas preguntas sobre la educación de la salud sexual.

41. ¿Tus padres alguna vez hablaron contigo o te enseñaron acerca del sexo?
- a. Sí
 - b. No

42. ¿Tus padres alguna vez te hablaron o te enseñaron sobre las enfermedades o infecciones de transmisión sexuales?
- a. Sí
 - b. No
43. ¿Alguna vez en la escuela le enseñaron acerca de enfermedades de transmisión sexuales?
- a. Si
 - b. No
 - c. No estoy segura

Segun el Centros para el Control y la Prevencion para Enfermedades (CDC) El virus del papiloma humano genital (también conocido como VPH) es la infección de transmisión sexual (ITS). El Virus del papiloma humano (VPH) causa las verrugas comunes de manos y pies, y tambien causan las lesiones en la cavidad oral, anal y genital. Más de 50 tipos de VPH han sido identificados, algunos de los cuales están asociados con condiciones precancerosas y cancerosas.

44. ¿Ha usted le enseñaron acerca de VPH en la escuela?
- a. Sí
 - b. No
 - c. No estoy segura
45. ¿Ha usted le enseñaron acerca de VPH en las clases de Colegio?
- a. Sí
 - b. No
 - c. No estoy segura
 - d. Nunca he asistido la Universidad
46. Durante este año escolar, en que lugar de su campus universitario recibió información de como evitar el VPH?
- a. Clases de Colegio
 - b. En la Residencia o otra vivienda en el campus universitario
 - c. En los clubes de estudiantes u organizaciones
 - d. En los servicios de salud para los estudiantes
 - e. Nunca he asistido a la Universidad
47. ¿Alguna vez le han hecho una prueba de deteccion de VPH o un examen Papanicolau para deteccionar VPH?
- a. Sí
 - b. No
 - c. No estoy segura

48. ¿Alguna vez en su vida le han diagnosticado con VPH?
- a. Sí
 - b. No
 - c. No estoy segura
49. ¿Ha sido diagnosticada con VPH en los últimos 3 meses?
- a. Sí
 - b. No
 - c. No estoy segura
50. ¿Alguna vez en tu vida has sido diagnosticada con una enfermedad o infección transmitida sexualmente?
- a. Sí
 - b. No
 - c. No estoy segura
51. ¿En los últimos 3 meses le han diagnosticado con una enfermedad o infección transmitida sexualmente?
- a. Sí
 - b. No
 - c. No estoy segura
52. La última vez que fue diagnosticada con el VPH, donde busco atención médica: (marque todas las respuestas que aplican)
- a. Proveedor de cuidado primario
 - b. Los servicios de salud para los estudiantes en el campus universitario
 - c. Departamento de salud
 - d. Sala de emergencias
 - e. Servicios gratis comunitarios de salud
 - f. Otro
 - g. Nunca he sido diagnosticado con el VPH
 - h. No busque atención médica
53. La última vez que fue diagnosticada con una enfermedad de transmisión sexual o infecciones, donde busco atención médica: (marque todas las respuestas que aplican)
- a. Proveedor de cuidado primario
 - b. Los servicios de salud para los estudiantes en el campus universitario
 - c. Departamento de salud
 - d. Sala de emergencias
 - e. Servicios gratis comunitarios de salud
 - f. Otro
 - g. Nunca he sido diagnosticado
 - h. No busque atención médica

54. ¿Ha tenido una prueba de Papanicolaou?
- a. Sí
 - b. No
 - c. No estoy segura
55. Durante este año pasado ha tenido una prueba de Papanicolaou?
- a. Sí
 - b. No
 - c. No estoy segura
56. ¿Si no has tenido una prueba de Papanicolaou este año pasado, cuándo fue la última vez que tuviste uno?
- a. Hace un año
 - b. Hace 2 años
 - c. Hace 3 años
 - d. Hace 4 años
 - e. Hace 5 años o más
 - f. Nunca tuvo una prueba de Papanicolaou

Lea los siguientes declaraciones y indique si está de acuerdo o desacuerdo:

57. Basado en sus comportamientos sexuales del año pasado, ¿cuál es su percepción del riesgo de ser infectada con VPH?
- a. Ningún riesgo
 - b. Bajo riesgo
 - c. Riesgo medio
 - d. Alto riesgo
58. "Aunque la mujer está tomando la píldora anticonceptiva, mis amigos/amigas piensan que es necesario utilizar Condones "
- a. No estoy de Acuerdo
 - b. Yo estoy un poco en desacuerdo
 - c. Yo estoy algo de acuerdo
 - d. Yo acuerdo
59. "Mis amigos/amigas usan Condones regularmente"
- a. No estoy de Acuerdo
 - b. Yo estoy un poco en desacuerdo
 - c. Yo estoy algo de acuerdo
 - d. Yo acuerdo
60. "Mi pareja estaría de acuerdo conmigo si quiero usar condones"
- a. No estoy de Acuerdo
 - b. Yo estoy un poco en desacuerdo
 - c. Yo estoy algo de acuerdo
 - d. Yo acuerdo

61. ¿Cuántas veces ha estado embarazada?
- 0 veces
 - 1 vez
 - 2 o más veces
 - No estoy segura
62. ¿Durante los últimos 12 meses, su pareja la ha golpeado, dado una bofetada, o físicamente la hirio a propósito?
- Sí
 - No
 - No tengo pareja
63. ¿Alguna vez ha sido obligada a tener relaciones sexuales en contra de su voluntad?
- Sí
 - No
64. ¿Cuántos años tenía la última vez que fue obligada a tener relaciones sexuales en contra de su voluntad?
- Nunca he sido esforzado
 - 4 años o menos
 - 5 a 12 años
 - 13 o 14 años
 - 15 o 16 años.
 - 17 o 18 años
 - 19 o 20 años.
 - 21 a 24 años
 - 25 años o mayor
65. Usando una escala de 1 a 10, indique su nivel religioso? (Por favor circule uno)
- 1 2 3 4 5 6 7 8 9 10
66. Con que frecuencia atiendes a un servicio en una iglesia?
- Una vez a la semana
 - Mas de una vez a la semana
 - 1 a 3 veces al mes
 - Menos de una vez al mes
 - Nunca