ASIAN AMERICAN ORGANIZING PROJECT (AAOP)

Participatory Action Research
November 2021 - March 2022

Reproductive Justice on Abortion Rights & Access in APIDA Communities

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Table of Contents

ASIAN AMERICAN ORGANIZING PROJECT

Overview

Asian American Organizing Project (AAOP)'s "Reproductive Justice on Abortion Rights & Access in APIDA Communities" campaign was a five-month research project that utilized Participatory Action Research (PAR) to engage with Minnesota Asian Pacific Island Desi American (APIDA) and LGBTQ+ community members. This project was created and implemented by interns Marianna Xiong (she/her) and Unitas Vang (he/him) and supervised by AAOP staff member Michelle Vohs (she/her). This project was implemented to expand on the Gender Justice program at AAOP, which launched in January of 2019. Projects beginning with Gender Justice have paved the way to PAR on Reproductive Justice in APIDA communities.

Project Goals and Guiding Questions

The primary goal of the "Reproductive Justice on Abortion Rights & Access in APIDA Communities" campaign was to identify and meet with key community partners to expand and build upon AAOP's existing research on reproductive justice within our APIDA community. In order to accomplish this, a set of guiding questions was established to address important concepts within the field of reproductive health:

- How do APIDA views on reproductive health establish internalized stigma in youth?
- What are specific barriers that prevent APIDA folk from accessing the healthcare they need?
- What accommodations could be made to account for gaps in knowledge in regards to sexual and reproductive health?
- How do generational differences in APIDA folk affect how topics related to reproductive health are approached?

In response to these guiding questions, we developed five main categories to pursue discussion of over the course of the project. Research categories and descriptions in relation to APIDA perspectives are outlined below:

STIGMATIZATION OF SEX TALK:

This topic and questions focused on the social connotations attached to topics revolving around reproductive health and sexual intercourse. This included discussion related to sexual education, cultural values, and gender roles in society.

LGBTQ+ REPRODUCTIVE HEALTH:

This topic and questions focused specifically on members who identified as part of the LGBTQ+ community and their interactions with sexual health. This included discussion related to discrimination, gender identity, and sexual orientation in regards to seeking healthcare.

HEALTHCARE ACCESSIBILITY:

This topic and questions focused on APIDA folks and their relationship with acquiring easily obtainable healthcare in Minnesota. This included discussion related to common financial, cultural, and language barriers found in Minnesota's health systems.

BIRTH CONTROL & CONTRACEPTIVES:

This topic and questions focused on the role of birth control and contraceptives in regulating one's reproductive health. This included discussion related to the acquisition of, sexual education for, and the ability to access trustworthy information regarding birth control and contraceptives.

ABORTION:

This topic and the questions pertaining to this category focused specifically on the concept of abortion and its relation with APIDA communities. This included discussion related to the process of, the education for, and the ability to find trustworthy information about abortion.

Study Structure and Execution

Demographics & Consent Forms

The recruitment of participants for this study began in mid-December of 2021 with the initial release of the interest survey and consent form (linked here). Outreach occurred via AAOP's Gender Justice Base, email list, personal outreach, and through social media platforms with 28 unique participants in total. Eligible participants in question were initially:

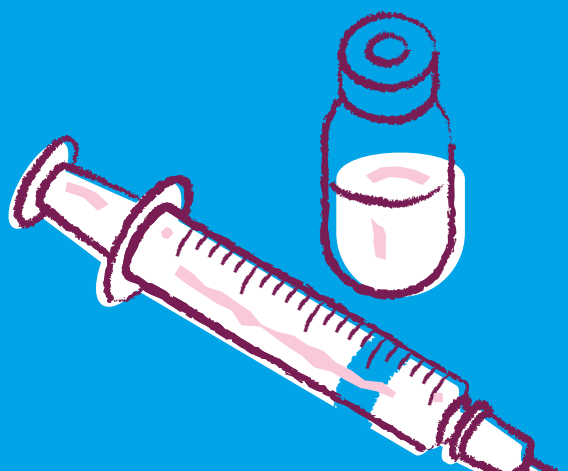
- Persons who identified as APIDA
- Persons who currently resided in Minnesota
- Between the ages of 18-25

Later exceptions regarding age and physical location for folks who had been raised in Minnesota but were away for schooling or new employment were made during the course of the study to better accommodate interested folks. An amendment to the age demographic was made in early January after careful consideration to include participants aged 14-17 following the completion of the Minor Participation Form (linked here) and with the consent of their guardian(s).

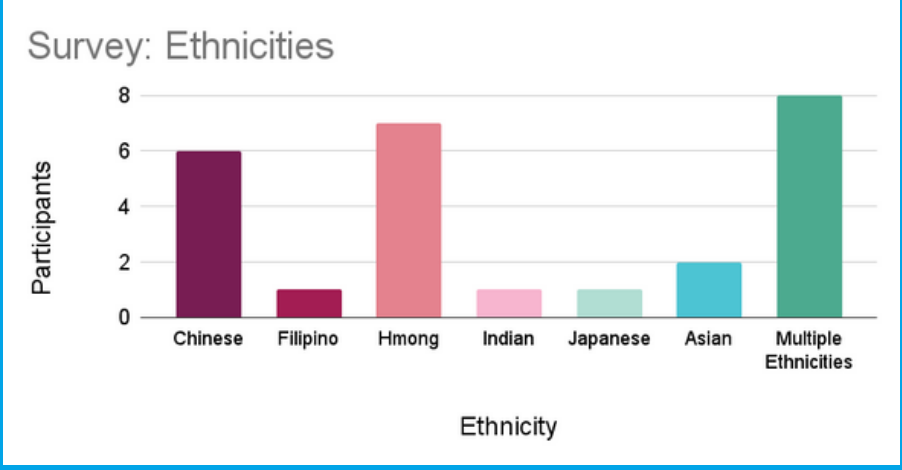
By submitting an interest survey, participants decided which of the three interview options they were interested in participating in. These data collection methods consisted of an online survey, a one-on-one interview, and a focus group, though it is important to note participants were not allowed to participate in both a one-on-one interview and focus group.

Furthermore, in filling out the consent forms, participants gave their explicit consent to have their interviews recorded and transcribed by AAOP, remain anonymous with an option to have their name and/or pronouns obscured in the final results of the study. Participants were notified that they were allowed to skip any questions they did not wish to complete and were also informed that they could cease participation in the study at any time.

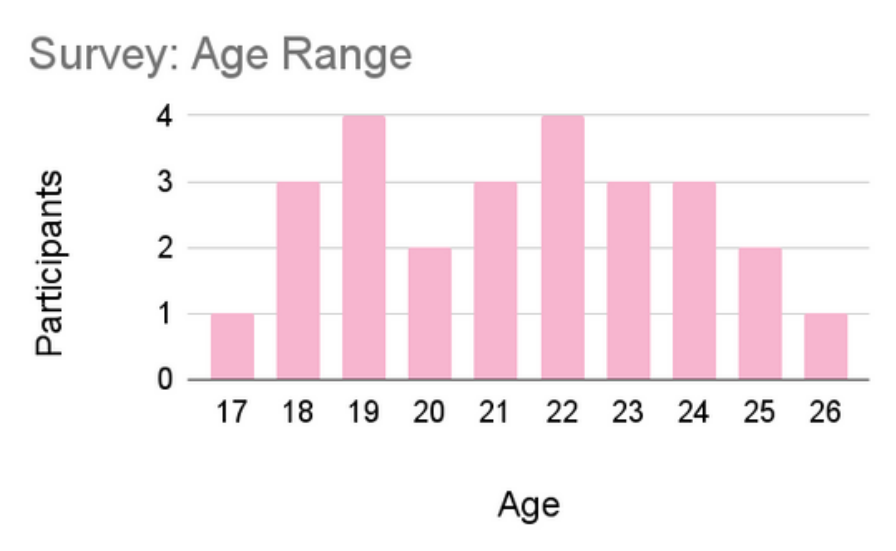
On the next page is a visual representation of the different demographic information collected for each research method.



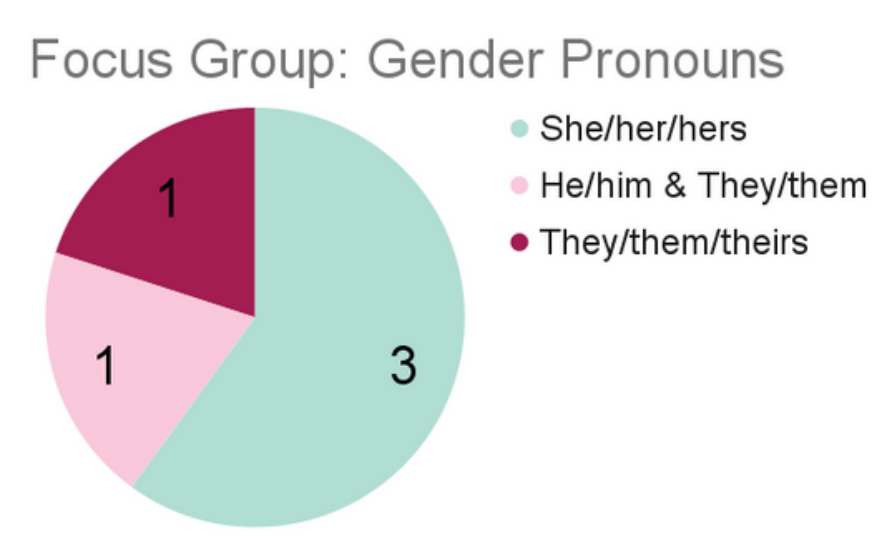
Survey Participant Demographics



Graphic A: Ethnic breakdown from survey participants reads: Chinese, 6; Filipinx, 0; Hmong, 7; Indian, 1; Japanese, 1; Asian, 2; Multiple: 8.

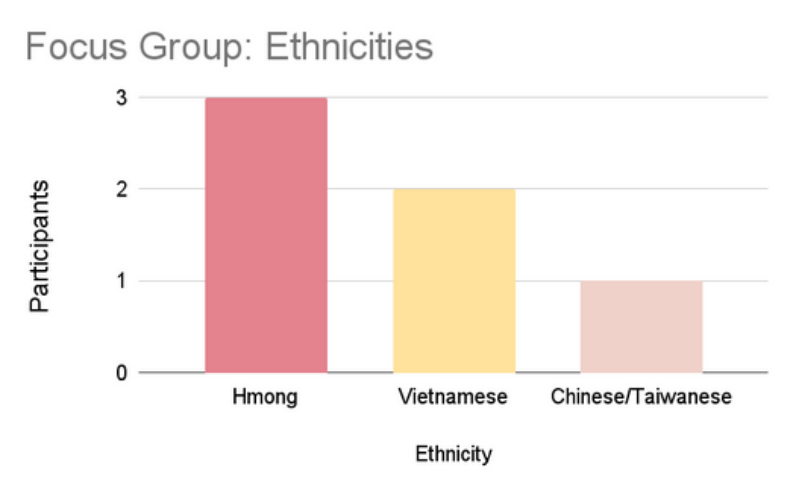


Graphic B: Age breakdown from survey participants ranging from 17 to 26 reads: 17, 1; 18, 3; 19, 4; 20, 2; 21, 3; 22, 4; 23, 3; 24, 3; 25, 2, 26, 1.

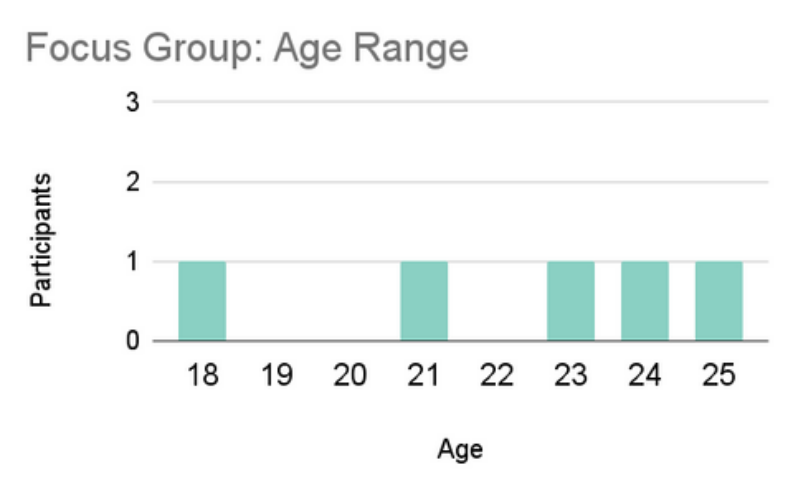


Graphic C: Gender pronoun breakdown of from survey participants reads: she/her/hers, 21; he/him/his, 2; she/her & they/them, 1; he/him & they/them, 1; they/them/theirs, 1.

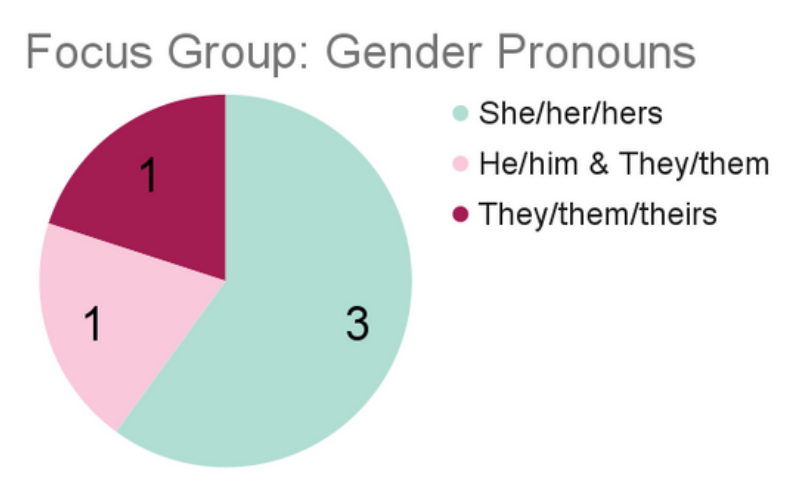
Focus Group Participant Demographics



Graphic D: Ethnic breakdown from focus group participants reads: Hmong, 3; Vietnamese, 2; Chinese/Taiwanese, 1.

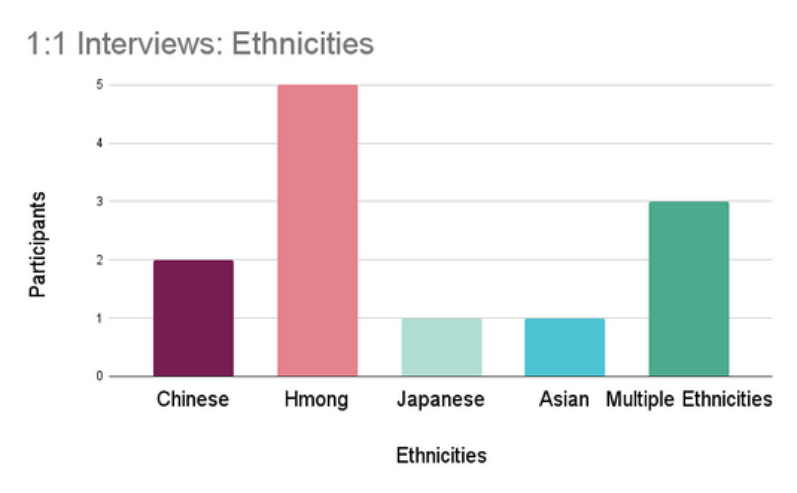


Graphic E: Age breakdown from survey participants ranging from 18 to 25 reads: 18, 1; 21, 1; 23, 1; 23, 1; 25, 1.

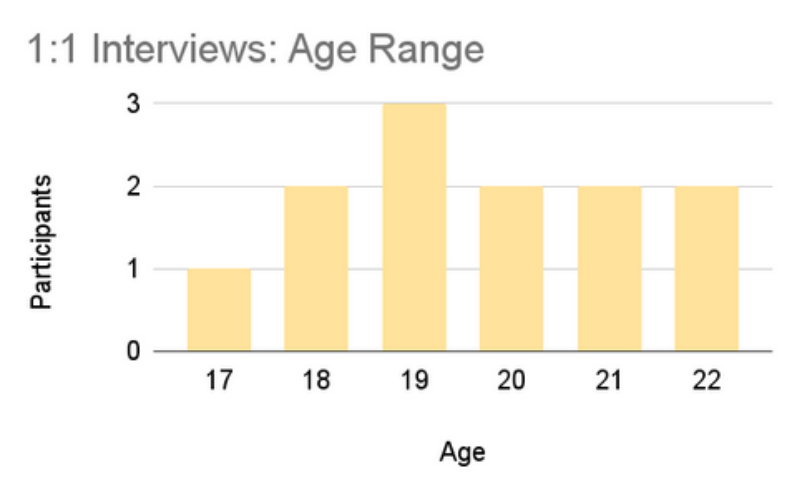


Graphic F: Gender pronoun breakdown of from survey participants reads: she/her/hers, 3; he/him & they/them, 1; they/them/theirs, 1,

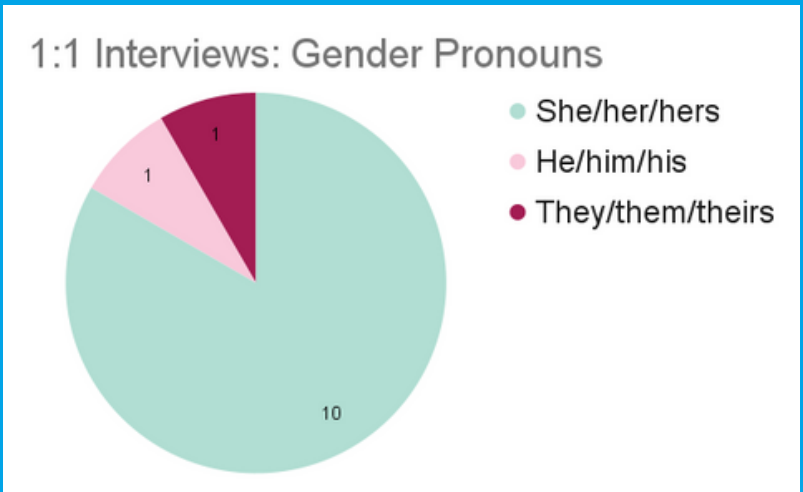
1:1 Interview Participant Demographics



Graphic D: Ethnic breakdown from focus group participants reads: Chinese, 2; Hmong, 5; Japanese, 1; Asian, 1; Multiple, 3.



Graphic E: Age breakdown from survey participants ranging from 17 to 22 reads: 17, 1; 18, 2; 19, 3; 20, 2; 21, 2; 22, 2.



Graphic F: Gender pronoun breakdown of from survey participants reads: she/her/hers, 10; he/him/his, 1; they/them/theirs, 1.

Quantitative Survey

The quantitative survey was an estimated fifteen minutes long and was completed via Google Forms (linked here). Participants who submitted a complete survey were given $10 dollars in compensation.

The survey was divided into the five categories created by us at the study's inception. Each category consisted of three linear scale questions and one short-answer question. Questions answered via linear scale were answered from a scale of one to six in order to limit the amount of neutral responses. An outline of the full scale is provided below. The questions for this survey were as follows:

STIGMATIZATION OF SEX TALK:

- Most of my knowledge about reproductive health comes from... (short answer)
- I am comfortable reaching out to family members with questions about my own reproductive health (Rank 1-6)
- My sexual education class in high school provided me with sufficient information to comfortably engage in sexual activity (Rank 1-6)
- How would you describe the general attitude towards sexual health within your family and culture? What are some ways these values have impacted your lives positively or negatively? (short answer)

LGBTQ+ REPRODUCTIVE HEALTH

- I worry about facing discrimination when interacting with healthcare staff due to my gender identity and/or sexual orientation. (Rank 1-6)
- I have to worry about healthcare professionals being unprepared or untrained to discuss my body. (Rank 1-6)
- I believe health care services are adequate for folks who do not identify as cisgender or heterosexual. (Rank 1-6)
- How does your sexual orientation and gender identity affect the way you interact with healthcare services? What are some ways you think healthcare professionals can better accommodate people who identify similar to you? (short answer)

HEALTHCARE ACCESSIBILITY

- I am comfortable reaching out to health centers with questions regarding my own sexual health without fear of outside intervention. (Rank 1-6)
- It is easy and cost-effective for me to access sexual healthcare materials. (1-6)
- I know how to and can find affordable health insurance that meets my needs. (1-6)
- Would you consider your access to reproductive healthcare practical and easily sustainable? What are some barriers you have encountered, or may face, when addressing these needs? (short answer)

BIRTH CONTROL & CONTRACEPTIVES

- I am aware of how different forms of birth control and contraceptives can affect my body positively and negatively. (Rank 1-6)
- I know how to reliably and comfortably get information about accessing different forms of birth control, contraceptives, and other forms of sexual protection from reliable healthcare professionals (Rank 1-6)
- I am confident in my understanding of the use of birth control and contraceptives to regulate reproductive health outside of pregnancy prevention (Rank 1-6)
- What were some details about the use of birth control and contraceptives that you wished you had known when you were younger? Why was this information absent from your life before? (short answer)

ABORTION

- I am confident in my understanding of how the different processes of getting an abortion work (Rank 1-6)
- I was made aware that abortion was a method to stop pregnancy outside of birth control and contraceptives from a young age (Rank 1-6)
- Given current healthcare standards, getting an abortion and subsequent treatment is affordable and easily accessible (Rank 1-6)
- What might be some factors that hold people in your community back from pursuing a possible abortion? What do you wish you knew about the steps leading up to an abortion when you were younger? (short answer)

The quantitative survey was made available in early January and closed by the end of the month, with 26 surveys being successfully completed in this manner.

Focus Group

The focus group was estimated to be 45-60 minutes long and was also initially planned on being completed in-person at AAOP's office. However, due to similar complications as were faced in the individual interviews, the focus group took place over Zoom. Community members who participated in the focus group were given $40 in compensation.

The focus group was led by the researchers and consisted of an interactive Google Slides presentation (linked here) in which participants responded to questions using the same 1-6 linear scale outlined in the quantitative survey. Each category consisted of two questions. After answers were received, participants were given the space and were encouraged to speak further on the reasoning behind the number they chose. Participants were able to change their answers at any time during this phase.

The questions for the focus group were as follows:

STIGMATIZATION OF SEX TALK:

- Growing up, I wished my family would have helped me learn more about my reproductive health.
- Seeking help for matters about my sexual health is difficult for me to do without feeling uncomfortable.

LGBTQ+ REPRODUCTIVE HEALTH

- Our healthcare services could better accommodate folks in the LGBTQ+ community.
- Cultural beliefs play a big role in stopping queer, nonbinary, and trans-APIDA folk from seeking sexual healthcare.

HEALTHCARE ACCESSIBILITY

- It would be more comforting to have healthcare professionals who look like me in the workforce.
- Our healthcare system makes it more difficult for people like me to get the attention they need.

BIRTH CONTROL & CONTRACEPTIVES

- I am confident in my understanding of how birth control and contraceptives can affect the human body.
- APIDA cultural views have influenced my perception of birth control and contraceptives in any way.

ABORTION

- APIDA cultural views have influenced my perception of abortion in any way.
- I am confident in my understanding of how abortion can affect the human body.

The focus group was held in late January 2022 with 5 participants.

Individual Interviews

The individual interviews were estimated to be 45-60 minutes long and were initially planned on being completed in-person at AAOP's office. However, due to complications regarding participant accessibility and COVID-19 restrictions, the majority of the interviews took place over Zoom. Participants who completed an interview were given $50 in compensation.

Interviews were conducted by us and followed a short question template involving the study's five main categories. Due to the time constraints of the interviews, only two questions were required to be asked. These questions were as follows:

STIGMATIZATION OF SEX TALK:

- How does your family/culture approach the topic of sex and reproductive health? (taboos, stigma, etc.) How did these views impact your own understanding of these topics?
- How would you compare and contrast the difference in the way western and APIDA cultures address topics revolving around sexual health? How does your knowledge of both of these cultures affect your understanding of reproductive justice?
- Were there any times in particular where you had to unlearn internalized prejudices and stigmas about reproductive health?
- What caused you to realize there needed to be a change in understanding?

LGBTQ+ REPRODUCTIVE HEALTH

- Why do you think it's important for healthcare professionals to understand different sexual and gender orientations?
- Do you think our healthcare system is designed to treat LGBTQ+ folks? Why or why not?
- How do you think views on queerness in the APIDA community affect how queer APIDA folks interact with their own reproductive well being?
- In your opinion, what are your thoughts on our current sexual-education curriculum and how it addresses and represents queer folks and identities? What accommodations could be made to make this curriculum better?

HEALTHCARE ACCESSIBILITY

- Does your APIDA identity change how you view western healthcare?
- Do you think cultural representation is important to have in healthcare? Why or why not?
- Are there any barriers that exist that prevent you, or people like you, from accessing the healthcare they need? Why do you think these barriers exist and how can we overcome them?

BIRTH CONTROL & CONTRACEPTIVES

- What are your thoughts on the accessibility of feminine hygiene products, birth control, and contraceptives? If you could, how would you change modern-day distribution of these products to better fit the needs of the community?
- Growing up, how easy would you consider the learning process of correctly using and accessing birth control and contraceptives was? Why do you think this was the case?
- How would you say your APIDA identity affects how you approach the concept of birth control and contraceptives?

ABORTION

- Why do you believe the concept of an abortion carries so much stigma in the APIDA community? What are some ways you try to address these beliefs in your culture?
- Do you think our sexual-education curriculum does an efficient job discussing the topic of abortion? What are some ways you would like to see abortion described more efficiently in a way that could help APIDA folks make educated decisions as they grow older?
- In the case that you or someone close to you wanted to get an abortion, how confident would you describe your own knowledge of the actual process of abortion itself? Are there gaps in your knowledge that you wish were addressed at some point in your life? If not, how could our healthcare better accommodate the needs of those seeking abortion?
- What is something you wished you could tell a younger you about sexual health?

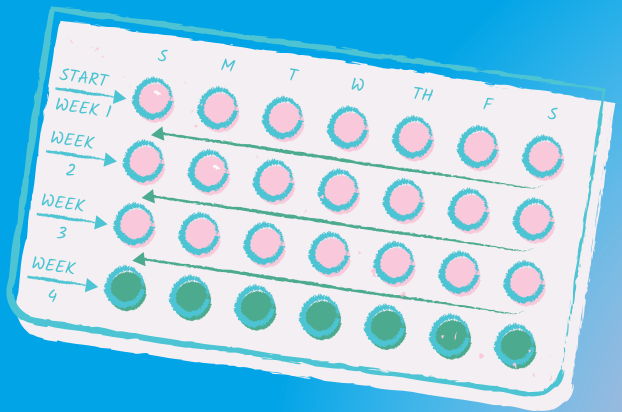
Participants were given the opportunity to discuss topics they felt were important by the end of the interview as well. 12 one-on-one interviews were conducted from mid January to early February.

Analysis & Community Day

Analysis for the research methods above consisted of the creation of multiple graphs and other visuals for quantitative data (surveys, focus groups) and transcriptions of interviews were made and collected for qualitative data (interviews, focus groups). The next section will further highlight the findings formed from the analysis section of this study.

Furthermore, on March 22nd, 2022, AAOP hosted its Reproductive Justice Community Day for its “Reproductive Justice on Abortion Rights & Access in APIDA Communities” campaign where common themes and findings were shared with the public. The presentation for this event can be found linked here.

Photo (Above): Marianna (left) and Unitas (right) stand in front of their presentation on RJ Community Day.



Findings

Key Takeaways

Key takeaways from the quantitative and qualitative findings consisting of responses taken from the survey, one-on-one interviews, and focus groups are outlined below, sorted into four categories below (with the Abortion and Birth Control/Contraceptives sections grouped together):

*note: some filler words removed from quotes for clarity purposes
*[ ] indicates one word was omitted for clarity

- Persons who identified as APIDA
- Persons who currently resided in Minnesota
- Between the ages of 18-25

Stigmatization of Sex Talk:

Participants stated that they believed the stigmatization of talk around sex and reproductive health in APIDA families was a direct result of cultural beliefs, traditions, superstitions, and faith.

"In Hmong culture, ... babies choose their parents. ... But it's like, we choose our own parents before we're even born. ... If [someone] were to be pregnant ... and [they] were to abort that baby, it's [them] saying that [they]don't want it. Especially because [ ] getting pregnant is like, 'this child is choosing you to be their parents' and then if you abort it, it's like, you don't want them to be your kid or you don't want them as a kid. So then we end up with a lot of bad karma from killing a life."

"We talk about sexual health at ... school, but then in conversations in my family, or even with a lot of my Asian friends growing up, we just wouldn't talk about in sexual health or sex or intimacy or pleasure."

"There are a lot of really conservative values around queerness and transness in APIDA cultures and I think the way Christian guilt – Christian colonization being [a] very common source for anti-queer and anti-trans sentiments in Asian culture also has impacts on individuals like queer- and trans- Asians if they were raised in cultures or families that really had a very conservative interpretation of Christianity."

None of the participants responded that family was a main source of information about sexual health. Some participants cited their unease with the validity of their family's knowledge and advice as a reason they did not ask their family questions.

"We definitely have to start ... with the older generation. How do we give them this information in a bite sized way for them to understand [reproductive health] and not lash out? Or, you know, feel like they're being attacked?"

"It would be helpful to just know things and to not be lied to, and just to have the words to know about my own body."

"the atmosphere where it's like, it's not really suddenly talked about, like, it's very private. And, yeah, it's more stigmatized, I would say..."

Participants often attributed gaps in their knowledge of reproductive health to family systems and the sex-ed curriculum. Topics that were often left out of said systems ranged from consent to abortion, birth control, and contraceptives.

"I think white sex education, I think of abstinence, I think sex after marriage. And then with my community, it's just not touched upon, it's just basically if you're gonna do it, don't tell anyone or if you, let's say, if you end up getting pregnant or whatever, you instantly have to get married."

"There are ways that you can incorporate sexual health education to ... for very [youth] even if you don't go into the mechanics. It's the idea around being honest with [youth] about their own bodies or ideas about pleasure or ideas about consent."

* Curating or having the space to freely discuss sex talk with other like-minded people, especially when removed from family systems and put into external community spaces, was the best way to have open discussion about sex talk.

"It's like better that they have the tools to be able to do it safely, and be able to understand, like things like consent, and just like all the different contraceptive methods."

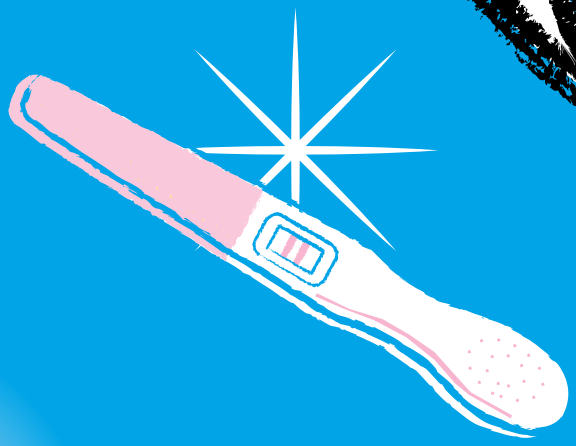
"Having friends who were sexually active talk about their experiences and realizing the diversity of different experiences [and] all types of different sexual orientations [ ]and then talking openly as friends just about their sexual experiences and just through that having those conversations destigmatize [sex talk]."

LGBTQ+ Reproductive Health:

The sex-ed curriculum was stated by participants to be extremely exclusive towards LGBTQ+ reproductive health, whether that meant the mere discussion of LGBTQ+ identities or how queer folks should approach their own sexual health.

"[The sex-ed curriculum] definitely does not include [queer identities] at all. Even with the curriculum that I had, it was a really brief six day, 24 hour total curriculum that I had... It didn't include people who are queer, trans, non binary, gay, or lesbian, or bi, didn't include any of that, and although I didn't get my sex education from high school, I know that it definitely was just not talking about people who aren't cisgender and hetero."

“I think even with schools with comprehensive sex ed programs, queer and trans people are still left out. And a lot of that content is being taught in a very white, European immigrant, Christian heteronormative lens. So if you know if there are programs out there that are doing a really good job at providing racially and culturally diverse and competent, queer and trans, inclusive, ... intersex, inclusive, sex ed, like, I would really love to see that because I think that that is really rare right now. At least in the U.S.”



“In the medical field, ... they also need to be open, educate themselves on [queer and trans identities] as well, and be able to have that conversation without, you know, without the boxes of just girl and boy.”

Furthermore, many participants also talked about the need for medical professionals to educate themselves on LGBTQ+ identities due to it playing such a vital role in getting the proper attention and services required by queer and trans-APIDA folk.

Another component that further complicated the comprehension of LGBTQ+ health in APIDA communities was due to the intersectionality between ethnicity and queerness which, in many participants stated, are both part of marginalized communities in U.S. society.

“There's this layer of race and ethnicity and culture that also is not often spoken about. So like, at [my institution], there's a lot of ... white folks who are also queer. And, you know, it's great because they're like, yes, pride, yes. ... That's great.

But it's also ... if you are white and queer, you have white privilege, right? So it's like, yes, you're queer. But [ ] also part of that experience is not colored by ... being a marginalized race or ethnicity in America.”

“If you can't even think about sex, then you can't think about having sex, then you definitely can't think about having sex safely. And then if you add queerness and transness to that layer, there's the dual, right? If I can't think or acknowledge being trans, think about or acknowledge being trans or queer, then I can't think about having queer and trans sex. And then I can't think about having safe queer and trans sex. So I think that [is] the power of shame. Cultural shame, family shame, and personal shame.”

“If you think about the axes of being Asian-American, queer, and sexual health, ... there's this stigmatization, or marginalization just not being centered and not being talked about.”

Healthcare Accessibility:

An overwhelming majority of 20 out of 26 participants who completed the quantitative survey stated that the Internet was the biggest source of information for reproductive health. These findings highlight the need for people, and especially youth, to be able to recognize reliable sources of online sexual health information.

"I learned a lot about [sexual health] from this TikTokker, like they were a healthcare professional. It wasn't like I was just going off influencer or whatever. But they themselves provided a lot of research and I think stuff like that is a great way to interact with the younger generations."

"I didn't grow up having the sex talk, but I knew what it was like. I learned it from my friends and from TikTok. I learned a lot of stuff on TikTok and I learned a lot of stuff from social media and my friends."

"What would I say to my friends if they ask about [abortion]? I would do some researching myself and then try and help them that way. But I also would suggest they do some research. I'm not sure how much information is available online. Hopefully, there's a suffice amount of information. But there could still be gaps out there online."

Many participants commented on the distrust and discomfort they felt when interacting with the U.S.'s healthcare system, especially in regards to language, cost, and the whiteness of hospital staff.

"My parents didn't talk about [sex] and even when they do, they don't use specific words, you know, like there isn't a Hmong word for condoms."

"I understand that in certain interactions in health care, I have to put on my westernized mask or I have to conform to the Western way of thinking about health."

Another concern brought up often by participants was the role health insurance played in accessing sexual healthcare materials. Some barriers identified were regarding cost, availability (i.e. through work), and limitations surrounding what services were included in insurance packages.

"With [ ] most people being covered by health insurance through their job, it's like how would I be able to get access to health care if it's so inaccessible and expensive?"

Abortion, Birth Control, and Contraceptives:

A majority of the participants commented that they believed their knowledge of birth control, contraceptives, and abortion (in no specific order) was less than stellar, but also that it was difficult to know where to begin in their search for expanding their knowledge of the topics.

Furthermore, participants described how their APIDA identities clashed with the acceptance of the usage of birth controls and contraceptives, which many said were more mainstream in western culture.

"For someone who has a similar identity [to] me, ... I feel like family isn't as supportive of contraceptives, like birth control for women, even though the doctor was like, oh, it's like birth control for skin specifically."

"I didn't learn about [birth control or contraceptives] from my parents... I think health class was where I learned it. But it was a very, very brief overview of it, just like, oh, abstinence is key, but these are some of the contraceptives and birth control to stay safe. I never really looked into it because, I mean, it wasn't something that my parents ever really brought up."

Participants generally felt more comfortable discussing birth control in depth over contraceptives and abortion, but were often overwhelmed due to having to learn the (many) different methods and side effects with little to no outside help beforehand.

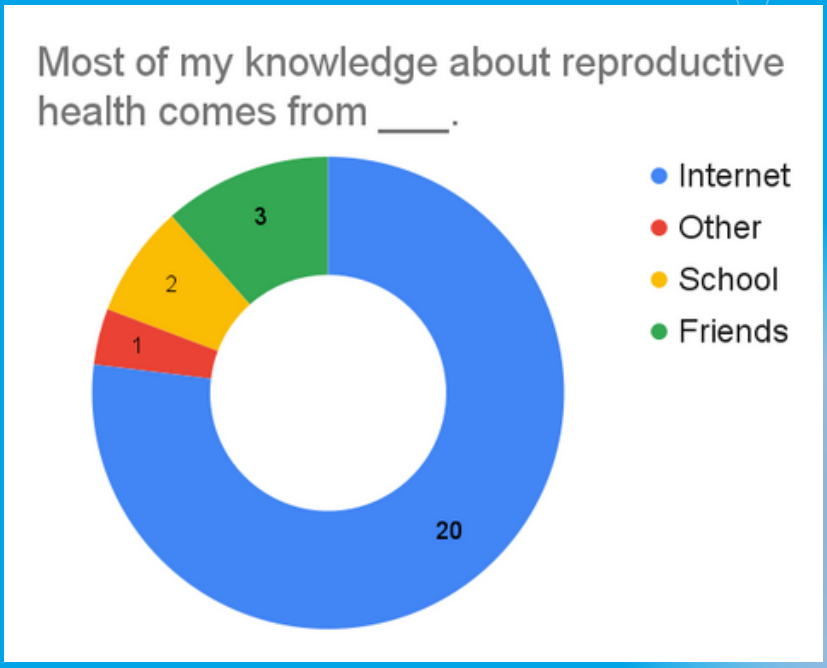
"I had a friend who was on birth control and, honestly, they were learning about birth control as they were using it. And I think that in itself was very alarming seeing that the professional did not tell them anything about the side effects and not tell them how, you know, it would work"

Abortion was the topic met with the least amount of confidence. Many participants stated they knew the general basics associated with making the decision to get an abortion, but that they were not as knowledgeable in the steps to get one.

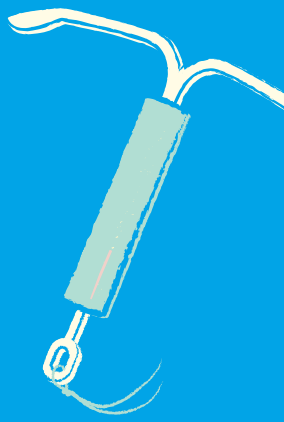
"I feel like in sexual health education, and abortion and consent, a lot of the, the problem is that we don't know what we don't know because it's literally never talked about. But if you even like knew the very basics about abortion, even if you did know all the politics and specifics and everything around it, at least you know, that you don't know those things."

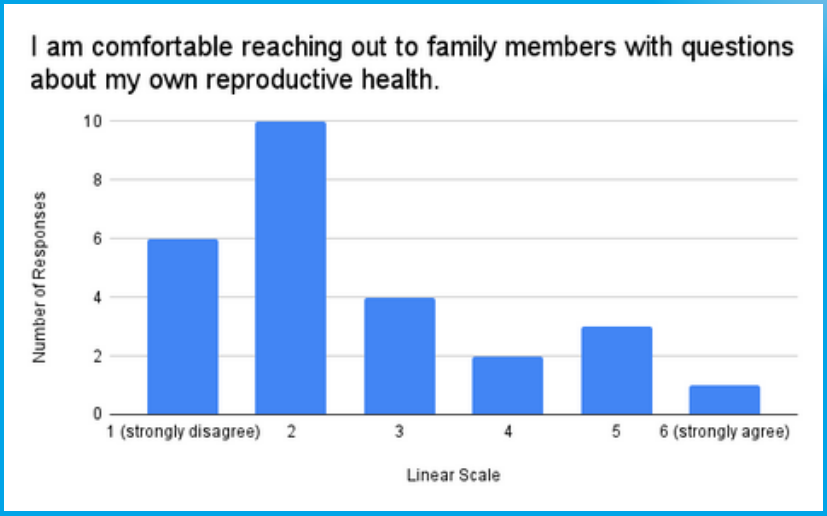
"I don't think I don't think I found out like abortion was a thing until either from my friend or from like watching movies. Honestly. Yeah. It wasn't talked about by like my parents."

Quantitative Survey Graphs

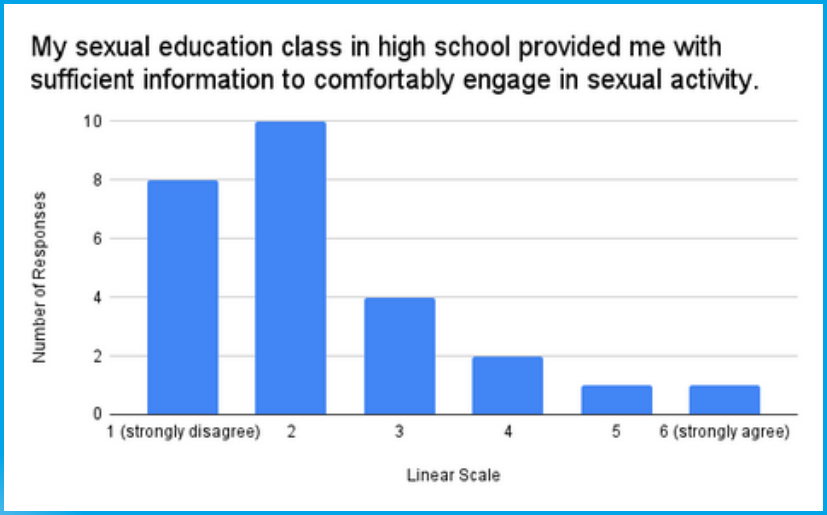


Graphic G: Graphic of pie chart reading: Most of my knowledge about reproductive health comes from: 20, Internet; 3, Friends; 2, School; 1, Other.



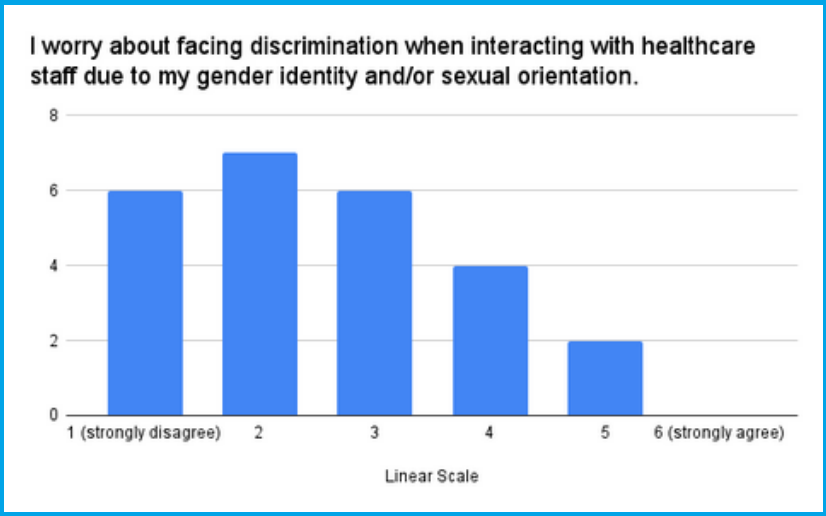


Graphic H: Graphic of bar chart reading: I am comfortable reaching out to family members with questions about my own reproductive health on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 6 said 1; 10 said 2; 4 said 3; 2 said 4; 3 said 5; 1 said 6.



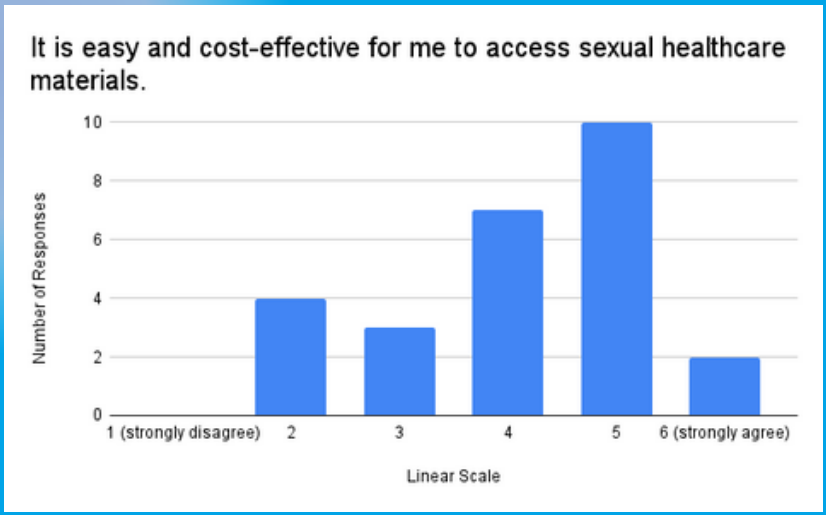
Graphic I: Graphic of bar chart reading: My sexual education class in high school provided me with sufficient information to comfortable engage in sexual activity on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 8 said 1; 10 said 2; 4 said 3; 2 said 4; 31said 5; 1 said 6.

Quantitative Survey Graphs



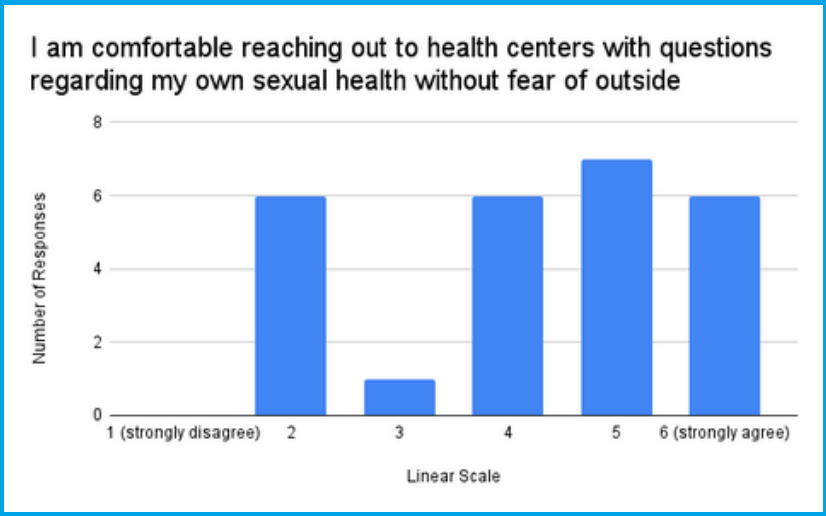
Graphic J: Graphic of bar chart reading: I worry about facing discrimination when interacting with healthcare staff due to my gender identity and/or sexual orientation on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 6 said 1; 8 said 2; 6 said 3; 4 said 4; 2 said 5; 0 said 6.

Graphic K: Graphic of bar chart reading: I have to worry about healthcare professionals being unprepared or untrained to discuss my body on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 4 said 1; 5 said 2; 11 said 3; 5 said 4; 0 said 5 and 6.

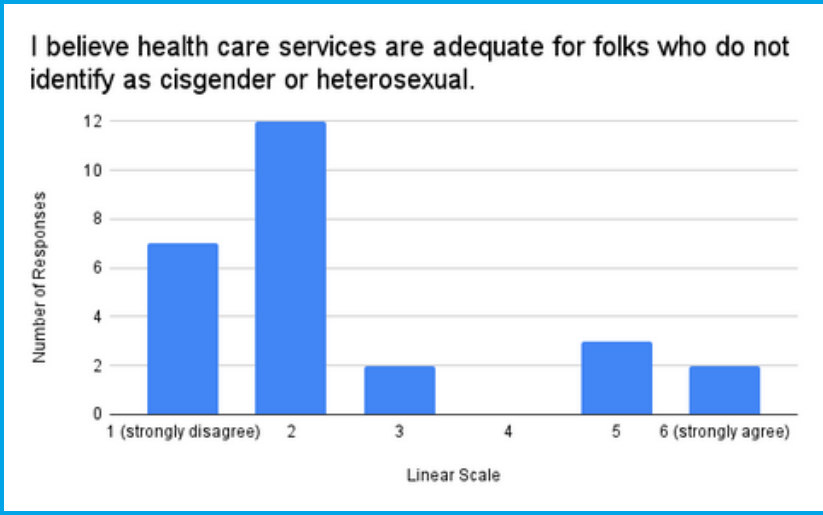


Graphic L: Graphic of bar chart reading: It is easy and cost-effective for me to access sexual healthcare materials on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1; 4 said 2; 3 said 3; 7 said 4; 10 said 5; 2 said 6.

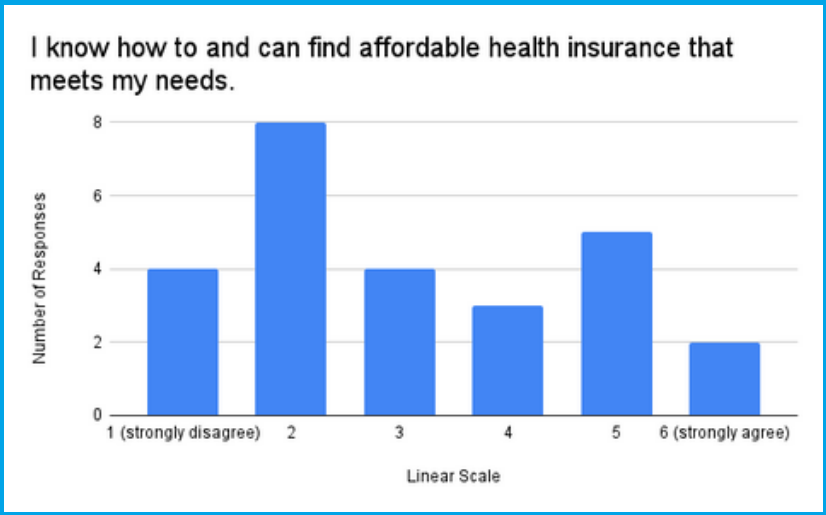
Quantitative Survey Graphs



Graphic M: Graphic of bar chart reading: I am comfortable reaching out to health centers with questions regarding my own sexual health without fear of outside intervention from my family on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1 ; 6 said 2; 1 said 3; 6 said 4; 7 said 5; 6 said 6.

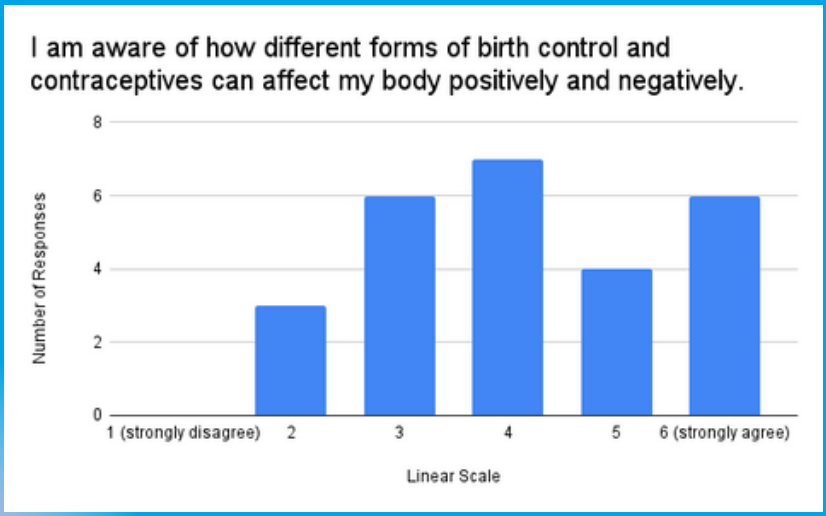


Graphic N: Graphic of bar chart reading: I believe health care services are adequate for folks who do not identify as cisgender or heterosexual on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 7 said 1; 12 said 2; 2 said 3; 0 said 4; 3 said 5; 2 said 6.

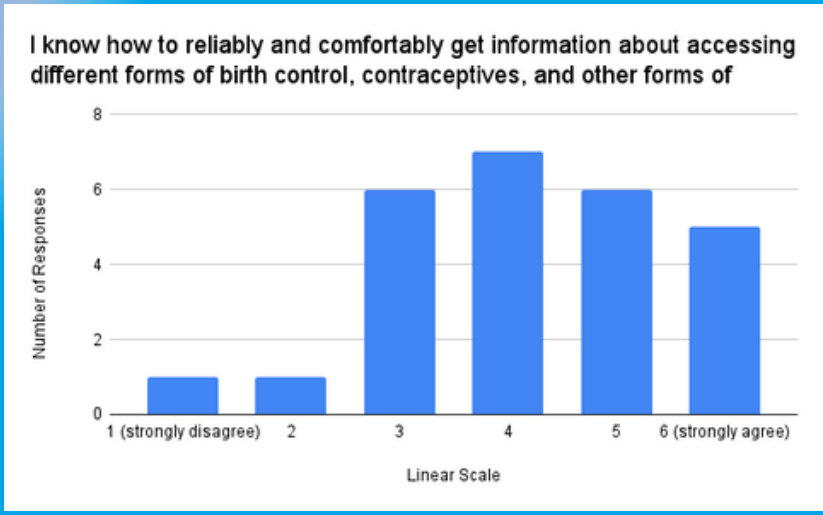


Graphic O: Graphic of bar chart reading: I know how to and can find affordable health insurance that meets my needs on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 4 said 1; 8 said 2; 4 said 3; 3 said 4; 5 said 5; 2 said 6.

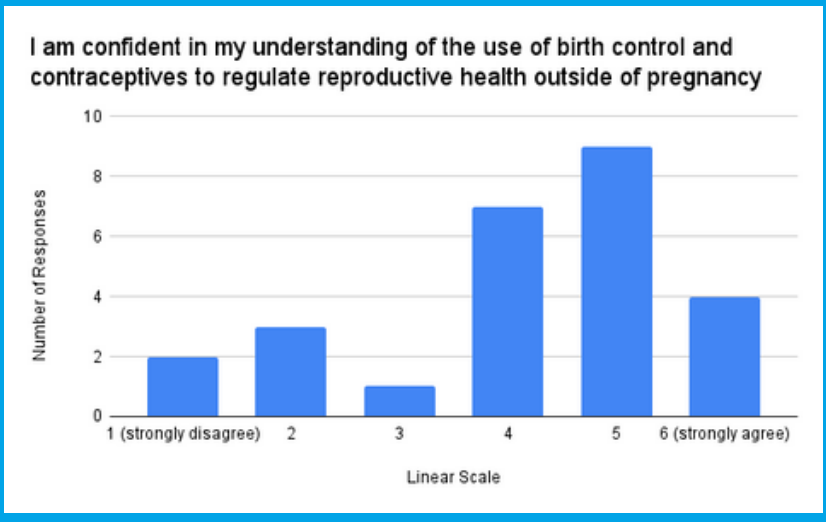
Quantitative Survey Graphs



Graphic P: Graphic of bar chart reading: I am aware of how different forms of birth control and contraceptives can affect my body positively and negatively on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1 ; 3 said 2; 6 said 3; 7 said 4; 4 said 5; 6 said 6.

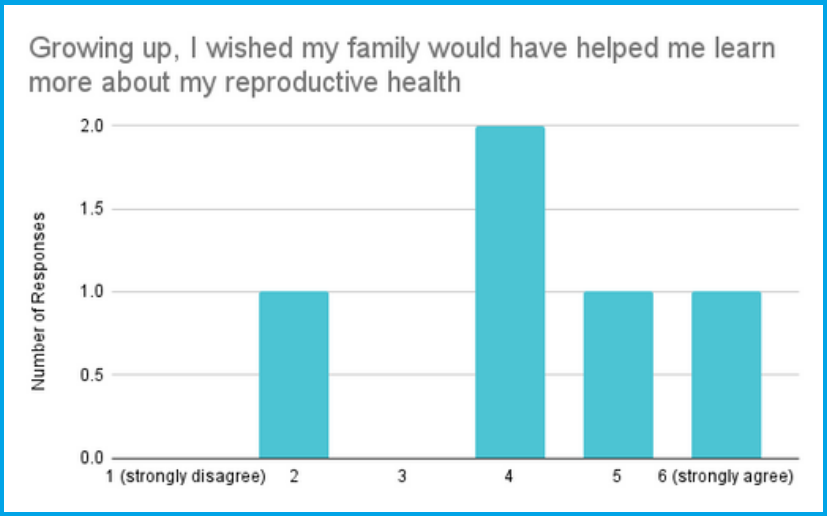


Graphic Q: Graphic of bar chart reading: I know how to reliably and comfortably get information about accessing different forms of birth control, contraceptives, and other forms of sexual protection from reliable healthcare professionals on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 7 said 1; 12 said 2; 2 said 3; 0 said 4; 3 said 5; 2 said 6.

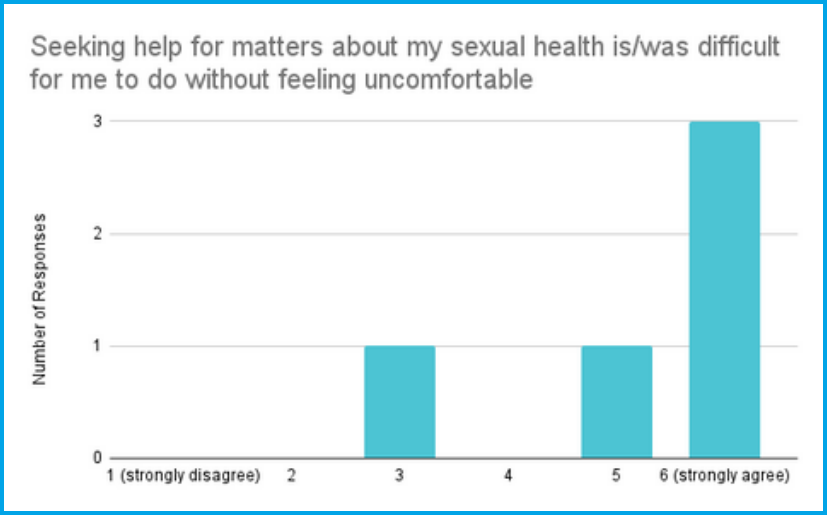


Graphic R: Graphic of bar chart reading: I am confident in my understanding of the use of birth control and contraceptives to regulate reproductive health outside of pregnancy prevention on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 2 said 1; 3 said 2; 1 said 3; 7 said 4; 9 said 5; 4 said 6.

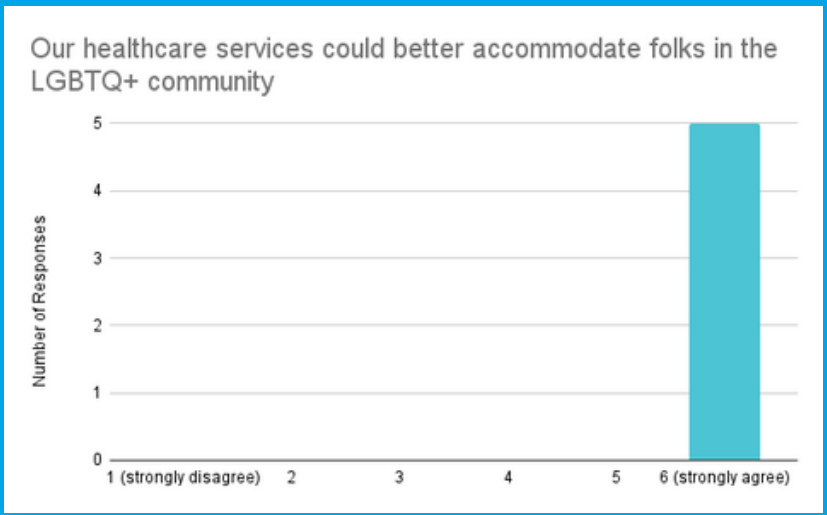
Quantitative Survey Graphs



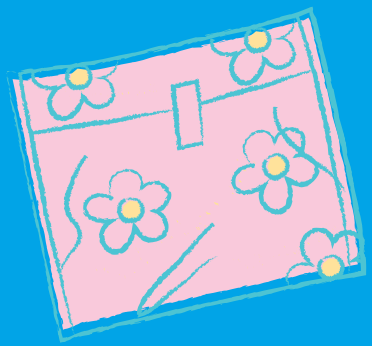
Graphic S: Graphic of bar chart reading: Growing up, I wished my family would have helped me learn more about my reproductive health on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1 and 3 ; 1 said 2; 2 said 4; 1 said 5; 1 said 6.



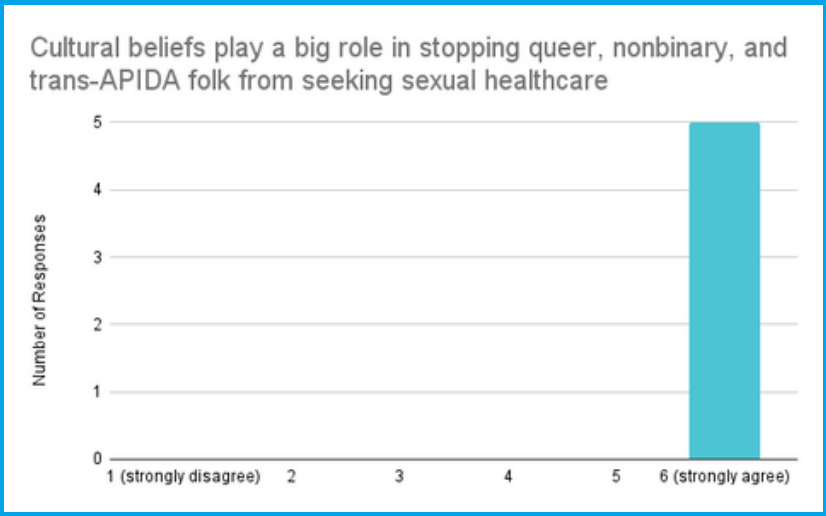
Graphic T: Graphic of bar chart reading: Seeking help for matters about my sexual health is/was difficult for me to do without feeling uncomfortable on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1, 2, and 4; 1 said 3; 1 said 5; 3 said 6.



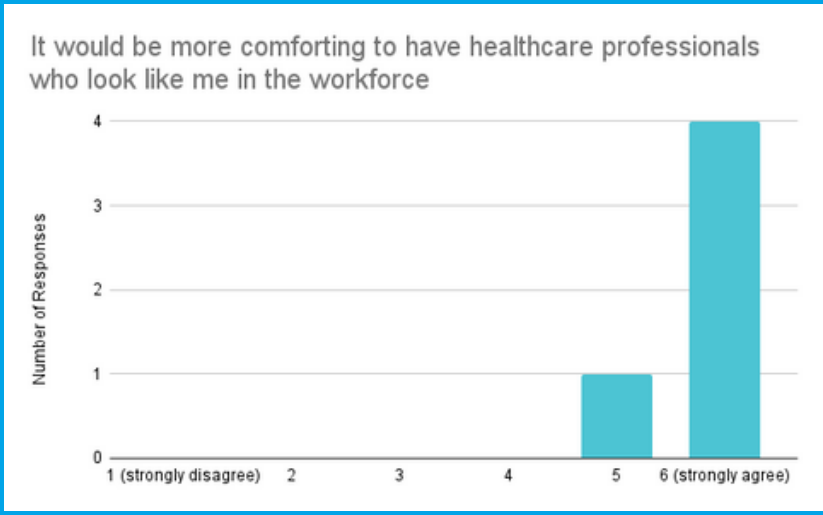
Graphic U: Graphic of bar chart reading: Our healthcare services could better accommodate folks in the LGBTQ+ community on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). All 5 said 6.



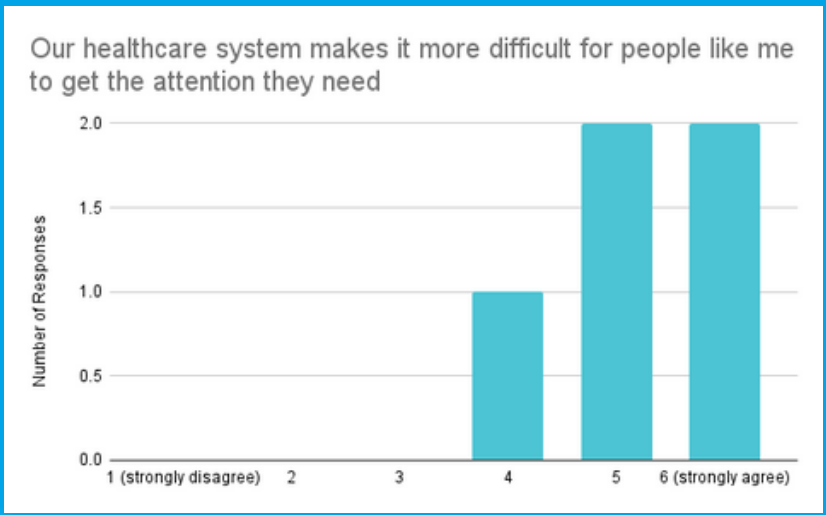
Focus Group Graphs



Graphic V: Graphic of bar chart reading: Cultural beliefs play a big role in stopping queer, nonbinary, and trans-APIDA folk from seeking sexual healthcare. on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). All 5 said 6.

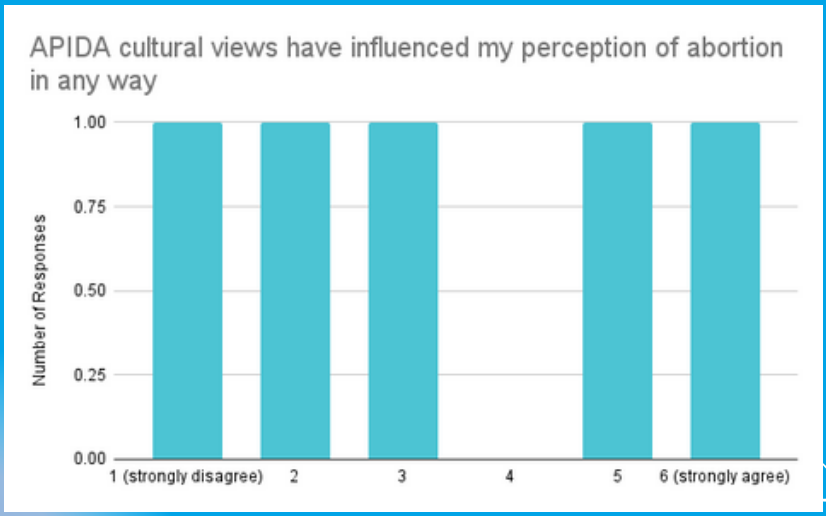


Graphic X: Graphic of bar chart reading: It would be more comforting to have healthcare professionals who look like me in the workforce on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1-5; 1 said 5; 4 said 6.

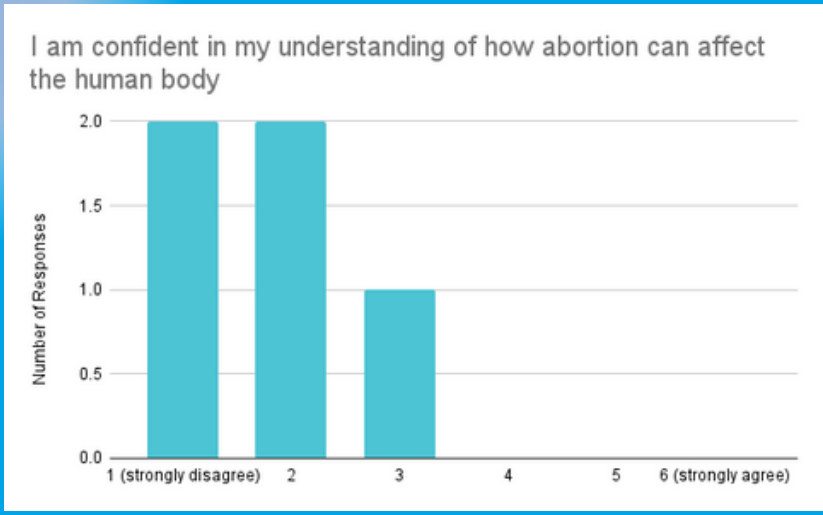


Graphic Y: Graphic of bar chart reading: Our healthcare system makes it more difficult for people like me to get the attention they need on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1-3; 1 said 4; 2 said 5; 2 said 6.

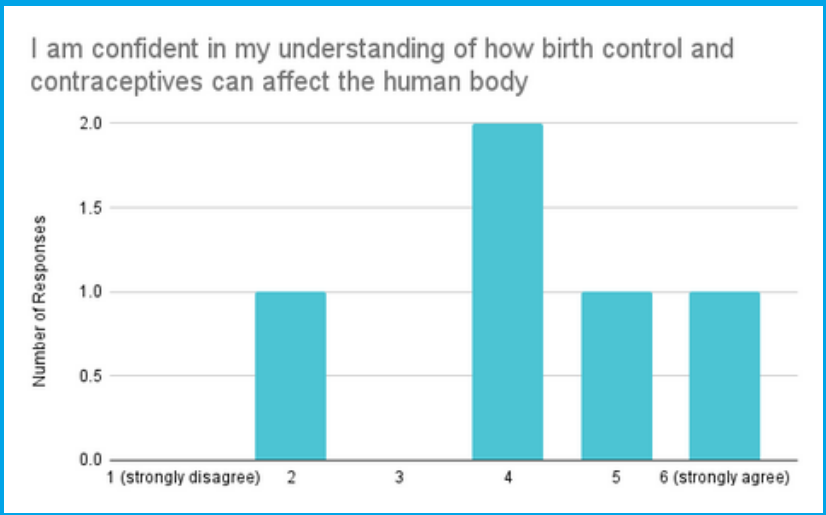
Focus Group Graphs



Graphic Z: Graphic of bar chart reading: APIDA cultural views have influenced my perception of abortion in any way on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 4; 1 each said 1, 2, 3, 5, or 6.

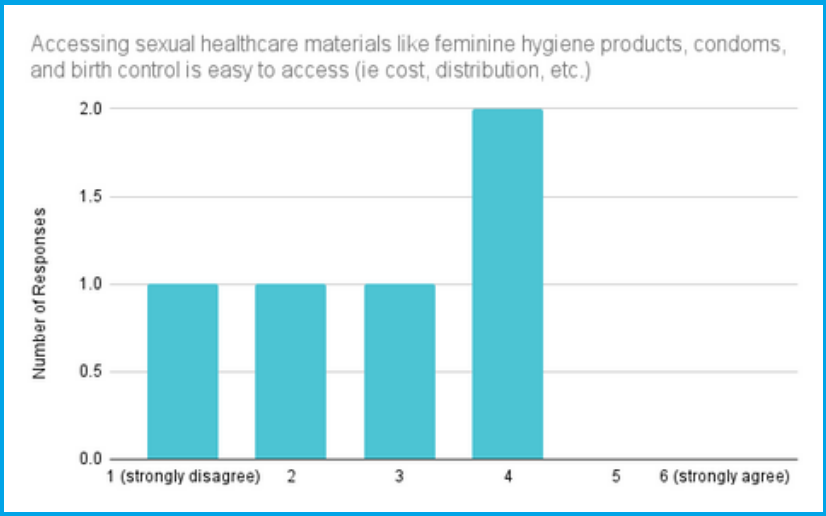


Graphic A1: Graphic of bar chart reading: I am confident in my understanding of how abortion can affect the human body on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 2 said 1; 2 said 2; 1 said 3; 0 said 4, 5, or 6.

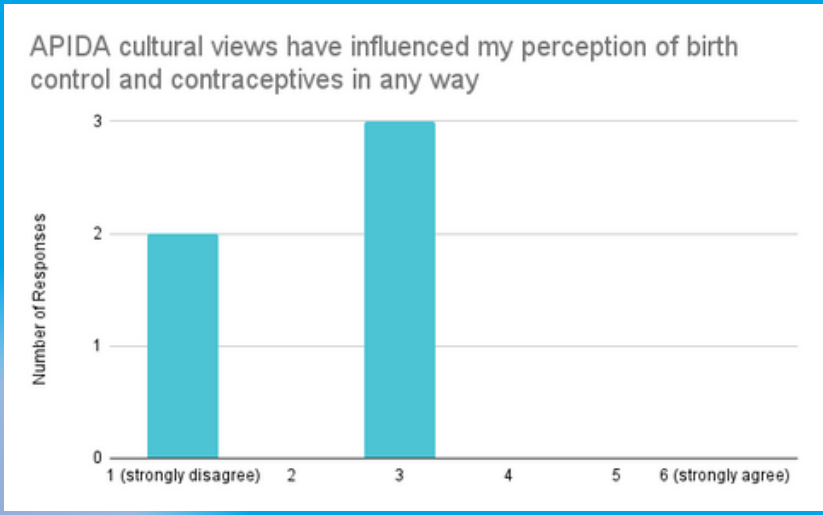


Graphic B1: Graphic of bar chart reading: I am confident in my understanding of how birth control and contraceptives can affect the human body on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 0 said 1 or 3; 1 said 2; 2 said 4; 1 said 5; 1 said 6.

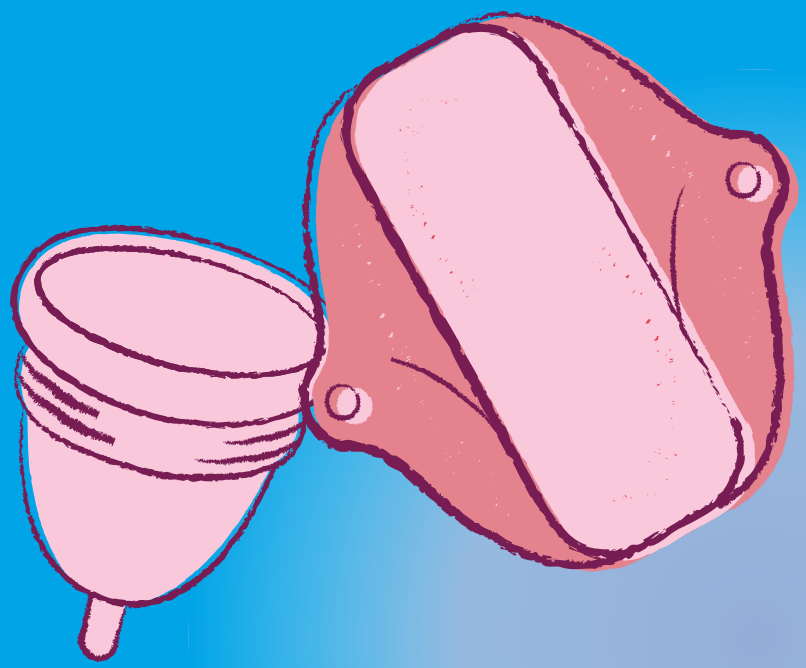
Focus Group Graphs



Graphic C1: Graphic of bar chart reading: Accessing sexual healthcare materials like feminine hygiene products, condoms, and birth control is easy to access (ie cost, distribution, etc.) on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 1 said 1; 1 said 2; 1 said 3; 2 said 4; 0 said 5 or 6.



Graphic D1: Graphic of bar chart reading: APIDA cultural views have influenced my perception of birth control and contraceptives in any way on a scale from 1 to 6 (1, strongly disagree. 6 strongly agree). 2 said 1; 0 said 2, 4, 5, or 6; 3 said 3.



Conclusion

Research Gaps

Despite the information collected from the research methods above, many gaps in the study's direction and execution became apparent over the course of the project. Research gaps in this sense are topics where an inadequate amount of information has limited our ability to make concrete conclusions about a given area of interest.

Listed below are some of the largest research gaps identified during the study:

Limited data set and participants:

Overall, there were 28 unique participants that took part in this study, with multiple intersectionalities occurring between the different research methods within. A wider range of unique participants would have given us more insight into the greater APIDA community and allowed us a new perspective on the topics of reproductive justice, abortion, birth control, and contraceptives.

Demographic majorities:

The demographic range of participants that engaged with the study followed a similar trend throughout the different research methods. The majority of participants identified as Hmong and with she/her pronouns. The age range of participants was much more nuanced, with an average age of 21.3 among the 28 unique participants.

The term "APIDA" itself describes those of Asian, Pacific Islander, and Desi descent, though none of the participants in this study identified as Pacific Islander or Desi-American. Insight into these aspects of the APIDA classification would have added more perspectives to the research topic.

Sexual orientation and gender identity specificity:

The sexual orientation and gender identity of participants was not asked for in the demographic portion of the study, though topics relating to these became vital in understanding how different identities affected how participants viewed topics. This was made most apparent in the LGBTQ+ Reproductive Health section of the research methods.

Next Steps

After the research conducted above through the channels of a survey, individual interviews, and a focus group, AAOP has been able to conclude where the area of concern or major interest is. The following themes were the most predominant topics:

- Abortion, birth control, and contraceptives
- Adequate, comprehensive, and inclusive sexual education
- Breaking the cycle of stigmatization around sex and reproductive health

These topics will be further explored in future PAR work, and AAOP will continue expanding their “Reproductive Justice on Abortion Rights and Access” campaign in APIDA communities. Summer in person events to engage with APIDA community, as well as a PAR on abortion access, care, and support will help build toward our RJ canvassing efforts this fall 2022.

Final Thoughts

Reproductive health in APIDA communities, which so often prioritize the wellbeing of the community over the individual, as demonstrated on this above map, continues to be a relevant topic as cycles of stigmatization are broken in our society, a shift that we are beginning to see more of in the world around us as members of the APIDA community ourselves. It is important to have access to reliable information and resources to aid us in the pursuit of the cultivation of our understanding of sexual health, which many APIDA youth find themselves unequipped to confront due to years of generational trauma, Eurocentric values, and cultural censorship. This study has been extremely helpful in pinpointing a base understanding for future projects and work within AAOP.

For further inquiries about our work and organization, feel free to visit our website or contact us with the information provided below:

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