Medication abortion among Asian Americans, Native Hawaiians, and Pacific Islanders: Knowledge, access, and attitudes

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napawf
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Ibis Reproductive Health

EXECUTIVE SUMMARY

Almost no research to date examines abortion attitudes and knowledge among Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) in the U.S. While previous research shows lower rates of abortion among Asian women compared to other racial ethnic groups, abortion rates vary by subgroups when disaggregating data by ethnicity or country of origin. In addition, no literature currently exists documenting AANHPI experiences with and/or use of medication abortion (MA).

To help address this research gap, National Asian Pacific American Women's Forum (NAPAWF), in partnership with Ibis Reproductive Health, conducted a two-year study examining AANHPI people's knowledge of, access to, and attitudes about abortion, with a specific focus on medication abortion. While medication abortion accounts for over half of all abortions in the U.S., participants in this study described limited knowledge of abortion methods, including medication abortion.

Our study identified a range of barriers to medication abortion. For AANHPI communities, this includes community stigma towards abortion and sexual and reproductive health (SRH), a lack of family support, and the unavailability of language support for limited-English or non-English speaking patients at abortion clinics. Other barriers included the high cost of abortion care, lack of insurance coverage, limited appointment availability, lack of transportation, legal restrictions, longer wait times at the clinic, and protesters outside of clinics.

The taboo nature of SRH topics, including abortion, in addition to the general lack of openness among AANHPI community members impacts access to information and services related to their reproductive health. There is an overall need to provide accurate and culturally relevant information about all abortion methods to AANHPI communities to help bridge information gaps and overcome barriers to access.

Introduction

The unique abortion needs and experiences of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities are often masked due to a lack of AANHPI-specific abortion research. Within the literature that does exist, rarely does it disaggregate among AANHPI subgroups. When describing literature in this report we use terms to describe each population as they are presented in the relevant research, however, we will use the term AANHPI to describe the populations represented in our findings.

While the Centers for Disease Control and Prevention (CDC) publishes annual surveillance reports on abortion, data on race/ethnicity is limited to White, Black, Hispanic and Other – with AANHPI grouped under the 'Other' category.[1] As such, there is very limited information on AANHPI abortion rates or methods most used, and few studies that disaggregate into specific ethnic subgroups, despite unique geographic, social, and demographic differences among AANHPIs, as well as distinct histories within the U.S. which contribute to abortion experiences and pathways among these communities.

The term "AANHPI" represents an extremely vibrant and diverse population, comprised of more than 50 ethnic subgroups and 100 languages and dialects.[2] For decades, this inherent diversity has been overshadowed by the "model minority" myth, or the idea that certain Asian ethnicities in the U.S. have fared better than other minorities due to their educational attainment and work ethic.[3] The "model minority" myth further masks important health differences between groups and the diverse needs and preferences of these communities.

Almost no research to date has examined the reproductive healthcare needs and experiences of specific AANHPI communities. A study published in 2021 found that the abortion rate among Asian women in New York City was 12.6 per 1,000 women, a rate lower than other racial and ethnic groups. When disaggregating this data by country of origin, Indian women had abortion rates approximately two to six times higher than other Asian subgroups in the study. This study also found that abortion rates were higher for U.S.-born Asian women compared to immigrant Asian women.[4] Evidence also indicates that Asian women were more than twice as likely to choose medication abortion over other methods since they felt it was safer.[5]

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[1] Kortsmit K, Mandel MG, Reeves JA, et al. Abortion Surveillance — United States, 2019. MMWR Surveill Summ 2021;70(No. SS-9):1–29. DOI: https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm?s_cid=ss7009a1_w.

[2] NAPAWF, Equal Pay for Asian American, Native Hawaiian, and Pacific Islander Women. https://www.napawf.org/equalpay.

[3] National Asian Pacific American Women's Forum. "Still Fierce, Still Fighting: A Reproductive Justice Agenda for Asian Americans and Pacific Islanders". 2017. https://www.napawf.org/uploads/1/1/4/9/114909119/stillfiercestillfighting.pdf.

[4] Desai S, Huynh M, Jones HE. Differences in Abortion Rates between Asian Populations by Country of Origin and Nativity Status in New York City, 2011–2015. International Journal of Environmental Research and Public Health. 2021; 18(12):6182. https://doi.org/10.3390/ijerph18126182.

[5] Clark S, Ellertson C, Winikoff B. Is medical abortion acceptable to all American women: the impact of sociodemographic characteristics on the acceptability of mifepristone-misoprostol abortion. Journal of the American Medical Women's Association (1972). 2000 ;55(3 Suppl):177-182. PMID: 10846333.

In a polling survey of 1,617 women of color following the 2020 election, a majority (85%) of AAPI women believe that women should have the right to make their own reproductive choices[6] Amidst this overwhelming backdrop of support, this study recognizes the importance of acknowledging the diverse range of attitudes and experiences with medication abortion among different AANHPI ethnicities and subgroups. The evidence generated from this study will help inform our advocacy which aims to increase access to medication abortion among ethnically diverse communities.

Methodology and Study Sample

To ensure relevance, bring the expertise of communities to the design, implementation, analysis, and dissemination of the study, and make findings as comprehensive as possible, this study utilized a mixed-methods, community-based participatory research (CBPR) approach that included qualitative in-depth interviews (IDIs), focus group discussions (FGDs), and a quantitative survey contribute to abortion experiences and pathways among these communities.[7,8,9]

Community Advisory Board (CAB)

This study was conducted in collaboration with a community advisory board (CAB) composed of seven members from community-based organizations and experts on AANHPI issues. Several CAB members were selected to represent sub-groups of interest including Southeast Asian, Pacific Islander, and LGBTQ+ communities. An abortion care provider who identifies as and works with AANHPIs was also selected. CAB members served as advisors throughout the research process including study design, instrument development, recruitment, as well as interpretation and dissemination of results.

Key Research Terms

- **Medication Abortion (MA)**[10] – commonly referred to as "the abortion pill(s)" is a safe and effective abortion method. There are two types of MA – the first consists of taking two medications (mifepristone followed 24-48 hours later by one dose of misoprostol), or taking three (or more) doses of misoprostol three hours apart. MA can be used throughout pregnancy, however, most clinics in the U.S. provide medication abortion up to 10 weeks of pregnancy. *Note: Medication abortion is not the same thing as emergency contraception.*

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[6] Intersection of Our Lives. AAPI Women Voted in the 2020 Election Like Never Before: Here's Why. July 2021. https://intersectionsofourlives.org/wp-content/uploads/2021/07/ISOOL_Fact-Sheet-Summary-AAPI-Women-final.pdf.

[7] Srinivasan S, Guillermo. Toward improved health: disaggregating Asian American and Native Hawaiian/Pacific Islander data. Am J Public Health. 2000;90(11):1731-1734. doi:10.2105/AJPH.90.11.1731

[8] Choi JY. Contextual effects on health care access among immigrants: Lessons from three ethnic communities in Hawaii. Social Science & Medicine. 2009;69(8):1261-1271. doi:10.1016/j.socscimed.2009.08.001

[9] Tseng W, Kwon SC. Introduction: Shining the Light on Asian American, Native Hawaiian, and Pacific Islander Health. Journal of Health Care for the Poor and Underserved. 2015;26(2A):vii-xiv. doi:10.1353/hpu.2015.0052

[10] Kaiser Family Foundation (KFF). "The Availability and Use of Medication Abortion". (April 2022). https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/

- **Procedural Abortion** – sometimes referred to as surgical, in-clinic, suction or aspiration abortion, is a procedure that often takes place in a medical office or clinic by a medical provider who uses instruments to remove a pregnancy from the uterus.

- **Self-managed abortion (SMA)** – The use of abortion pills or other methods such as using herbs, drinking special teas or mixes, etc. to end a pregnancy without clinical supervision.

- **Sexual and Reproductive Health (SRH)**[11] – the health of an individual's reproductive system and sexual well-being during all stages of their life.

Qualitative data collection

The qualitative component of this study, with a total of 121 participants, consisted of 29 in-depth interviews (IDIs) and 17 focus group discussions (FGDs). Eligible participants were people of reproductive age (18-49 years) who identified as a woman, transgender, non-binary or gender expansive, and that self-identified as Asian American, Native Hawaiian, and/or Pacific Islander (AANHPI) or mixed race including Asian American, Native Hawaiian, and/or Pacific Islander. Due to challenges recruiting NHPI participants, only a small proportion (1%) of the FGD participants identified as NHPI. Given the small sample of NHPI participants, qualitative findings primarily speak to Asian and Asian American experiences.

IDIs were conducted in English with people who had a medication abortion in the U.S. between January 2016 and March 2021. The average age of IDI participants was 28 years old, with an age range between 20 to 43 years old. Twelve FGDs were conducted in English and five were conducted in either Korean, Vietnamese, Mandarin, Urdu, and Bangla resulting in 60% of the total FGD participants being English speakers and 40% speaking a primary language other than English. A portion of FGD participants were grouped together based on specific demographic characteristics, including being between the ages of 18-20, and self-identifying as Native Hawaiian and/or Pacific Islander (NHPI). The average age of FGD participants was 27 years old, with an age range between 18 to 46 years old. To maintain anonymity of qualitative participants, pseudonyms are used for each direct quote in this report. Additionally, demographics related to the race or ethnicity of FGD participants is based on the information that was recorded at the time of the discussion.

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[11]World Health Organization (WHO). "Sexual and Reproductive Health and Research (SRH)". https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health

Quantitative data collection

The survey component of this study included a randomly recruited U.S. sample of 1,500 people of reproductive age between 16-49 who identified as a woman, transgender, non-binary or gender expansive. Using online and phone-based strategies, the survey sample included a roughly equal number of respondents who identified with at least one of the following ethnic groups: Chinese, Korean, Vietnamese, Filipino, Asian Indian, and/or NHPI.

The survey was fielded in September 2022 and took approximately 15 minutes to complete. It was available in multiple languages, including English, Chinese, Korean, and Vietnamese. [12] Eighty-five percent of survey respondents identified as Asian and 17% identified as Native Hawaiian and/or Pacific Islander. Among NHPI respondents, the majority identified as Native Hawaiian (62%), Samoan/American Samoan (13%), Other Pacific Islander (12%), and/or Guamanian or Chamorro (6%).

The average age of survey respondents was 33 years old, ranging in age between 16 to 49 years old. The proportion of U.S. to foreign-born respondents was 46% and 54% respectively. In addition, 53% had previously given birth while 47% of respondents had not.

Key Findings

Sexual and Reproductive Health Attitudes and Knowledge

Participants in both in-depth interviews and focus group discussions shared their experiences accessing sexual and reproductive health (SRH) services, including their personal opinions and views on sex and relationships. Participants broadly discussed the taboo or secretive nature of SRH topics, including abortion, within their community:

> *"...until a very late age, there wasn't any talk about any kind of reproductive or sexual health...I really didn't learn about that stuff until I got to high school."*
>
> – **Sarah**, Asian American FGD Participant

For some, SRH topics were used as a scare tactic by parents or other community members as a way to discourage premarital sex, as well as to reinforce overarching community values such as getting married and/or having children. For example:

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[12] Respondents allowed to select more than one option.

"...I know someone who had an unwanted pregnancy and she ended up having the kid...that was the story that all our parents [told] to us as a warning. [They told us] 'see what happens if you don't get married and have a kid traditionally? Look how much she's struggling because she did this.'"

– **Erika**, Asian American FGD Participant

"Both my parents just scared me away from sex at all. So I was a pretty late bloomer in life because of it, but those were the values that I grew up with, very anti-abortion, very anti-sex, no relationships because your only relationship should be with God."

– **Emmy**, Vietnamese IDI participant

"...the stigma on having abortions I think sometimes comes from like, 'Oh, you're unmarried. You're young. You're stupid, and look at what you did, and now you need to suffer the consequences and raise a whole child'... It's like, 'you learned your lesson'. And 'if you can't raise your child we'll hanai your baby' or 'we'll take care of your baby or someone [in the community] will'."

– **Epi**, NHPI FGD participant

A lack of openness around SRH topics has been described in previous literature for some AANHPI populations, but has not been linked specifically to abortion attitudes and stigma.[13,14] Participants of this study expressed that the lack of openness around SRH topics in their community impacted their knowledge and decision-making:

"There's a stigma around general birth control, as well as abortion, that makes it really, really hard to have conversations...if a person can't have conversations about sex...they will make these decisions without knowing everything they should...I think that puts people in vulnerable situations."

– **Sanya**, AANHPI FGD Participant

"Initially I would say that one of the reasons why I burst out in tears when I found out that I was pregnant was because of the influence that I'd had from...the Christian community [and] Korean culture where it's looked down upon to get an abortion...I think that's why I cried... because of the way that I was raised to think about abortion, that it's the wrong thing to do, and that I shouldn't even get myself in that position to begin with."

– **Mindy**, South Korean IDI participant

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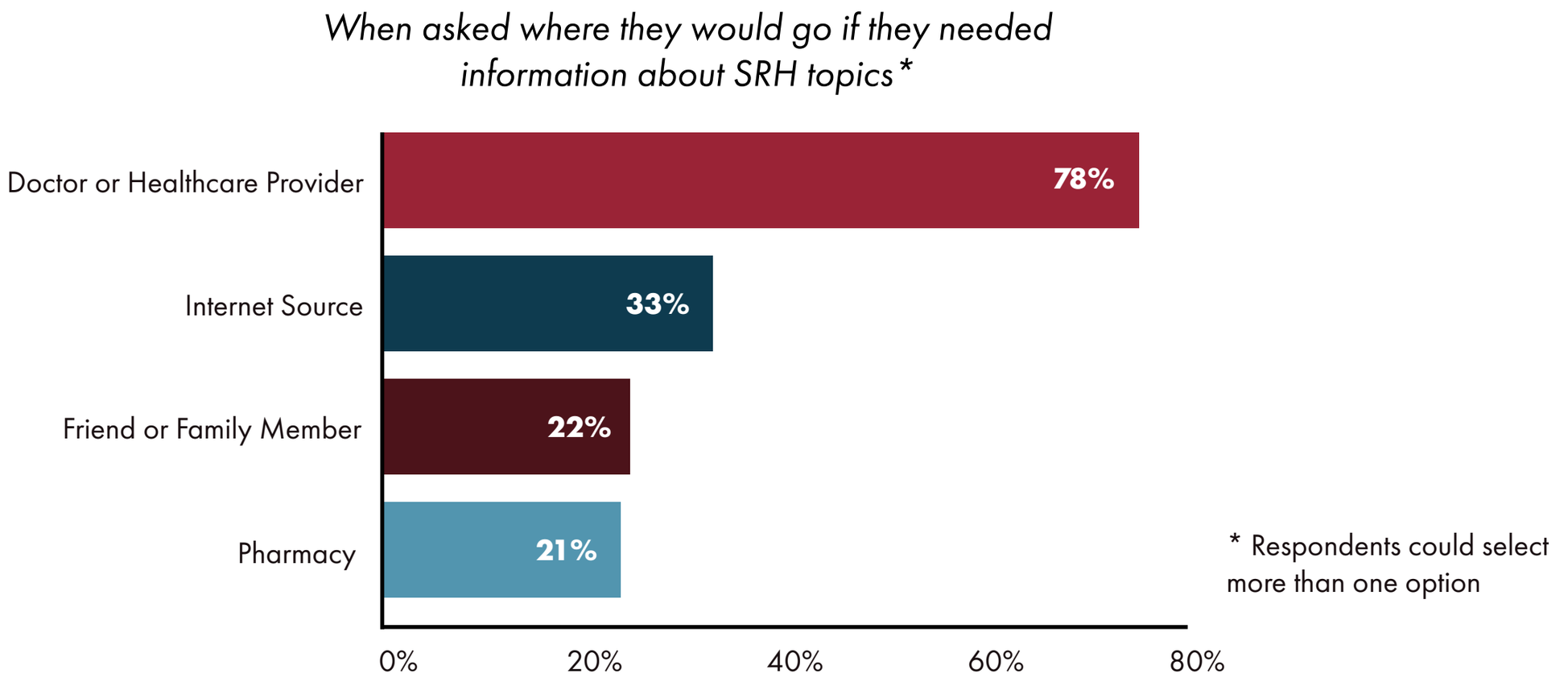
[13] Kim, J.L. and Ward, L.M. (2007). Silence Speaks Volumes: Parental Sexual Communication Among Asian American Emerging Adults. Journal of Adolescent Research, 22(1). https://doi.org/10.1177/0743558406294916

[14] Frost, M., Cares, A., Gelman, K., & Beam, R. (2016). Accessing sexual and reproductive health care and information: Perspectives and recommendations from young Asian American women. Sexual & Reproductive Healthcare : Official Journal of the Swedish Association of Midwives, 10, 9–13. https://doi.org/10.1016/j.srhc.2016.09.007

Figure 1. SRH Information Sources



The scarcity of knowledge about SRH topics was compounded by a lack of available and accessible information sources for AANHPIs. When asked where they would go if they needed information about SRH topics, 78% of survey respondents said a doctor or healthcare provider, 33% said an internet source, 22% said a friend or family member, and 21% said a pharmacy. Similarly, qualitative participants reported seeking information about SRH topics from online sources, peers/friends, older siblings, and even their university health centers. However, participants often felt "lost" about where to go and relied on online information:

> *"I just always knew that Planned Parenthood was a good option for [having] no guidance, no direction, and no prior [obstetrics] experience. I pretty much Googled a lot of the stuff too because I didn't know who to ask."*
>
> – **Mei**, Chinese/Taiwanese IDI Participant

> *"We looked on Google pretty extensively… I Googled like what are abortions like…Because I think there's so much societal secrecy about them, it's very painful actually just emotionally, that it's so limited in information that I actually had no idea what really happened."*
>
> – **Christine**, Filipina IDI participant

With the reliance on digital sources of information, it is also important to recognize the legal risk associated with accessing abortion information and services online,

especially in legally restrictive states.[15] And while online resources might be accessible to some, others stressed the importance of community resources that were offered in-language and distributed by trusted organizations. At the same time, many participants did not have these in-person resources available to them, furthering the lack of knowledge around SRH topics:

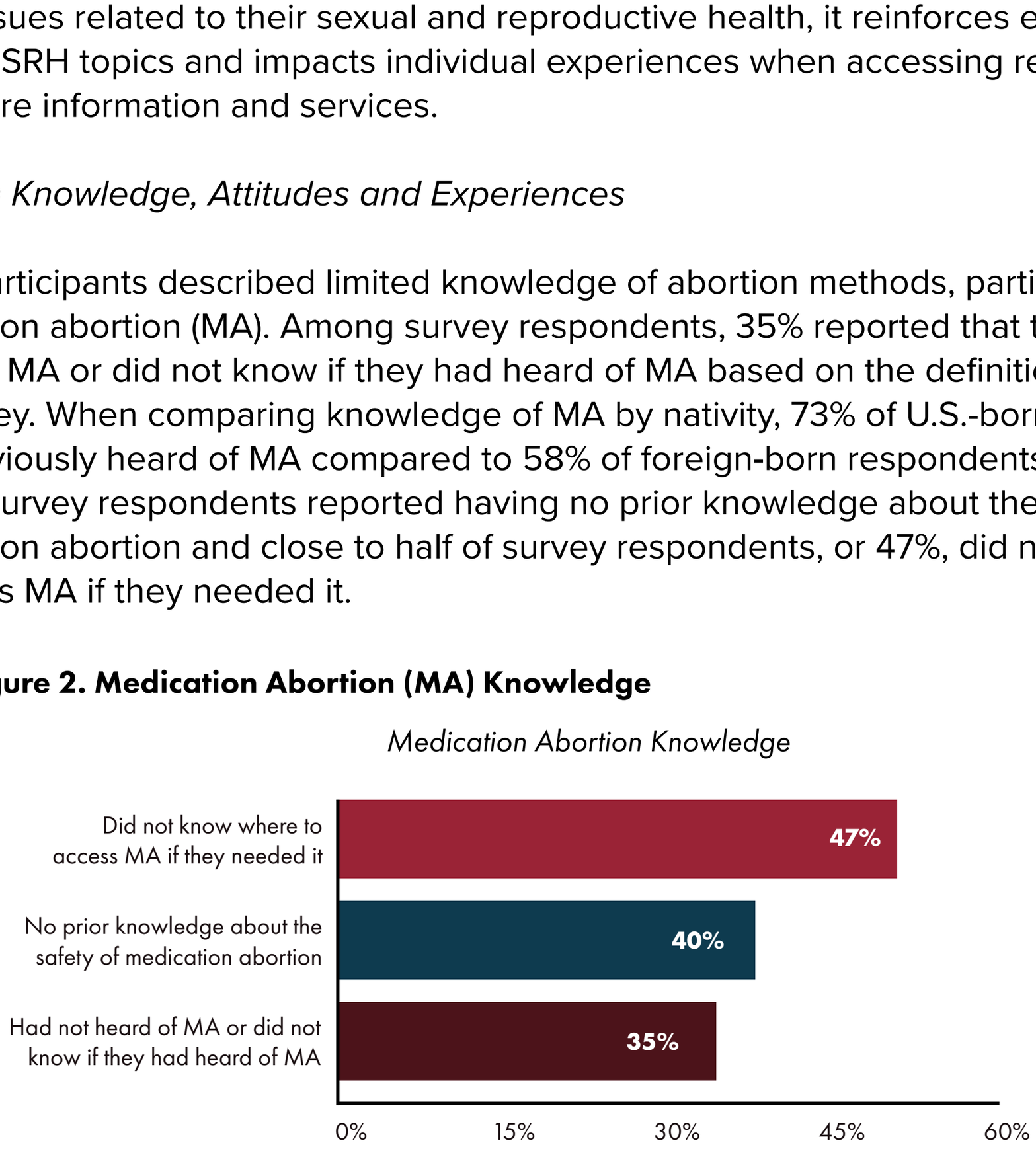
> *"There's not really any [resources] even in our local Japantown. There's not even any literature about medical [medication] abortion."*
>
> **– Asami**, Japanese IDI Participant

Overall, the taboo nature of SRH issues within AANHPI communities leads to a lack of openness related to SRH topics. When community members are forced to keep silent about issues related to their sexual and reproductive health, it reinforces existing attitudes towards SRH topics and impacts individual experiences when accessing reproductive healthcare information and services.

Abortion Knowledge, Attitudes and Experiences

Study participants described limited knowledge of abortion methods, particularly medication abortion (MA). Among survey respondents, 35% reported that they had not heard of MA or did not know if they had heard of MA based on the definition provided in the survey. When comparing knowledge of MA by nativity, 73% of U.S.-born respondents had previously heard of MA compared to 58% of foreign-born respondents. Additionally, 40% of survey respondents reported having no prior knowledge about the safety of medication abortion and close to half of survey respondents, or 47%, did not know where to access MA if they needed it.

Figure 2. Medication Abortion (MA) Knowledge



[15] Kim, J. Data privacy concerns make the post-Roe era uncharted territory. https://www.npr.org/2022/07/02/1109565803/data-privacy-abortion-roe-apps

When discussing knowledge of different abortion methods, IDI and FGD participants spoke to the misinformation they heard in their communities. Some participants shared that they previously thought procedural abortions were the only available abortion method and had negative imagery associated with the procedure. For example:

> *"I think [procedural abortion] might involve a certain degree of trauma [as] an invasive surgical procedure. So, it could cause a greater degree of trauma both physically and mentally."*
>
> – **Chang**, Chinese FGD Participant (*response translated from Mandarin)

> *"I've only heard that the medication exists, and I don't know much about the side effects. But when I heard about it, I think I was personally relieved…if you watch movies or TV, there are so many abortions that are shown to be so violent… So if I have to make a decision like that, I would definitely choose medication. You can do it privately in your private room and you just swallow [pills]."*
>
> – **Jung Soo**, Korean FGD Participant (*response translated from Korean)

Even with prior knowledge of MA, some qualitative participants lacked a clear understanding of the difference between MA and emergency contraception.

By comparison, survey findings do not indicate a difference in knowledge of MA among those who took the survey in English and non-English languages. Whereas participants in non-English speaking focus groups overall described less knowledge of abortion methods and MA. For instance:

> *"Actually, I don't have any idea about [abortion] because I didn't see anybody do that… nobody had ever talked to me about this."*
>
> – **Nasrin**, Bangladeshi FGD Participant (*response translated from Bangla)

When provided with a definition of medication abortion, qualitative participants described it as being preferable over other abortion methods because they believed it was easier, less invasive, and more private. One participant described their previous experience with medication abortion as such:

> *"...before [doing it] I had no idea you could just take pills. I always thought that abortion was a...process with surgery, so I was very relieved to find out that I could do this option."*
>
> – **Emily**, Taiwanese IDI Participant

And when asked how their communities viewed the option of medication abortion, one participant shared:

> *"In my family...[medication abortion] would be the preferred method because it's less invasive. And I think the ability to do it from home or go to a clinic and take the pill and then come home for the recovery period...I think that would make more sense."*
>
> – **Hannah**, Asian American FGD Participant

Participants in this study overwhelmingly had little to no knowledge regarding MA, which was often attributed to the lack of openness around SRH topics in general. In fact, it was only after learning about the method that many participants described it as preferable for themselves and their respective community.

Barriers to Accessing Medication Abortion

This study also brought to light specific barriers to accessing an abortion. Qualitative participants recounted barriers to abortion care that have been documented in previous research among all racial groups as well as additional barriers unique to AANHPI communities. Those that have been identified in previous research include the high cost of abortion care and lack of insurance coverage, limited appointment availability, lack of transportation, legal restrictions, wait times at the clinic, and protesters outside of clinics.

While these additional barriers are common among all people seeking abortion care, some barriers such as high cost of abortion care may be particularly devastating for the large populations of AANHPIs living in states that severely restrict Medicaid coverage of abortion to the narrowest circumstance making it challenging for low-income AANHPIs to pay for their abortion.

> *"I wasn't able to make [the abortion appointment] in a time that was appropriate for me because I wanted it to be done as soon as possible. So I had to make an appointment in a different city and drive an hour and a half to get there [which] made it a little more difficult. [On] the night that I took the abortion pills, I booked a hotel because I didn't want to go through it at home.*

I was living with my parents at the time…[so] it was [an] extra cost and also extra work."

– **Ji-a**, South Korean IDI Participant

"… I was trying to figure out how much it [a medication abortion] cost because I couldn't find it [the cost] anywhere on their website, and I didn't want to be paying so much, because I was already going to pay so much money to go over to state. I ended up calling them again later and found out the medication abortion was like $500 or $600, even when they considered my income."

– **Emmy**, Cambodian IDI Participant

Qualitative participants also identified additional barriers to seeking abortion care due to stigmatizing attitudes towards abortion and SRH topics in their community. For example, participants regularly noted a lack of knowledge of abortion resources and methods because of a lack of openness with family members about these issues. One participant described this in her own community:

> *"…there's such a taboo in us even talking about [abortion]. If I had a greater…acceptance to freely talk about [it] then I probably would have had a better general understanding about what a medication abortion would have meant."*
>
> – **Nicole**, Japanese IDI Participant

Among participants who had sought abortion services, a lack of family support or not being able to share their decision with family members often led to feelings of isolation.

"When it comes to additional support I wish that it was something that I could have freely talked to my parents about, because they are a big part of my life. That would have been a great additional support…My partner was definitely more than enough but…I was living with my parents at the time, so having the people that I was living with like understand what I was going through and try to support me would have made a big difference."

– **Miyoung**, South Korean IDI participant

"I feel very isolated. Like I pretty much carry this experience with me and only like me right now but…I've never really talked to my family about it, so during that time, nobody knew. I don't know if – if barrier was – is the right word,

> *because I feel like I was going to have to find a way regardless, so I just think maybe it's not a barrier, but it kind of just sucked having to go through that alone."*
>
> – **Shruthi**, Asian Indian IDI participant

When accessing abortion services, a dearth of language options at clinics was identified as another barrier specific to AANHPI communities. One participant described the limitations of language and translation services as follows:

> *"There's no Urdu option available when I did the initial intake phone call…they asked if I needed any translation needs or anything like that…while I do applaud the clinic for offering any sort of translation services…Urdu is not a very rare language…millions of people speak it. And, so, to me, I definitely do think that offering a more inclusive language option would be great."*
>
> – **Ghazal**, Asian Indian Participant

Among survey respondents who previously had a procedural or medication abortion, 61% reported experiencing at least one of the common community-related barriers, identified by qualitative participants, when seeking or receiving abortion care. Most commonly, survey respondents reported: 1) personal religious or moral concerns (37%), 2) they had concerns about the method of abortion (35%), 3) someone close to them not wanting them to have an abortion (33%), and 4) barriers related to arranging childcare or care for another family member (27%). Given financial and logistical barriers are common types of barriers among all abortion seekers in the U.S.,[16,17] these community-related barriers are likely experienced in addition to barriers captured among IDI participants in this study.

> *"…one [barrier] is like, you know, knowledge of [medication abortion], like if somebody grows up only thinking like an abortion's like, "oh, the doctors are going to slice you open and take the fetus out", like that's one thing. Another I think is like distance to travel and not everybody has access to a car, and not all public transport goes close enough to an abortion facility or an abortion provider…I think Hawaii has one Planned Parenthood."*
>
> – **Ane**, NHPI FGD participant

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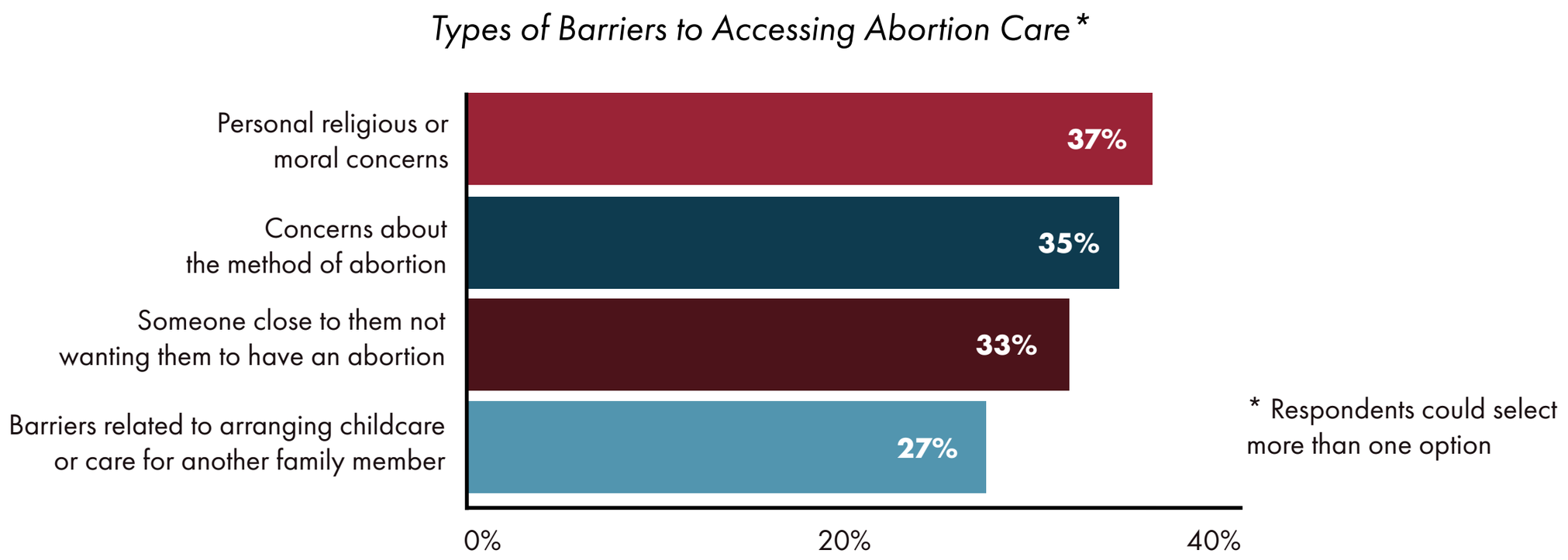
[16] Blanchard, K., Meadows, J. L., Gutierrez, H. R., Hannum, C. P., Douglas-Durham, E. F., & Dennis, A. J. (2017). Mixed-methods investigation of women's experiences with second-trimester abortion care in the Midwest and Northeast United States. Contraception, 96(6), 401–410. https://doi.org/10.1016/j.contraception.2017.08.008

[17] Jerman, J., Frohwirth, L., Kavanaugh, M. L., & Blades, N. (2017). Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States: Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States. Perspectives on Sexual and Reproductive Health, 49(2), 95–102. https://doi.org/10.1363/psrh.12024

Figure 3. Community-related Barriers Accessing Abortion Care



In the face of these barriers, qualitative participants in this study expressed a desire for open conversations about SRH topics within their family and more AANHPI-specific abortion stories, as well as the need for culturally sensitive post-abortion support groups and counseling services.

Conclusion

For AANHPI people of reproductive age, a salient stigma towards sexual and reproductive health topics often leads to detrimental knowledge gaps about different abortion methods, including medication abortion. This cultural stigma is further exacerbated by a dearth of language options when navigating abortion care inside clinics and healthcare settings. As our study illustrates, this reality both creates and perpetuates a cycle of isolation, secrecy, and information deficit for AANHPI people seeking abortion care.

Access to reliable and accurate information about different abortion methods is critical in states and cities with large AANHPI populations, especially in local communities with less robust public health programs. With bans and restrictions to abortion care increasing across the country, AANHPI communities need more culturally sophisticated and language-appropriate information on sexual and reproductive health issues, and specifically about abortion. Community-based organizations and providers serving large immigrant, limited-English proficient (LEP) populations will be integral to dismantling common misconceptions and misinformation related to abortion care. In addition, culturally competent intake specialists and medical providers at abortion clinics and health centers are equally important to removing access barriers to sexual and reproductive healthcare within AANHPI communities.

Resources

To learn about different methods of abortion go to: Abortion Procedures – Advocates for Youth. If you need/want reliable information about abortion and other sexual/reproductive health topics all in one place, download Euki for free (on the App Store and Google Play). Euki is completely anonymous and secure and does not store any data or tracking info. For more information about other resources and ways to secure your data, particularly related to information about abortion, go to: https://digitaldefensefund.org/learn.

If you or anyone you know needs an abortion: go to www.ineedana.com to find a clinic. If seeking financial or logistical support, find and contact a local Abortion Fund. If seeking legal support go to Repro Legal Helpline.

Suggested Citation

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Community Advisory Board Members

About NAPAWF

The National Asian Pacific American Women's Forum (NAPAWF) is the only multi-issue, progressive, community organizing and policy advocacy organization for Asian American and Pacific Islander (AAPI) women and girls in the U.S. NAPAWF's mission is to build collective power so that all AAPI women and girls can have full agency over our lives, our families, and our communities. For more information, visit napawf.org or email info@napawf.org.

About Ibis Reproductive Health

Ibis Reproductive Health is a global nonprofit driving change through bold, rigorous research and principled partnerships that advance sexual and reproductive autonomy, choices, and health worldwide. We believe that research can catalyze change when the entire process is viewed as an opportunity to shift power, is undertaken in partnership with the communities most impacted, and includes a focus on how data can be most effectively used to make change. We focus on increasing access to quality abortion care, transforming access to abortion and contraception through technology and service innovations, and expanding comprehensive sexual and reproductive health information and services. Ibis works with partners in more than 30 countries on six continents. For more information, visit ibisreproductivehealth.org.

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