

**NEW YORK CITY
ASIAN AMERICAN**
Organizing Blueprint
FOR REPRODUCTIVE JUSTICE





Contents

	Acknowledgements	03	Letter from Authors	04	
Terminology and definitional considerations	06	Introduction	07	Who are our respondents?	10
What's getting in our way of accessing the care we need?	12	What can we do to change this?	22	About the Authors	30

Acknowledgements

Many people have supported us, both in this project and our growth as organizers. We would like to thank and acknowledge:

the Lenape, who are the native people of Mannahatta / Lenapehoking. We live and do our work on land that is stolen,

our Asian and Asian American women, trans, and gender non-conforming ancestors who have given us the tools and knowledge to survive and do this work,

the NYC Fund for Girls & Young Women of Color managed by The New York Women's Foundation for their radical generosity in supporting our work,

our partners at Desis Rising Up and Moving (DRUM), Divine House Cooperative, Housing Works, Judson Memorial Church, Planned Parenthood of New York City, Project Reach, Sakhi for South Asian Women, and Womankind for offering their physical space, time, and energy to us,

Preston Van Vliet, National Campaign Organizer at LGBTQ Work-Family Project (a Joint Initiative of A Better Balance and Family Values @ Work) for his help on shaping questions on family definition,

past and present staff at NAPAWF who have helped the development of this work, including Roula AbiSamra, Satyam Barakoti, Leng Leng Chancey, Sung Yeon Choimorrow, Aliya Khan, Melissa Kwon, Mohini Lal, Ashley Moy-Wooten, Christine Posadas, and Miriam Yeung,

individual donors who financially supported us,

and our 242 participants who generously shared their time, creativity, and brilliance.



Dear reader,

The journey to this blueprint started for us in September 2016, when we, a group of sixteen young Asian and Asian American women, trans, and gender non-conforming people living in New York City, started working with the National Asian Pacific American Women's Forum (NAPAWF) through the Reproductive Justice Leadership Institute (RJLI). We come to this work as students, social workers, educators, healthcare workers, community organizers, technologists, artists, performers, (and more!) who are committed to the Reproductive Justice framework that centers the power of women, trans, and gender non-conforming people of color to make decisions for their own bodies, families, and communities. It's hard to believe that we were mostly strangers to each other back in September!

We conducted community-based research to inform our ongoing and future organizing for Reproductive Justice in our communities. This meant creating spaces for young Asian and Asian American women, trans, and gender non-conforming people to connect, strategize, and organize with each other. Our driving question was: "What are the barriers to meaningful access to reproductive and sexual health care in NYC for Asian and Asian American women, trans, and gender non-conforming people ages 18-35?" To answer this question, we created and circulated a survey, conducted four focus groups, and held a community forum. A total of 242 community members were involved in this process.

We are excited to share the insights we've found in our research with you. This page contains the highlights of our findings and the rest of this blueprint delves into more detail. Our hope is that this research and these recommendations will bolster our work in holding local policy makers, health care providers, and community workers accountable for the needs of our communities. Thank you for joining NAPAWF in our work to build grassroots political power for AAPI women, trans & GNC folks. We hope that this information is as meaningful to you as it is to us!

Barriers to meaningful access to reproductive and sexual health care

- The political and social positioning of Asians and Asian Americans in the U.S.
- Internalized oppression amongst our communities and families of origin
- Experiences and fear of identity-based violence
- The relationships we rely on when we need care are not legitimized in the current medical system
- The sex education we receive(d) is incongruent with our bodies and experiences
- Providers are not equipped to competently address the needs of our communities
- Existing systems and processes for finding providers are inadequate
- The healing practices we often turn to are not institutionally supported
- Federal and state policies limit our health care options



Recommendations towards a vision of Reproductive Justice

- Commitment to anti-oppression in organizing practice
- Shared education around the political and social positioning of Asians and Asian Americans in the U.S.
- Conversation spaces around mental health, sex, sexuality and gender
- Intergenerational organizing spaces
- Support the work of Black, Arab, Muslim, and trans organizers against police violence
- Community alternatives to policing
- Legislation that protects survivors of violence
- More inclusive and realistic definitions of family in legislation
- New media representation of queer and non-western family structures
- Accountable implementation of local law 2017/090
- Community-based sex and gender education programs
- New multilingual online media on sex and gender in our communities
- Anti-oppressive curriculum for medical, psychology, and social work school
- Training for NYC health care providers by our communities
- Community education on non-western healing practices
- Expansion of public insurance coverage to include non-western medicine
- Crowd-sourced resources on community-recommended providers
- Alternative community-based structures of support
- Passage of New York City and New York State legislation that supports Reproductive Justice within our communities



Terminology & definition considerations

These are some of the terms we will be using in this blueprint. We recognize that many of these words hold different meanings in different contexts and that English is the limited language of our colonizers. Here are some definitional considerations on how we are using these terms.

Asian American

A term used to describe panethnic identities that includes U.S. residents with ancestral origins in South Asia, Southeast Asia, and East Asia.

Cisgender

Denoting or relating to an individual whose gender identity is aligned, according to a society's expectations, with the sex (most often male or female) they were assigned at birth. For example, a cisgender woman, or cis woman, is someone who was assigned female at birth and identifies as a woman.

Chosen family

A group of individuals who do not have blood or legal connections but are tightly knit and consider each other family.

Family of origin

The significant caretakers and siblings that a person grows up with or the first social group a person belongs to, often a person's biological and/or legal family.

Gender

The relationship a person has to masculinity, femininity, both, or neither. It could include internal understanding of oneself (gender identity) and external manifestations (gender expression).

Gender binary

The classification of sex and gender into two distinct, opposite, and disconnected forms of masculine and feminine, or male

and female. The binary tells us that a person's sex and gender can only be one of two opposing things. We are given gender roles which tell us what kind of behaviors are acceptable for a person of a given gender; for example, men are supposed to be unemotional and tough, while women are supposed to be passive and caring.

Gender non-conforming (GNC)

Denoting or relating to a person whose behavior or appearance does not conform to prevailing social expectations about what is appropriate to their gender, regardless of their gender identity or sexual orientation. Not all GNC people identify as transgender, nor are all transgender people GNC.

Non-binary

Denoting or relating to a person who does not subscribe to the gender binary and identifies with neither, both, or a combination of masculine and feminine genders.

Queer

A term used to refer to a sexual orientation, gender, or gender expression when it does not conform to societally enforced norms.

Sex

A category that people are assigned at birth, typically by a medical professional, based on the genitals, chromosomes, and hormone levels a person is born with. Many people are assigned "male" or "female" at birth. People who were born with

chromosomes, gonads, and/or genitals that vary from normative male and female standards may describe themselves as intersex. A former medical term, intersex has been reclaimed by intersex people as a personal and political identity.

Sexual orientation/sexuality

To whom an individual is physically and/or emotionally attracted to, often categorized by gender. Some examples of sexualities are queer, lesbian, bisexual, and gay. Sexual orientation is distinct from gender.

Transgender (also trans, trans*)

People whose gender identity is incongruent with what society deems as appropriate for their sex assigned at birth. Some trans people identify and present themselves as either a man or a woman; others identify with a non-binary gender category. Trans people describe themselves by many different terms, some of which are specific to local cultures, including transsexual, fa'afafine, travesti, hijra, genderqueer and transpinoy, to name just a few. Many people have started to use transgender, trans, trans* or T/GNC as a term referring to the entire range of possible gender identities that fall under the broad definition.

Undocumented

An immigration status that refers to people who do not have legal paperwork to live in a given country.

Introduction

Our research question

What are the barriers to meaningful access to sexual and reproductive healthcare for Asian and Asian American women, trans, and GNC people ages 18-35 living in New York City?

Who are we?

In the fall of 2016, we, a group of sixteen Asian and Asian American women, trans, and gender non-conforming people between the ages of 20 and 27 living in New York City, came together through the Reproductive Justice Leadership Institute (RJLI) by the National Asian Pacific American Women's Forum (NAPAWF). NAPAWF is a national, multi-issue community organizing and policy advocacy organization for Asian and Pacific Islander (AAPI) women, trans, and gender non-conforming people in the U.S. One part of NAPAWF's work is RJLI, a year-long program that aims to give young AAPI organizers the training and tools they need to advocate for their communities.

Why research?

To shape our future organizing

We understand research to be a crucial step in the process of building power through community organizing. In order to know what our communities need, we sought to deepen our understanding of the experiences faced by young Asian and Asian American women, trans, and GNC people in NYC around Reproductive Justice. This information will ultimately shape how we and future RJLI cohorts organize for the wellbeing of our communities.

To fill the data gaps that exist

With a population of over two million Asian Americans, New York City is home to the second largest Asian American community in the United States (Asian Americans Advancing Justice, 2013). Asian Americans are not only extremely diverse, but are also the fastest growing population in New York City. Nevertheless, many

data collection efforts in NYC treat Asian Americans as a homogenous group or ignore us entirely. As a result, the wellbeing of Asian Americans in New York City is not adequately understood and is often disregarded by funders, government officials, policy makers, and service providers. Concrete data on our communities' reproductive and sexual health is sparse, largely outdated, and often leaves out the voices and experiences of those who are most affected by injustice.

Previous studies reporting on our sexual and reproductive health cited barriers to accurately capturing the experiences of Asian Americans. Some of these barriers were limited English proficiency and small sample sizes of some ethnic groups (Kim and Keefe, 2010). Those past studies suggest that high poverty rates, language access, community stigma, violence, lack of access to information, barriers to help seeking, and lack of access to insurance may influence disparities in sexual and reproductive health care access among Asian Americans (Firdous, 1989; Kim and Keefe 2010; Bhushan, 2010; Ngo-Metzer 2004). While this information is valuable, our research seeks to fill gaps left by this data.

To build power in our communities

For many of us, the process of building power with other Asian and Asian American women, trans, and GNC people is transformative. Like many people of color in the United States, we have been denied access to our histories of resistance and taught that our needs and stories do not matter. Gathering with each other to heal, learn our own strength, and connect our communities has been an essential part of our research process.

How did we do the research?

Reproductive Justice Framework

We strive to organize through the Reproductive Justice (RJ) movement-building framework that was articulated and coined by Black women in the early 1990s. RJ, as defined by SisterSong, is “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.” The intersectional RJ framework recognizes that the mainstream reproductive rights movement has centered white, middle-class cis women who tend to focus on individuals’ choices around abortion and contraception. Instead, RJ centers the power of women, trans, and GNC people of color to make decisions for our own bodies, families, and communities and works to dismantle the systems of power that prevent access to resources and services. As SisterSong frames it: “Even when abortion is legal, many [people] of color cannot afford it, or cannot travel hundreds of miles to the nearest clinic. There is no choice when there is no access.” In order to improve meaningful access to reproductive health care for Asians and Asian Americans in NYC, we must understand how different structures (family, immigration, policing, etc.) influence our communities’ ability to get the care we need.

Principles of community based participatory research (CBPR)

Our approach is grounded in principles of community-based participatory research (CBPR). As opposed to more traditional research practices where researchers enter a community that is not their own to conduct studies, our






process was conducted by, in, and for our communities with the goal of direct benefit and sustained involvement of affected community members. Our research process is shaped by our belief that our communities possess the knowledge of our own experiences and are best equipped to develop strategies to address the challenges we face. The sixteen of us are members of the communities we researched with and have deep, personal commitments to their wellbeing.

Community members not only drove our research, but also carried out all components of the process, from problem definition to data analysis. We collectively developed and administered data collection instruments, created outreach materials, and planned community engagement events. Throughout this process, we worked to increase the skills and capacity of not only our co-fellows, but also the broader community. Members of our communities strengthened their skills and knowledge of Reproductive Justice, survey design, fundraising, facilitation, copywriting, editing, and event planning.

Intention setting

Our process of problem definition and method development was a product of a series of discussions about our experiences as young Asian and Asian American women, trans, and GNC people living in NYC. While determining our research topic and methods, we agreed on community intentions to guide our process, determine our values, and ensure the sustainability of working together.

Some of our community intentions

-  *We will not refer to Reproductive Justice issues as “women’s issues.”*
-  *We will give voice to experiences born out of pain.*
-  *We will remember there is no quick fix.*
-  *We will make room for stumbling.*
-  *We will invest in these friendships.*

Our research process

While our RJLI cohort includes a wide range of cultural backgrounds, identities, and experiences, we are not representative of the full diversity of Asians and Asian Americans living in NYC. For this reason, we strove to learn with and from a broader group of people. In order to gather descriptive data on our communities and uplift the voices and experiences of our fellow community members, we chose a mixed methods approach that included a survey, a series of focus groups, and a community forum.



Survey

Designed by RJLI fellows, the questionnaire was administered through Survey Monkey. It asked questions about identity, experiences with government and healthcare institutions, health care choices, preferences, and experiences. The survey had 242 respondents in total, and all of them were invited to the next two steps in our process: the focus groups and community forum.



Focus Groups

We selected four identities (queer, T/GNC, non-citizens, and South Asian) for four focus groups to further explore the experiences of individuals whose narratives are often left out of studies on Asian and Asian American communities. In addition to providing critical information, the focus groups were centers of community development. Following the focus groups, we reviewed the data to identify trends and themes.



Community Forum

We invited 40 community members to participate in issue cutting and solution development by holding a community forum on May 5th, 2017. During the forum, we presented preliminary data from our focus groups and survey. In addition, we invited forum participants to share their personal experiences relevant to the emerging themes and to develop recommendations to address challenges they face.

Throughout the data-collection process, participants learned about Reproductive Justice, identified common experiences alongside other community members, and reflected on the nuances of identities and experiences they did not share. We, along with participants, grew in our power, gained access to resources, and built relationships with one another.

Who were our respondents?

We reached 242 unique participants in our survey, some of whom later participated in our focus groups and community forum. The following graphs illuminate the demographic identities of those who participated in our process.

242

unique
participants

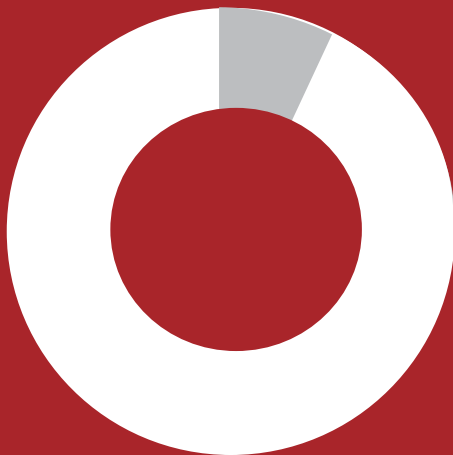
36%

do not identify
as cisgender

51%

are not employed
full-time

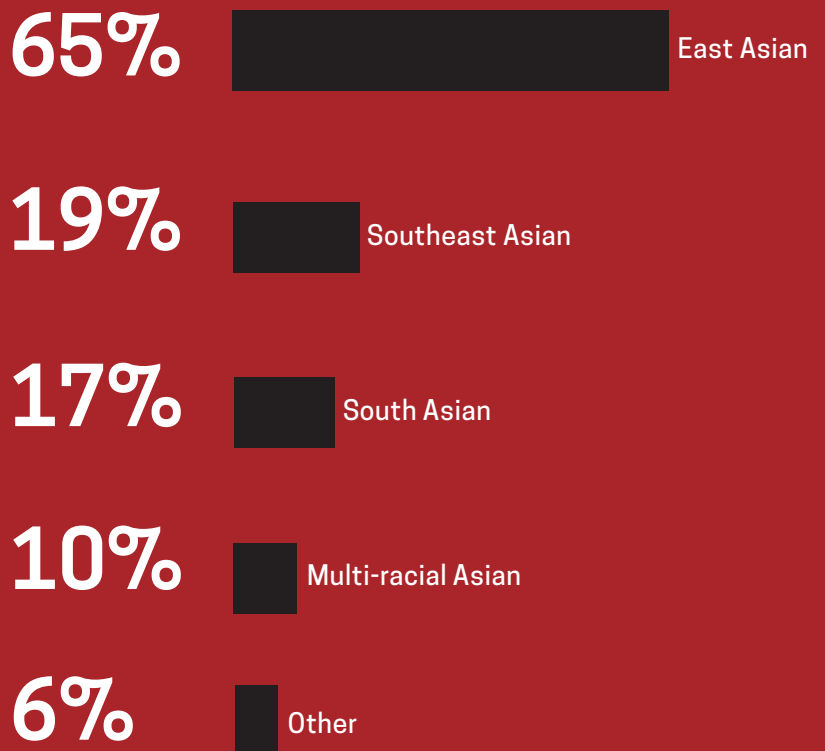
LANGUAGE



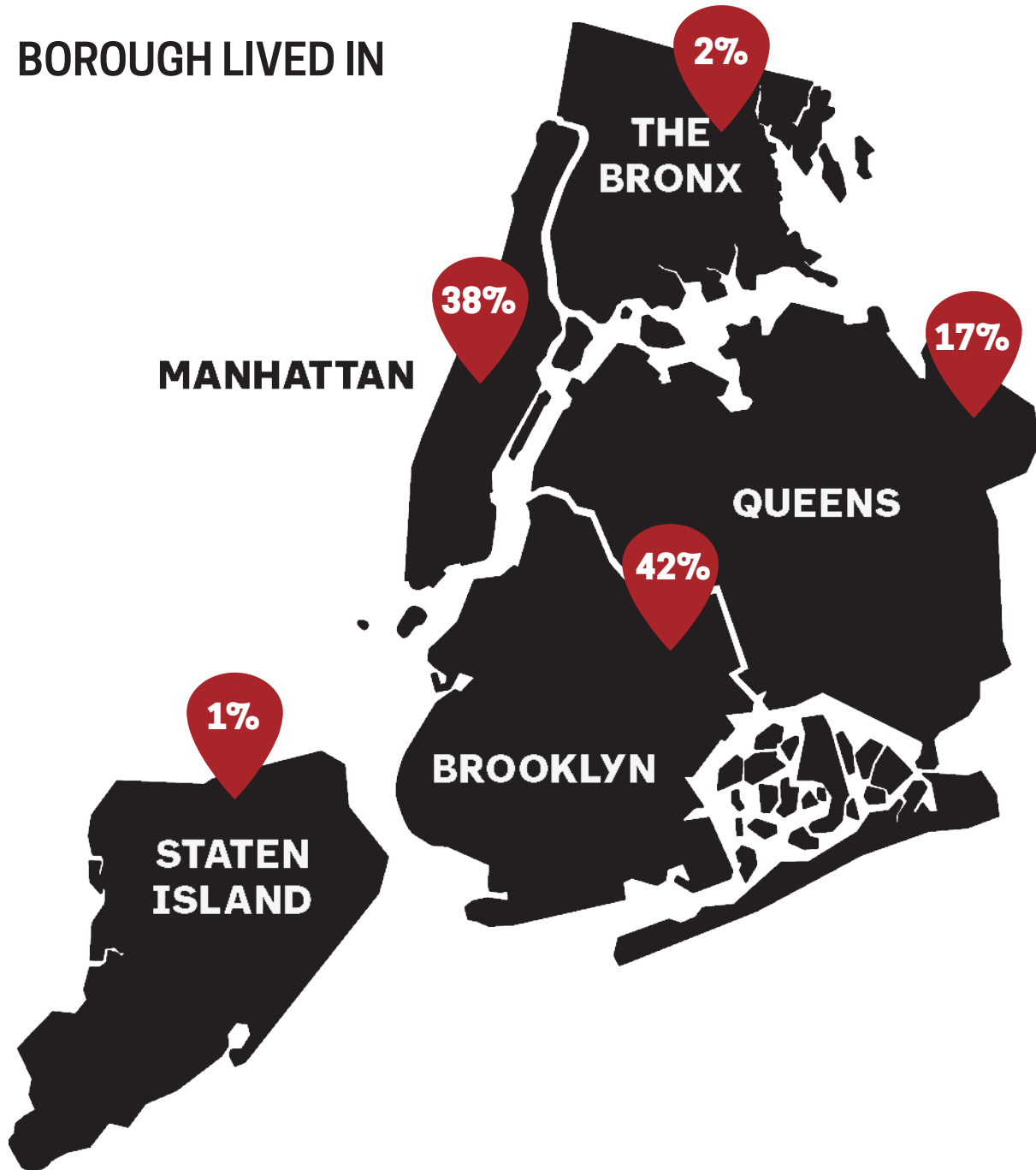
88%
feel most comfortable
communicating in English

12%
feel most comfortable
communicating in a
language other than English

ETHNICITY



BOROUGH LIVED IN



What's getting in our way of accessing the care we need?



49%

Discomfort with provider

Almost half of the respondents said that they are unable to find a health care provider that makes them feel comfortable.



35%

Financial instability

Over a third of the respondents did not agree with the statement "I am able to financially support myself."



71%

Poor mental health

Under a third of the survey respondents reported very good or good mental health in the last year.

Taking time off work



3 in 10 respondents are not able to take time off work to access health care.

76%

Experienced harassment in public, workplace, or at school.



The survey data we gathered makes it clear that our communities are facing many barriers to meaningfully accessing reproductive and sexual health care. For example, we found that almost a third of respondents have been turned away from a health care provider for reasons such as their inability to pay, insurance mismatches, and discrimination.

Community members identified that the barriers to accessing meaningful reproductive and sexual health care stemmed from **structural oppression**, specifically the political and social positioning of Asians and Asian Americans in the United States and the ways that this has been internalized by our communities and families of origin over time. Structural oppression causes experiences and fear of identity-based violence. We also found that this oppression manifests itself in a **medical system that does not support the needs of young Asian and Asian American women, trans, and GNC people**.

Structural Oppression

The political and social positioning of Asians and Asian Americans in the U.S.

While the challenges of accessing reproductive and sexual health care are typically measured on an individual scale, our community members consistently referred to the structural origins of the barriers. A central concept in our discussions was the model minority myth. First coined in the 1960s, the model minority myth cast Asians as obedient, hard-working, asexual, and intelligent when directly compared to other people of color, especially Black people, in an effort to divide solidarity efforts during the Civil Rights Movement (Wu, 2014). This myth designates Asians as the “good” people of color who do not challenge white supremacy.

Asians’ mythical ability to access high economic statuses is used to blame other people of color for their own hardship. This veils the wide income disparities amongst Asians. It gives Asian communities, particularly East Asians, proximity

to whiteness and the social and political capital that comes with whiteness. This myth emphasized rigid “Asian” family structures, featuring strict parenting and chaste morals (Office of Planning and Research, United States Department of Labor, 1965).

Despite our proximity to whiteness, Asians and Asian Americans in the U.S. have been deliberately designated as perpetually foreign and unable to fully assimilate into American culture. Asian cultural practices are rendered exotic yet illegitimate, tantalizing yet barbaric. While some are lifted up in tales of success, South and West Asian communities in particular have been cast as dangerous and been the target of increased policing and violence. The paradoxical positioning of our communities as passive, asexual nerds in orderly families practicing alien cultures was and is a political strategy to dehumanize us, impacting the way we are able to access reproductive and sexual health care in the U.S. today.

Internalized oppression amongst our communities and families of origin

Throughout this research process, our community members reflected on the ways that these myths have been internalized in our present family and community relationships and structures. The expectation of being a model minority often expressed itself through shaming and avoiding sexuality. Many of our focus group participants shared that conversations regarding mental health, sexual health, and gender were nearly nonexistent growing up, and most still felt that it was culturally expected to never talk about these topics with family members. As one focus group participant shared, “Culturally, in my family, mental illness as a concept is so undesirable and unwanted and taboo. Talking about it is not something that I feel like is valued in my family, for that kind of treatment, I guess, or way of coping. When I did have a therapist... I heard my family’s voice say to me, this takes up time, money and resources that I don’t have” (Southeast Asian, trans femme, U.S. Citizen, queer).

The stigma attached to these conversations is made more complicated by the fact that many of our families of origin communicate in languages other than English. In our community forum, a trans participant shared that even after figuring out how to talk about sex and gender in English, they did not know how to find the words in Cantonese to begin a conversation with their mother.

For some, the internalized oppression within families impacted who and where they go to for health care. One participant expressed concern about going to providers who share their ethnic identity because of confidentiality issues within small communities: “I think it’s just a general paranoia in seeing gynecologists or even therapists. A paranoia that somehow this information will get out [to my community]. Whether it’s a phone call to my house, because that’s the number on record. Because things of sexual nature are so taboo, and Muslim, South Asian women, they’re even more intense” (South Asian, cis woman, U.S. citizen, queer). Another participant echoed this sentiment: “When I first wanted to go on the pill in 2011, instead of going to a local gynecologist, I went to the Planned Parenthood on Bleecker because I didn’t want my mom to find out from Chinese aunties. Like, ‘Oh I saw your daughter at this gynecologist’s office, what was she doing there?’” (East Asian, cis woman, U.S. citizen, queer). The fear of information about

“My mom still whispers the word ‘gay’ when she HAS to say it. There’s no way I could ever bring up sex with her, much less sex work, my gender... I mean, there’s love but there is also so much pain.”

(East Asian, trans, approved visa, queer)

their identities and experiences being released to families and communities makes accessing convenient and affirming health care very difficult and sometimes prevents our community members from seeking care at all.



“When I first wanted to go on the pill in 2011, instead of going to a local gynecologist, I went to the Planned Parenthood on Bleecker because I didn’t want my mom to find out from Chinese aunties. Like, ‘Oh I saw your daughter at this gynecologist’s office, what was she doing there?’”

(East Asian, cis woman, U.S. citizen, queer)

Experiences and fear of identity-based violence

Structural oppression also results in our communities facing violence. More than a third of respondents disagree that they are able to live without fear of violence from individuals or the government, and cisgender respondents were more likely to agree that they are able to live without this than trans respondents. National statistics on reported violence corroborate this fear by showing that trans people disproportionately experience hate violence. In 2016, The National Coalition of Anti-Violence Projects (NCAVP) found that 32% of the reports of hate violence across twelve anti-violence organizations were committed against trans and GNC people.

Statistics on intimate partner violence in Asian and Asian American communities are also severe. 41 to 61% of Asian women report experiencing physical and/or sexual violence by an intimate partner in their lifetime.

In 2016, CAIR, the largest Muslim civil rights organization in the U.S., found that anti-Muslim hate crimes increased 44% from 2015. Many of our community members are perceived as being Muslim or actively practice Islam.

These numbers are sobering and highlight the history of trauma that our communities carry. The ability to live without fear of violence is a crucial part of our vision for Reproductive Justice.

I agree that I am able to live without fear of violence from individuals or the government



The current medical systems do not support us and our needs

The relationships we rely on when we need care are not recognized in current medical systems and other legal protections

Our data revealed that our communities heavily rely on chosen family when navigating healthcare systems, demonstrated by the fact that 97% of

20% of respondents who said they would turn to their family of origin.

Current laws do not capture our reliance on non-biological and/or legal families. Paid leave laws for workers fail to include use of leave for self-care or caregiving for chosen family. Additionally, hospital visitation policies cover only biological or

76% of respondents indicated that they would rely on their chosen family over their spouse or family of origin for caretaking and other forms of support if they had to take time off work for health-related reasons.

our respondents stated that they believe chosen family is a valid and important part of an individual's network. When feeling mentally unwell, 70% of our respondents said they would turn to their chosen family-- a significantly higher percentage than the

legally recognized relationships. Our communities' inability to legally rely on our most important networks when navigating the healthcare system threatens our meaningful access to sexual and reproductive health care.

“My [blood] family has no say on what I do. I’m independent from them financially... It’s so much better for my mental health to keep my personal health separate from them. My friends have been my biggest supporters in terms of access to mental health. It’s more of a found family thing than a blood family thing in my life.”

(Southeast Asian, non-binary, U.S. Citizen, queer)

The sex education we receive(d) is incongruent with our bodies and experiences

Many participants in our focus groups reflected on how their current knowledge and practice of reproductive and sexual health care was negatively impacted by receiving inadequate sex education. Overwhelmingly, the sex education that our communities received was focused on reproduction-only sex for straight, cis people. This education often reinforced the social need to adhere to strict gender roles, which are particularly harmful lessons for the trans and queer members of our communities. Many participants recall abstinence being touted as the only option for pregnancy and sexually transmitted infections (STI) prevention, as well as for social acceptance. Consent, respect, and pleasure were noticeably absent from conversations about sex.

“[My sex education growing up had] no mention of queer people, no mention of consent or other social ethical dimensions of sex, [it was] just biological and pathologizing.”

(East Asian, trans femme, U.S. citizen, queer)

Because our communities’ identities and experiences were excluded from our formal sex education, many of our community members turn to their peers and the internet for information on reproductive and sexual health. As one focus group participant remembered, “Tumblr.com was my sex ed teacher” (East Asian, non-binary, U.S. citizen, queer). While peers and the internet can be highly accessible sources, the information received tends to be inconsistent.

In 2011, New York City required public middle and high schools to teach sex education to their students. This law only applies to NYC, not New York State. However, the implementation of this requirement is inconsistent depending on the school district and funding. One of our respondents noticed that in her experiences working as an advocate in public schools, some schools did not have

“I grew up here, and you would think that in New York City that the sex ed would be decent or less conservative... but nope. They split the boys into one room and the girls into another and talked about STIs the whole time.”

(East Asian, non-binary, U.S. citizen, queer)

sex education because there were no educators who would teach it. Having sex education that affirms our bodies and experiences is crucial in reaching our vision of Reproductive Justice.

Providers are not equipped to competently address the needs of our communities

Another problem shared by many community members was the experience of discrimination and shaming when discussing their reproductive and sexual health with health care providers. Many participants felt as if their providers did not understand core parts of their identity (such as sexuality, gender, race, etc.) and that assumptions were made about their experiences. These encounters made them uncomfortable and less honest with providers. 2 in 5 of our respondents have health care providers who do not know their correct sexual orientation, yet most of our community members indicated a strong desire to be able to be open with their providers about their lives without fear of discrimination. This finding aligns with a study conducted by Zhao, Lau, Vermette, Liang & Flores (2017), which found that Asian American teenagers often lie to



“I’ve straight up been ignored by doctors who see that I’m a Muslim woman who wears a hijab and assume that I don’t have a sexuality.”

(South Asian, cis woman, U.S. citizen, queer)

their health care providers about their sexual health and desire their providers to be more aware of their cultural context. Additionally, nearly half of respondents indicated that their health care providers do not use the anatomical words they want for their body that affirm their gender. The impact of this is most strongly felt for trans folks. More than 75% of respondents indicated that their care is limited to strict “male” and “female” categories, making care for those of us who are trans and/or gender non-conforming particularly hard.

These situations caused some of our community members to fear going to health care appointments and/or to feel like they had to educate their providers. This frustrated a focus group participant, who said, “I didn’t sign up to do all of this stuff for my care provider. They’re the ones who are supposed to be taking care of me” (East Asian, cis woman, U.S. citizen, queer). Our experiences with providers who do not understand our needs often deter us from seeking out health care.

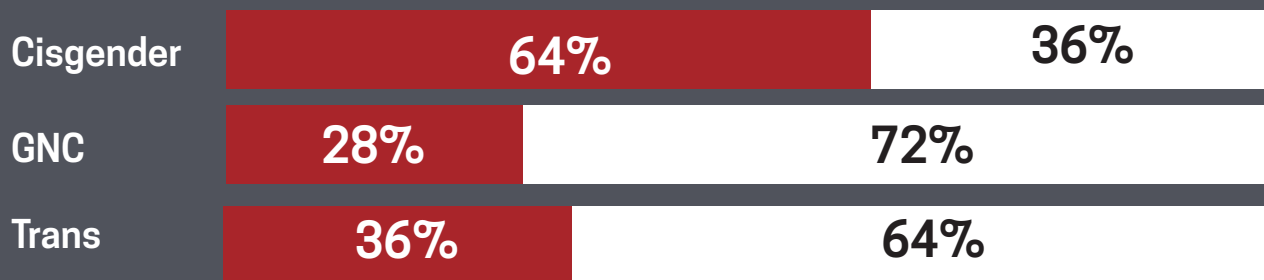
**2
in
5**

respondents have providers who do not know their correct sexual orientation

“When I went to the OB-GYN it was so uncomfortable, it’s just like everyday interactions where people just assume [you are cisgender]. I don’t know if I should correct you... I generally don’t.”

(East Asian, non-binary, U.S. citizen, queer)

Comfort discussing reproductive health with provider



Comfortable
 Uncomfortable

“I feel like I’m going through a phone book and don’t know who to choose, like who will be good to me.”

(South Asian, GNC, U.S. Citizen, queer)

Existing systems and processes for finding providers are inadequate

Identifying health care providers that treat us well and make us feel comfortable is an arduous process for many of our participants. Based on our survey data, most of our community members find their provider through their insurance plan’s search engines (70%), on the internet (50%), and through recommendations from friends (45%).

Many of our participants vocalized anxiety around being unsure about how a provider would treat them based on existing online systems. One participant said, “I generally base [which provider to choose] off of the doctor’s photo, book and see what happens...” (East Asian, GNC, U.S. citizen, queer). This randomness was particularly difficult for queer and trans people: “It would be nice if ZocDoc had icon for queer-friendly doctors. You often don’t know. When people rate doctors on ZocDoc it’s just ‘wait time was 5 minutes, she was nice,’ which is not actually helpful” (Southeast Asian, non-binary, U.S. Citizen, queer).

People with limited insurance plans have even fewer options and are less likely to find providers they are comfortable with. As one participant said, “It has just been so difficult to find a primary care physician at all. I’m on Medicaid, so there are quite a few doctors who take my insurance, but I feel like I’m going through a phone book and don’t know who to choose, like who will be good to me” (South Asian, GNC, U.S. Citizen, queer). Without the means to find providers with whom our communities feel comfortable, we often are not able to access meaningful care.

The healing practices we often turn to are not institutionally supported

By and large, the current healthcare system in the United States relies heavily on western medical practices. When asked what practices they turn to when they are feeling physically unwell, more than half of our survey respondents indicated that they would turn to a remedy that they cannot access from a western health care provider’s office. Some of the many healing practices that our participants mentioned in focus groups include acupuncture, cupping, scraping, herbs, reiki, and ayurvedic foods. Many shared that the methods that work best for them are methods that have been practiced by their families and ancestors.



Despite the importance of non-western healing practices to our communities, these practices are difficult to access through the current medical system in the U.S. As a GNC community member shared, “Going to the ‘official’ doctor is second to doing it myself. Personally, I am really interested in alternative and holistic medicine, acupuncture and massage, but that’s not covered by insurance. Food is not an aspect of health that is really considered here and that feels foreign to me. [There’s a] cultural disconnection” (East Asian, GNC, U.S. citizen, queer). Insurance rarely covers non-western medicines, forcing people to pay out of pocket. With over a third of survey respondents disagreeing with the statement, “I am able to financially support myself,” having to pay out of pocket is a financial burden that often becomes a barrier. Additionally, these healing practices are delegitimized by many medical providers who often lack knowledge about non-western healing. Some of our participants shared that their providers actively discouraged them from pursuing these practices because they were perceived to be inferior to western medicine, if not useless and “fake.”

Federal and state policies limit our health care options

Current laws make accessing health care that meets our communities' needs difficult to impossible. Politicians put up legislative barriers to accessing abortion and contraception, despite the fact that our communities

could face jail time, fines, and lawsuits. As of 2017, these bills are currently in effect in eight states, and are under consideration in Congress and six states, including New York.

PRENDA is a deliberate attack on the reproductive freedom of our communities. It capitalizes on the racist

“.... (A) lot of citizens or documented people can go to the doctor more easily than undocumented folks. Filling out the form is also traumatizing. Should I write this address down or are they cooperating with NIC or ICE?”

(East Asian, cis woman, undocumented, straight)

desire and need these services. 88% of our survey respondents have had sex, while 97% of them believe that people should be able to determine whether or not and when to have a child. Of the respondents who indicated that they could physically carry a child, 89% of them would consider terminating a pregnancy via a medical or surgical abortion. Of the eighteen people who indicated that they had been pregnant, 77% of them have terminated a pregnancy.

Over the past few years, Congress and a large number of states across the country have introduced sex-selection abortion bans, also known as the Prenatal Nondiscrimination Act (PRENDA). PRENDA makes it illegal for doctors to perform an abortion when they know or suspect that the patient is seeking an abortion due to a preference for the sex and/or race of their fetus. Doctors are required to report patients that they suspect want an abortion for these reasons to law enforcement. If doctors are found guilty of failing to report these cases, they

stereotype that paints Asians and Asian Americans as perpetual foreigners who prefer sons over daughters, even though studies show that foreign-born Chinese, Indians, and Koreans have proportionately more babies assigned female at birth than white Americans. PRENDA can scare providers into making assumptions about the intentions of an Asian or Asian American patients seeking abortions. It also erodes trust between health care providers and patients from our communities.

Additionally, immigration policies make accessing health care difficult for immigrants, especially undocumented people, who have to be constantly vigilant about who they give their information to for fear of being deported. From 1998 to 2016, 16,101 Southeast Asian immigrants have received deportation orders, many of whom have been lawful permanent residents (LPRs). As long as such policies exist, meaningful health care will be inaccessible to our communities.



What can we do to change this?



Problem Area: Internalized oppression



Commitment to anti-oppression in organizing practice

In order to combat structural oppression, we must focus our organizing practices towards liberation for all oppressed peoples. We need to actively engage in anti-oppressive practices when organizing our communities, meaning that the strategies we use, the people we organize, and the action steps we take should always take into account our historic and current complicity in colonialism. We can apply these ideas by centering the people who are most affected by structural oppression. For example, we need to center trans people, particularly trans women and femmes, and South and Southeast Asian people rather than cis women and East Asian people. Our work should also go beyond advancing our own wellbeing. We can do this by showing up for other people of color and working on dismantling anti-blackness in our communities.



Shared education around the political and social positioning of Asians and Asian Americans in the U.S.

Understanding the historical roots of the barriers that we face to accessing reproductive and sexual health care is crucial to our healing processes. We need to create learning spaces where our communities can reconnect with our histories of resistance in order to move towards our liberation.



We are excited to share these recommendations with you! Our intention is to use these ideas to shape our organizing. If you are interested in how this information is currently being used or want to get involved and support our work, get in touch with us at www.napawf.org!

We invite Asian and Asian American women and gender non-conforming people living in New York City to join us as we organize around these solutions.

We ask our allied organizations to join us in advocating for better policies and in supporting community-based initiatives by sharing access to resources.

We encourage funders to invest in the policy advocacy work and community-based initiatives that we and other Asian and Asian American organizers are building and leading.



Conversation spaces around mental health, sex, sexuality, and gender

Participants from various focus groups believe that a way to combat structural oppression is to build up systems of social and community support for Asian and Asian American women, trans, and GNC folks. Because we can often feel isolated and experience violence in society and within our families of origin, creating ways for us to connect and find support could be vital in our survival and wellbeing. Programs and systems created by community members that directly address homophobic, transphobic, and other oppressive beliefs and behaviors within our own communities would continue efforts to lift internalized oppression.



Intergenerational organizing spaces

Our community members expressed desire to have intergenerational organizing spaces to build power with Asians and Asian Americans of various ages. We think it is important that knowledge is passed through generations rather than lost through time. We encourage people from our age demographic (18-35) to organize with and learn from those who have been working towards liberation for many years. Learning from people from various generations-- both those who have been in the movement for a long time and those who are just entering-- can help us more effectively identify strategies to undo internalized oppression in our communities.



Support the work of Black, Arab, Muslim, and trans organizers against police violence

We advocate for the end of discriminatory policing and acts of violence by the NYPD, including but not limited to the murder of black people, the heightened surveillance and targeting of Arab and Muslim communities, and the ongoing violence against trans people, particularly trans women and femmes of color. Within this work we must center those in our own community who are most targeted by and vulnerable to police violence and organize in solidarity with other people of color who experience such violence.



Community alternatives to policing

It is important that we build and invest in alternatives to policing that involve more sustainable and less disposable ways of holding ourselves and our communities accountable to shared values. People who avoid interacting with the criminal legal system for their own safety, including survivors of violence and undocumented immigrants, should be able to access justice.



Legislation that protects survivors of violence

The reauthorization of the Violence Against Women Act (VAWA), which President Obama signed into law in 2013, bolstered protections for survivors of violence. With its reauthorization up in 2018, we must strengthen housing and employment security, fortify protections for the most impacted groups, and increase funding to support survivors.



More inclusive and realistic definitions of family in legislation

We call for inclusive and realistic family definitions for policies governing paid sick and safe days and paid family and medical leave. These policies need to cover workers and their chosen families when it comes to recovering from illness, providing caregiving for their loved ones, attending medical appointments, and/or in giving assistance following intimate partner violence, sexual assault, or stalking. The particular needs of pregnant workers should be lifted up in these definitions. We want the diversity of Asian and Asian American families and communities to be reflected in our legislation.



New media representation of queer and non-western family structures

Many of our community members expressed the importance of creating a culture shift around the current normative ideas of family. We recommend the creation of more media that accurately depicts our families and relationships and showcases how our people support each other.



Accountable implementation of NYC law 2017/090

We want the accountable enforcement of local law 2017/090, which would create a sexual health education task force. The task force would be responsible for reviewing the current recommended sexual health education curricula in NYC public schools and would issue a report with findings and recommendations for its implementation in grades kindergarten through twelve by December 2017.

Members will be appointed to the taskforce by the Mayor after consultation with the Speaker of the Council. We urge the Mayor to appoint someone from our communities who can speak to our needs. We recommend that the taskforce make their final findings public, that next steps be enforced, and that they center women, trans, and GNC people of color.



Community-based sex and gender education programs

Our community members shared the idea of creating (or expanding existing) community-based education around sex and gender. It is essential that we craft our own programs around the specific needs of our communities. During our community forum, participants voiced their desire to create learning spaces in which people can roleplay difficult conversations about sex and health; for example, how to ask about safer sex practices or how to consensually reach agreements about sex. Openly talking with fellow community members could help us feel more comfortable identifying our boundaries and desires, building a culture of communication.



New multilingual online media on sex and gender in our communities

Since we found that many of our community members turned to the internet to learn about sex, sexuality, and gender when their sex education in school was not serving them, creating more culturally accessible and accurate online material is a valuable undertaking. For instance, some community members at our forum decided to crowdsource a list of vocabulary words around sex, sexuality, and gender in various Asian languages. This could be a gateway to having more honest conversations.



Anti-oppressive curriculum for medical, psychology, and social work schools

We call for the review and revision of training curricula for health care providers to reflect the needs and realities of our communities. It is crucial that the training programs for providers respect the experiences of the communities they serve to best inform students on the intricacies and nuances of their clients.



Training for NYC health care providers by our communities

We advocate for continual professional development opportunities for health care providers that focus on anti-oppressive practices and that center and are led by members of queer, trans, and GNC communities of color.



Community education on non-western healing practices

A way to increase understanding and access to non-western healing practices is to fund and educate about such practices through community events and small businesses.



Expansion of public insurance coverage to include non-western medicine

We call on policymakers to expand coverage to methods used by non-western communities so more groups can heal in effective and culturally-affirming ways.



Crowd-sourced resources on community recommended providers

Expanding networks for resources and information about health care providers would connect members of our communities to health care that works for their needs. For example, because many of us do not feel comfortable with our health care providers, it would be helpful to have readily-available resources and information about specific providers who other community members found to treat them well. It is important that such compilations are built by community members.



Alternative community-based structures of support

Across our focus groups, there were many ideas offered by community members for alternatives to current processes for finding providers. For instance, a number of our trans participants expressed that having a buddy go to gynaecologist appointments with them would mitigate some of their fear and anxiety in attending appointments. Creating the infrastructure for a buddy system could potentially be a simple and effective tool to help people access the health care they need. Another suggestion was to create or augment an online search tool like ZocDoc that would collect reviews and give ratings based on a provider's demonstrated ability to effectively care for queer, trans, and GNC Asians and Asian Americans.

Passage of New York City and New York State legislation that supports Reproductive Justice within our communities



Problem Area: Policies limit our access

In line with the Reproductive Justice framework, we must look beyond traditional reproductive rights goals that center white, middle class cis women. We will fight for full access to a wide range of health care options including contraception and abortion services, regardless of our income, where we live, the language we speak, or our immigration status. We seek legislation that affirms our rights and the rights of other communities of color to live full lives. We call upon our allies and legislators to work toward the passage of laws that promote Reproductive Justice within our communities. These are a few of the many campaigns that we support:



Passage of anti-PRENDA resolutions at the city and state level

We call on the New York City Council to pass a city-wide resolution denouncing PRENDA. Fighting against sex-selection abortion bans is a step to ensuring that our communities have the full range of reproductive health care options they need.



Passage of New York State's universal health care bills

We call on New York State legislators to pass the New York Health Act (NYHA). NYHA would provide affordable and comprehensive health coverage to all New Yorkers, regardless of employment and immigration status. NYHA would improve access to health services without financial risk and allow us to choose the providers that best serve our needs.



Decriminalization of self-induced abortions

We call upon legislators to eliminate the criminal consequences for self-administered abortions that stigmatize and endanger those seeking to end a pregnancy. New York State should repeal Penal Laws §125.55 and §125.50 (National Institute for Reproductive Health @NIRHealth).



Right to a fair work week

We encourage New York State to follow the lead of New York City and the state of Oregon by passing legislation that ensures predictable work schedules and reasonable working hours for hourly wage earners at the state level (Center for Popular Democracy @popdemoc).



Coverage of gender affirming health care

We fight for the inclusion of gender-affirming health care coverage in all public insurance plans, and for accurate and affirming gender markers on all state and city identifying documents (Sylvia Rivera Law Project @SRLP).



Health care regardless of status

We urge our legislators to ensure the health and safety of all our community members by proposing and passing bills that provide public health insurance coverage and benefits for all immigrants, regardless of status, and by ending the five-year waiting period for green card holders to access Medicaid and Medicare.



Closure of all NY criminal and immigration detention facilities

We call for the deep transformation of our criminal and immigration enforcement systems, an end to the inhumane treatment of those in custody, and the cessation of family separation via incarceration, deportation, and family visa backlogs. #CLOSErikers



Right to Know Act

We support the passage of the Right to Know Act in New York City, which would provide protections to civilians during interactions with the NYPD (Communities United for Police Reform @changethenypd).



Decriminalization of sex work

We call for the decriminalization of sex work. People who work in the sex industry need legislation that protect their rights, their health, and their safety (Red Umbrella Project @RedUPnyc).

Conclusion

Our research highlights the myriad of obstacles we face within the current U.S. healthcare system and the many ways we can tackle these issues. In doing this research, we reaffirmed that our communities are brilliant, understand their own needs better than anyone, and are most fit to generate solutions to barriers they face. We hope that this blueprint elucidates valuable information about our communities and that our recommendations are helpful in creating more pathways for Asian and Asian American women, trans, and GNC people to access meaningful sexual and reproductive health care.

♥ In love and solidarity,

The first cohort of the
NYC Reproductive Justice
Leadership Institute

References

Asian Americans Advancing Justice. (2013). *A Community of Contrasts: Asian Americans, Native Hawaiians, and Pacific Islanders in the Northeast*.

Hacker, K. (2013). *Community-based participatory research*. Thousand Oaks : SAGE Publications, Inc.

Hishinuma, E. S., Johnson, R. C., Carlton, B. S., Andrade, N. N., Nishimura, S. T., Goebert, D. A., Yuen, N.Y.C., Nahulu, L. B. (2004). Demographic and social variables associated with psychiatric and school-related indicators for Asian/Pacific-Islander adolescents. *International Journal of Social Psychiatry*, 50, 301-318.

Kim, W., & Keefe, R. H. (2010). Barriers to healthcare among Asian Americans. *Social Work in Public Health*, 25, 3, 286-95.

National Coalition of Anti-Violence Programs (NCAVP). (2016). *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2016*. New York, NY: Emily Waters.

Office of Planning and Research, United States Department of Labor. (1965, March). *The Negro Family: The Case for National Action*.

Pitter, L. (2017, May 11). *Hate Crimes Against Muslims in US Continue to Rise in 2016*. Retrieved July 1, 2017, from <https://www.hrw.org/news/2017/05/11/hate-crimes-against-muslims-us-continue-rise-2016>

Raj, A. and J. Silverman. (2002). Intimate Partner Violence Against South-Asian Women in Greater Boston. *Journal of the American Medical Women's Association*. 57(2): 111-114.

The New York City Council - File #: Res 0920-2015. (n.d.). Retrieved July 7, 2017, from <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2530982&GUID=7868D0AB-FA6F-44F5-A415-C7838EF3D964>

Wu, E. D. (2014). *The Color of Success: Asian Americans and the Origins of the Model Minority*. Princeton University Press. Retrieved from <http://www.jstor.org/stable/j.ctt5hhphr>

Yoshihama, M. (1999). Domestic Violence Against Women of Japanese descent in Los Angeles: Two Methods of Estimating prevalence. 5(8):869-897.

Zhao, J., Lau, M., Vermette, D., Liang, D., & Flores, G. (2017). Communication Between Asian American Adolescents and Health Care Providers About Sexual Activity, Sexually Transmitted Infections, and Pregnancy Prevention. *Journal of Adolescent Research*, 32(2), 205-226. <https://doi.org/10.1177/0743558416630808>

About the Authors

Tara Adiseshan (*they/them*): Tara is a programmer, designer, and digital security trainer who cares about community-based knowledge building and access.

Olivia Ahn (*she/her*): Olivia is a third generation Chinese American New Yorker. She is a full spectrum doula, prison doula, and reproductive and sexual health advocate. Olivia is passionate about resilience and restoration through understanding, humility, and collaborative community-based care through interpersonal support systems. Her current work advocates for reproductive and sexual health education, access, services, and care that is attentive to histories of trauma, abuse, survivorship, and oppression. Olivia's practice ultimately strives for empathy towards the multiple truths, experiences, and subjectivities of the human condition.

Angelique Beluso (*she/her*): Angelique is the Community Organizer for Planned Parenthood Action Fund of New York City, where she manages over 1,500 activists involved in PPNYC's Activist Council and Youth Organizing chapter, Planned Parenthood Generation. She also currently serves as a part of the Young Women's Advisory Council for New York City Council's Young Women's Initiative where she advocates for programmatic needs and policy changes on behalf of young women of color.

Elisa Bokyung Kim (*she/her*): Elisa is a licensed social worker. Her work focuses on supporting youth leadership development, reforming the criminal justice and immigration system, restorative justice, and ending systemic and gender-based violence. She is also a school social worker with Democracy Prep Endurance High School.

Janine Ko (*they/them, she/her*): Janine is a student at Columbia University studying history, computer science, and ethnic studies. They are interested in technology, housing, and care work.

Michelle Chen (*she/her, they/them*): Michelle is a queer Chinese girl working in public health. She is interested in community building and health justice.

Ann Cheng (*she/her*): Ann is Chinese-American and Jewish mother, university administrator, and writer living in Brooklyn.

Vineeta Kapahi (*she/her*): Vineeta is a social worker, community organizer, and trainer. For the past decade, she has worked to promote gender, racial, and environmental justice through advocacy, counseling, research, and community outreach and education. She completed her undergraduate studies at Bard College at Simon's Rock and Rice University, earning a B.A. in Sociology. She also holds an M.S.W. in Community Organizing, Planning, and Development from the Silberman School of Social Work at Hunter College.

Anna Krist (*she/her*): Anna is a biracial Chinese queer woman who is still trying to figure out what all those labels mean.



Bex Kwan (*they/them, she/her*): Bex is a queer/trans chinese-singaporean organizer and multimedia artist. Bex is currently NAPAWF's Senior Organizer based in NYC. More at bexkwan.com.

Chi Nguyen (*she/her*): Chi is a community organizer, digital strategist, and interdisciplinary artist based in Brooklyn, New York. She uses durational performance, textile, and writing to reflect on contemporary issues dealing with feminism, reproductive justice, LGBTQ issues, globalization, and the search for one's identity. Her work has been featured on the Washington Post, Salon, Ms. Magazine, Huffington Post, BusinessWeek, Vice, New York Times, and Bustle, among others.

Anique Singer (*she/her*): Anique is a queer Okinawan American who was born and raised in Honolulu, Hawaii and has been living in New York City for three years.

Angel Sutjipto (*she/her*): Angel was born and raised in Jakarta, Indonesia, and currently resides in the border area between Brooklyn and Queens.

Yumnah Syed (*she/her*): Yumnah is a bleeding heart feminist and has dedicated her personal and professional life to empowering people of color and ending gender-based violence. She is a licensed social worker whose focus is working with survivors of trauma. She is currently the Coordinator of Evaluation and Training at the Institute for Adolescent Trauma Treatment and Training at Adelphi University. She holds a B.A. in Communication from UC San Diego and earned her M.S.W. at Adelphi University's School

of Social Work, with a specialization in Mental Health, Substance Abuse, and Trauma. As a first generation Pakistani American woman, it is important to Yumnah to continue the work of bringing visibility to the Asian American community.

Devanshi Tripathi (*she/her*): Devanshi holds a Masters of Public Health from CUNY School of Public Health, where she graduated from in December 2016. Her professional interests are quality of and access to care, especially as it pertains to maternal, child, sexual, and reproductive health. She recently started working at the NYC Department of Health and Mental Hygiene as School Mental Health Manager.

Adrienne Zhou (*she/her, they/them*): Adrienne is a reproductive and sexual health, justice, and rights advocate and community organizer. She has organized around sexual violence, in defense of student organizing, and has collaborated with other student organizers of color to organize a campus-wide Black Lives Matter rally. They have also spoken at Planned Parenthood rallies. Adrienne is committed to the fight for the liberation of all people, especially queer and trans people of color, women of color, people with disabilities, immigrants, people of low income, and those who are most marginalized.

Stephanie Zhou (*she/her*): Stephanie is an analyst at a software company based in NYC. She loves to dance and has previously worked for NAPAWF as the Communications and Online Engagement Associate.



