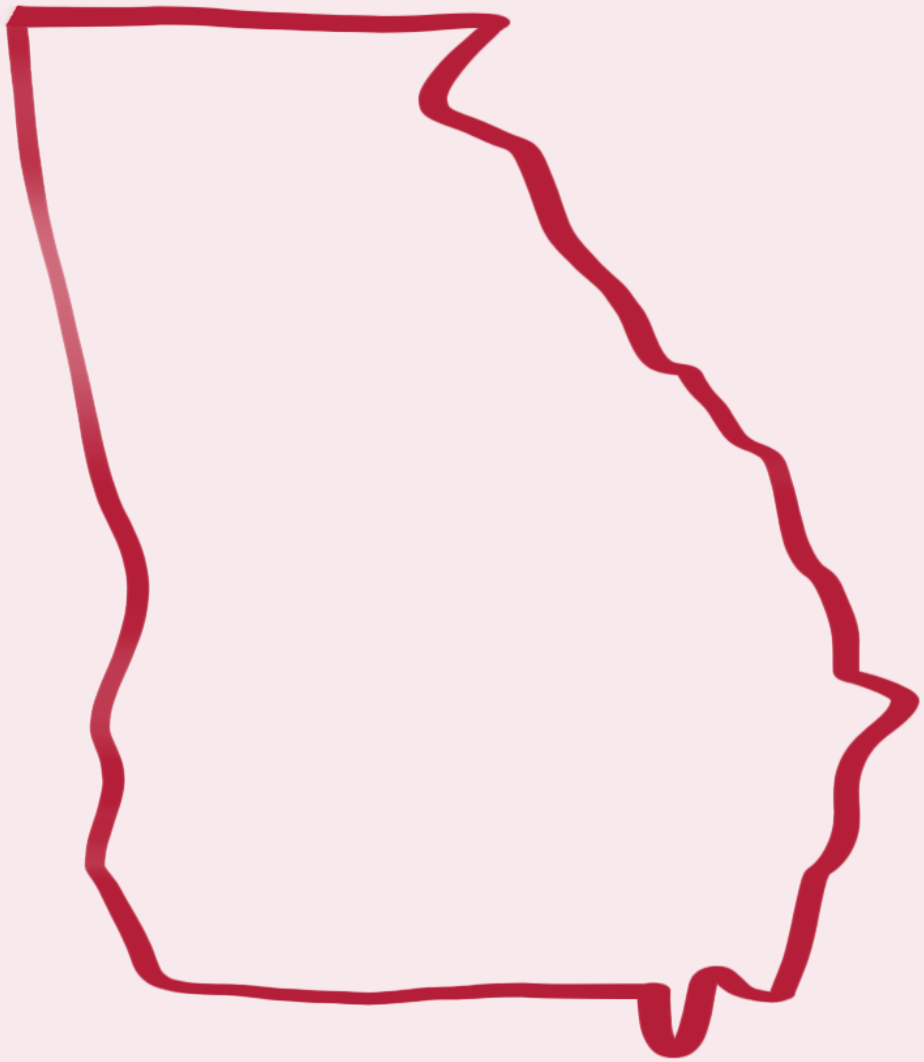
Sexual and Reproductive Healthcare in the Asian American, Native Hawaiian, and Pacific Islander Community:

Understanding Barriers to Access in Georgia



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napawf
NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM

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, Native Hawaiian, and Pacific Islander (AANHPI) women and girls in the U.S. NAPAWF's mission is to build collective power so that all AANHPI 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 RISE

Housed at the Rollins School of Public Health at Emory University, the Center for Reproductive Health Research in the Southeast (RISE) is a collaborative network of stakeholders engaged in producing research around person-centered access to reproductive healthcare in the U.S. Southeast using research justice-based approaches. Their mission is to improve reproductive health and equity of people in the U.S. Southeast through transdisciplinary research that informs social systems, and policy change. For more information, visit rise.emory.edu or email RISE@emory.edu.

Acknowledgments

This work was supported by a grant from RISE. The views and opinions expressed are those of the authors and do not necessarily represent the views and opinions of RISE.

Terminology Disclaimer

The "AANHPI" acronym is respectfully used to refer to Asian American, Native Hawaiian, and Pacific Islander people throughout the report. Where possible, specific racial, cultural, and ethnic groups have been made explicit. The phrase "women and girls" is used inclusively to encompass all individuals who identify that way, including gender expansive individuals.

Suggested Citation

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Executive Summary

Very little research has explored the barriers to accessing sexual and reproductive health (SRH) care for Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) in the United States. Previous studies with AANHPI communities have revealed economic disparities, varying levels of SRH knowledge, and a range of obstacles to medication abortion access. This project focuses on one of the most understudied and fastest-growing ethnic groups in Georgia, addressing a critical gap in the research.

In partnership with Emory University's Center for Reproductive Health Research in the Southeast (RISE), this report aims to explore access to SRH care and to identify the individual, community, and policy-level barriers that AANHPI communities face in accessing care. This mixed methods study used a survey to collect data from 483 AANHPI-identified women or gender expansive adults across four counties in the Atlanta metropolitan area: Cobb, DeKalb, Fulton, and Gwinnett. According to the 2020 Census, 62% of Georgia's AANHPI population lives in Cobb, DeKalb, Fulton, and Gwinnett counties; NAPAWF selected these counties to focus the study on the areas with the largest AANHPI presence, ensuring a representative look at the sexual and reproductive healthcare needs of these communities. Additionally, this study conducted six follow-up focus groups to expand on survey findings.

Key Findings

Our study found that AANHPI communities face multiple barriers to accessing SRH care in Georgia:

- **A majority of AANHPIs had a regular SRH provider, but faced uneven usage of SRH services across racial subgroups.** A large majority of surveyed AANHPI participants (83%) had a regular reproductive healthcare provider. AANHPI participants who did not have a regular SRH provider (15% of all AANHPI participants) cited financial constraints (33%), infrequent visits to SRH providers (32%), or a lack of perceived need for regular care (29%) as reasons. Most AANHPI survey participants (60%) last saw a reproductive healthcare provider in the past year, but this share fell for NHPI (29%) and Mixed Race (41%) respondents.

- **AANHPIs had biased or negative experiences with SRH providers.** Over six in ten surveyed AANHPI respondents (63%) perceived unfair or disrespectful treatment by reproductive healthcare professionals. A larger share of Asian respondents (70%) reported such experiences, compared to Mixed Race (24%) and NHPI (22%) respondents.

- **AANHPIs prioritized gender, nonjudgmental attitudes, and racial or ethnic similarity in their SRH provider.** Survey participants prioritized gender (42%), nonjudgmental attitudes (41%), and racial/ethnic similarity (37%) when selecting an SRH provider.

- **A majority of foreign-born AANHPIs perceived less stigma with SRH in the U.S.** Comparing community attitudes towards reproductive healthcare in their birth countries to the U.S., 64% of participants born abroad perceived less stigma in the U.S.

- **A majority of AANHPIs experienced pressure or judgment about contraception from non-medical sources.** Only 4% of AANHPIs felt pressured to use contraception, judged when seeking birth control information, or judged for not desiring birth control from doctors, nurses, or counselors.

- **SRH knowledge varied among AANHPIs, but all racial subgroups felt least knowledgeable about abortion.** Almost one in two NHPI respondents felt a little or not at all knowledgeable about abortion (48%), followed by Mixed Race (43%) and Asian (42%) respondents.

- **AANHPIs primarily sought information from AANHPI-specific community-based resources and healthcare providers.** Survey participants primarily sought information about SRH topics from AANHPI-specific community-based resources (43%), doctors and healthcare providers (41%), and the pharmacy (36%).

- **AANHPIs had limited family conversations about SRH, contraception, sex, sexually transmitted infections, and abortion.** Only one in ten (11%) turned to family as one of their top two resources for SRH information Growing up, across all racial subgroups, only one in three participants, or fewer, often discussed sexual and reproductive health, contraception, sex, sexually transmitted infections, or abortion with family.

Discussion

Individual barriers included stigma and misinformation, a difference in beliefs with providers, poor communication, lack of in-language resources, stigma, discomfort, and rushed or delayed healthcare results. Community barriers consisted of a lack of wraparound support services, limited sexual education, and judgmental providers. Policy barriers included discriminatory and inequitable healthcare, healthcare costs, and a lack of diversity within the broader SRH network.

Policy Recommendations

To address barriers to SRH services in Georgia, this report includes recommendations for policymakers to prioritize the needs of AANHPI communities while improving healthcare outcomes. The need to eliminate barriers to SRH services for AANHPI communities in the Southeast is more critical than ever in the face of ongoing threats to sexual and reproductive health, rights, and justice.

Introduction

Recent, widely publicized cases have drawn attention to critical gaps in Georgia's sexual and reproductive healthcare (SRH) system, particularly under the state's restrictive abortion laws. These incidents underscore the systemic barriers to care that disproportionately affect women of color and other marginalized communities, including Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations. While AANHPI individuals face unique challenges, they are part of the same healthcare system that has historically failed to provide timely and adequate care to underserved communities. This report aims to examine the landscape of sexual and reproductive healthcare in Georgia, with a particular focus on AANHPI communities, and to contribute to ongoing discussions about improving healthcare access and equity for all.

Despite representing over 50 ethnicities and 100 languages and being the fastest-growing minority group in the United States, AANHPIs are often overlooked in research, particularly concerning SRH.[1,2,3] At worst, AANHPIs are put into an "others" category, and at best, data on AANHPIs is presented in aggregate. The presentation of aggregated data is often highly problematic and inaccurate. Aggregated data lumps diverse AANHPI communities into one group and perpetuates the "model minority" myth, which is not only false, but also obscures the challenges faced by specific subcommunities. For instance, while overall wage analyses suggest AANHPI women earn 80 cents for every dollar their white male counterparts make, disaggregated data reveals significant disparities, with Southeast Asian and Pacific Islander women experiencing particularly large wage gaps.[4]

Over a year since Georgia's *HB 481*, which bans abortion after approximately six weeks, took effect, access to SRH care remains increasingly confusing and difficult to navigate. Research on emergency contraception (EC) knowledge further underscores disparities within AANHPI subgroups: South and Southeast Asian women were found to have 15-25 percentage points lower EC knowledge than their East Asian counterparts.[5]

Georgia's growing AAPI population, which has increased by 138 percent since 2000, makes it a valuable case study for understanding the experiences and barriers faced by AANHPI women in accessing SRH care. Three of the four metro Atlanta counties surveyed for this study–Gwinnett, Fulton, and DeKalb–have the highest AAPI populations in the state.

Since its inception in Georgia in 2015, NAPAWF has transitioned from grassroots organizing to building a base of directly impacted AANHPI women and girls. This includes immigrants, second-language English speakers, and older generations, often referred to as "aunties."

As NAPAWF has focused on building a base of directly impacted individuals, recurring patterns of patriarchal dominance have emerged across our campaigns and programming. In 2019, we observed that men frequently acted as gatekeepers, controlling access to women within households. During in-person canvassing and virtual phone banking efforts, it was

often necessary to establish relationships with the male head of household before being granted permission to speak with the woman. This phenomenon is particularly problematic for organizations addressing issues like domestic violence and reproductive rights, health, and justice, as women may be less likely to disclose sensitive information in the presence of a male guardian. Moreover, many women in these relationships may not recognize these dynamics themselves. **It's important to note that this observation is based on our experiences within the AANHPI community in Georgia and may not reflect all experiences within this group.*

In our recent report, *Clocking Inequality: Understanding Economic Inequity, the Wage Gap, and Workplace Experiences of AANHPI Women*, participants highlighted how domestic violence, including financial abuse, poses a significant barrier to economic stability for many women.[6] Abusers often exert control by managing finances, restricting employment opportunities, or undermining access to education, trapping survivors in cycles of abuse and economic vulnerability. Participants also noted that American-born spouses, typically male partners, sometimes exploit and control the finances of their foreign-born spouses. Another recurring theme was abusers taking control of childcare subsidies or limiting economic opportunities for victims, particularly when they are forced to assume full responsibility for childcare. Breaking free from abusive relationships often requires survivors to cut ties with their support networks, which not only heightens financial insecurity but can also hinder access to sexual and reproductive healthcare. A separate NAPAWF study conducted in DeKalb County echoed these findings. Based on our organizing work within the AANHPI community in Georgia, NAPAWF believes that the impact of gendered power dynamics on access to SRH care is both understudied and in need of greater attention.

In 2021, NAPAWF's Georgia chapter, in collaboration with the Amplify Georgia Collaborative's Atlanta Campaign, conducted a needs assessment survey among over 300 DeKalb County residents. This survey provided valuable data on gender-based violence, with 81% of AANHPI respondents identifying it as a concern. While the survey also collected information on income levels, it was unable to disaggregate data by ethnicity, limiting its usefulness. Additionally, constraints in funding and language capacity hindered our ability to gather more nuanced insights into the AANHPI community's attitudes towards accessing SRH care.

This study sought to fill in these gaps by engaging in culturally competent research to gain the most comprehensive and accurate data possible on access to SRH care in the AANHPI community in Georgia. The findings of this research provide an in-depth understanding of the individual, community, and policy-level barriers that AANHPIs, the fastest growing and one of the most understudied racial groups in Georgia, face to accessing SRH care.

Methodology and Study Sample

This study employed a sequential explanatory mixed-methods design to comprehensively examine the barriers encountered by AANHPI individuals when accessing SRH services in Georgia. The study consisted of two phases: a representative survey and a series of focus group discussions (FGDs).

Quantitative Data Collection

The first phase of the study involved administering a survey across four counties in the metro Atlanta area. To be eligible for the survey, participants needed to self-identify as AANHPI, be at least 18 years old, identify as a woman, transgender, non-binary, or another gender identity aside from cisgender man, speak one of the following languages: English, Hindi, Mandarin, Korean, Vietnamese, or Tagalog, have access to the internet or phone, and be able to provide informed consent. The sample was designed to represent the diversity of AANHPI ethnicities within Cobb, DeKalb, Fulton, and Gwinnett counties. The selected language groups align with those used in polling among AANHPI voters during the midterm elections and will contribute to expanding data for future advocacy work within these communities.

The study aimed to recruit 500 participants to enable subgroup analysis (e.g., East Asian, Southeast Asian, South Asian, and NHPI) and account for the underrepresentation of specific groups. However, the survey was compromised by bot activity, which generated hundreds of fraudulent responses, prompting a temporary halt in data collection to ensure data integrity. Ultimately, 483 AANHPI adults completed the online survey. Eighty-five percent of survey respondents identified as Asian, 11% identified as Mixed Race, including AANHPI, and 4% identified as NHPI. One participant identified as Other.

Conducted between July and October 2022, the survey took approximately 20 minutes to complete. IP address information was collected to verify Georgia residency and was deleted after the study concluded. Recruitment occurred both online and in person through social media and community partnerships, primarily facilitated by NAPAWF Georgia Chapter's canvassing team. Participants were given the option to complete the survey online or by phone. The survey, administered in English, included questions covering socio-demographic characteristics, SRH experiences, the quality of care, and barriers to accessing SRH services in Georgia. Descriptive analyses (e.g., means, medians, frequencies, and chi-square cross-tabulations) were performed on key outcome variables for the overall sample and various subgroups (e.g., Asian, NHPI, Mixed Race, and Other).

Study Sample

The survey included AANHPI participants identifying as Asian, Mixed Race, Native Hawaiian or Pacific Islander, or Other. Among Asian participants, Chinese (4%), Korean (3%), and Japanese (2%) were most represented. For Mixed Race participants, Asian American (71%) and Indian (8%) were predominant. Pacific Islander participants primarily identified as Samoan (33%) or Tongan (25%), with one participant identifying as Myanmar/Burmese. The average age of respondents was 31 years, with ages ranging from 18 to 49.

The appendix presents the demographic characteristics for the total sample of participants across DeKalb (28%), Fulton (27%), Cobb (23%), and Gwinnett (22%) counties. The majority identified as Asian American (85%), women (89%), and heterosexual (58%). Most spoke English at home (90%), were born in the USA (82%), and had health insurance coverage (52%). Nearly three-quarters of the participants had a college degree (33%), some professional or advanced education (23%), or a professional or advanced degree (16%). Most were employed part-time (53%) or full-time (29%). Less than a third reported meeting their basic needs consistently (28%).

Qualitative Data Collection

The second phase of the study involved conducting focus group discussions (FGDs) to build on the survey findings and delve deeper into AANHPI experiences and barriers related to SRH services. Participants were recruited from the pool of survey respondents. Before joining a focus group, participants completed a screener survey that captured basic demographic information, such as race and county of residence. A pilot focus group with NAPAWF Georgia Chapter members was also conducted to test the questions, but these responses were excluded from the analysis. In total, 18 AANHPI women and gender-expansive individuals aged 18 years or older participated in six FGDs, with an average of three participants per group. Each group was facilitated by a moderator and conducted virtually in English.

To analyze the focus group data, a modified grounded theory approach was applied, which included the following steps: (1) identifying emerging themes and ideas, (2) organizing these themes into preliminary codes, (3) iteratively refining and expanding the codes as needed, and (4) exploring relationships and patterns across codes and interviews.[7] To protect participant anonymity, pseudonyms are used for all direct quotes included in this report. Participants who did not specify their cultural background are identified as "AANHPI."

Study Sample

A significant aspect of the qualitative data collection involved participants sharing perspectives on their community and culture that influenced their SRH experiences. Participants were initially

invited to describe their sense of identity. Some identified more broadly as Asian American, while others had a strong sense of community and culture rooted in specific cultural groups, similar communities, and shared cultural events (e.g., Lunar New Year or Tết). Others described unique cultural aspects such as humility, self-care in public, respect for elders and husbands, strong religious beliefs, positive attitudes, and diversity.

> "Compared to other cultures, Asians might be perceived as a bit laid-back,"
>
> - Olivia, a Guamanian participant

> "Surrounded by loved ones… I'm a Pacific Islander woman and I believe so much in religion."
>
> – Alea, a Samoan participant

Some participants did not have a strong sense of culture. For example, one participant felt their physical appearance did not align with their cultural background, another struggled to answer questions about race, and another did not live near other AANHPI communities. Some participants described their communities as non-religious and lacking unique cultural aspects due to everyone speaking English.

Interestingly, one group of participants discussed ideas related to fertility and the pressure to have children. One participant mentioned superstitions and beliefs, such as the symbolism of a "pig" dream in Korean culture. In contrast, another participant shared the challenges of oral cultural traditions that limited open conversations about fertility.

> "Oral traditions have been passed down about certain foods for fertility or the meaning of menstruation…We wouldn't have in-depth conversations because Asians, at least in my community, don't talk about that."
>
> – Emma, a Korean participant

Limitations

While this study contributes to the limited body of literature on AANHPI SRH experiences, it is essential to address its limitations to strengthen future research.

Findings may only generalize to AANHPI experiences within the Cobb, DeKalb, Fulton, and Gwinnett counties. The specific characteristics and experiences of AANHPIs in these counties, including proximity to sexual and reproductive healthcare resources in a large metropolitan area, may limit the applicability of these results to AANHPIs living in other parts of Georgia.

Furthermore, while the survey and focus group sample sizes were sufficient to identify general trends and themes, the sample sizes may only partially represent the diversity of the AANHPI population within the Cobb, DeKalb, Fulton, and Gwinnett counties. Notably, smaller subgroups, such as the Native Hawaiian and Pacific Islander or gender expansive communities, may lack

adequate representation in the analysis, highlighting the need for additional research on these communities. In addition, the highly stigmatized nature of SRH topics attracted spam responses, which constrained data collection. Although the research team took measures to minimize the impact—such as ending survey collection early and screening Zoom usernames for accuracy—these challenges could not be entirely avoided. Future research on sensitive topics like SRH would benefit from larger sample sizes and implementing more rigorous checks and balances to prevent similar issues.

Moreover, data collection took place from July to October 2022, a limited timeframe that may not capture the full range of SRH experiences in a rapidly evolving sexual and reproductive healthcare landscape. This timing constraint may mean that significant shifts or trends that emerged later were not captured in the data.

Finally, while the disaggregated survey results offer insight into the Asian, Native Hawaiian and Pacific Islander, and Mixed Race subgroups, the findings mask important variations in the experiences and perspectives informed by age, ethnicity, socioeconomic status, and gender identity, to name a few. Survey results, for example, reveal that nearly half of the AANHPI respondents lacked health insurance and that less than one-third consistently met their basic needs in the past month. However, the findings in this study do not illuminate the SRH barriers specific to these populations. Further data disaggregation and analysis are imperative in future research for more nuanced conclusions on the SRH barriers experienced across the complex and multidimensional identities within the AANHPI community.

Key Findings

The survey gathered data on general health and sexual reproductive health (SRH) experiences to identify barriers faced by the AANHPI community in accessing SRH care in Georgia. Qualitative research participants expanded on survey findings by sharing their cultural background, SRH information sources, and personal experiences with SRH services. They also discussed barriers and facilitators to SRH access and provided general recommendations to improve access to SRH services for AANHPI communities.

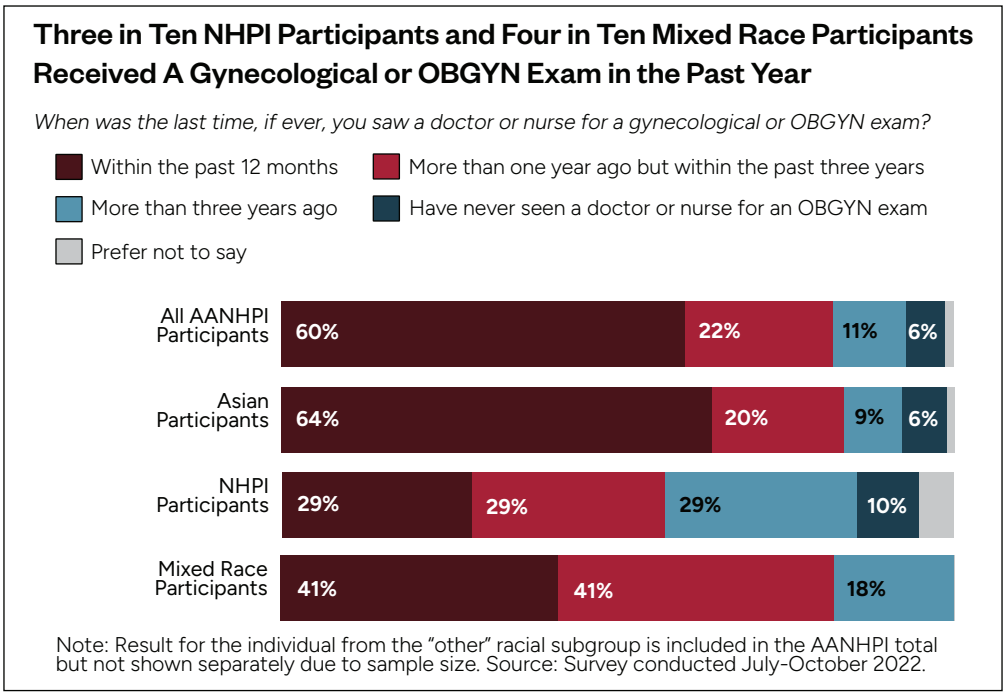
A majority of AANHPIs had a regular SRH provider, but faced uneven usage of SRH services across racial subgroups.

Survey results revealed that a large majority of AANHPI participants (83%) had a regular reproductive healthcare provider. Larger shares of Mixed Race (88%) and Asian (83%) participants reported having a regular provider compared to 71% of NHPI participants. AANHPI participants who did not have a regular SRH provider (15% of all AANHPI participants) cited financial constraints (33%), infrequent visits to SRH providers (32%), or a lack of perceived need

for regular care (29%) as reasons.

Overall, most AANHPI survey participants (60%) last saw a reproductive healthcare provider in the past year (Figure 1), but this share fell for NHPI (29%) and Mixed Race (41%) respondents. The most frequently reported medical tests received within the past two years were Pap smears (40%) and mammograms (37%).

Figure 1.



AANHPIs had biased or negative experiences with SRH providers.

Focus group participants shared both positive and negative experiences with SRH services. Positive experiences included highly informative sessions, supportive healthcare professionals, a holistic approach to healthcare, and access to patient healthcare records.

> "I've been lucky enough to have always or most of the times experienced or received quality healthcare services regarding reproductive and sexual healthcare."
>
> – Olivia, a Guamanian participant

> "The time [I] actually needed a high-quality health service was when I missed my period... For that reason, I needed a high-quality healthcare provider to be able to tell me one-on-one, [who] would be able to give me the lecture."
>
> – Alice, an AANHPI participant

"I think in terms of high quality, my current gynecologist, she's very informative. It's like a whole total, I guess, the whole body experience, not just-- I don't know how to really describe it. It's just total wellness, I guess."

– Hye-Jung, a Korean participant

"It's the way that they maintain the records where I can access my own records. That's important. Sometimes you want to know even the lab results, even though I may not necessarily understand what it means, but at least I know what range it is."

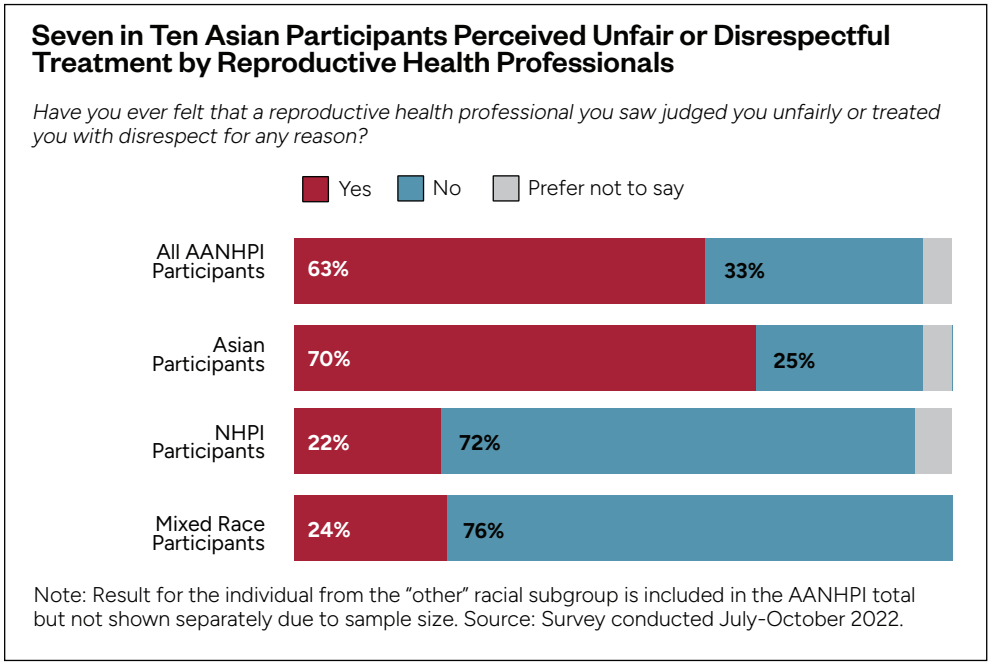
– Christine, an AANHPI participant

Negative experiences involved insensitive assumptions, lack of explanations, and dismissive attitudes. These qualitative findings reinforce survey results showing that 63% of AANHPI respondents perceived unfair or disrespectful treatment by reproductive healthcare professionals (Figure 2). A larger share of Asian respondents (70%) reported such experiences, compared to Mixed Race (24%) and NHPI (22%) respondents.

"I knew I had a UTI and my provider just stated like, 'Oh actually, you might have to ask your partner if he's being unfaithful to you because it looks [like] an infection or something.' That made me really upset because making that kind of assumption on someone's personal life is really rude and also completely invalidating my knowledge and intuition of my own body and knowing that it was a UTI. That made it very low-quality.'"

– Laura, a Korean participant

Figure 2.



AANHPIs prioritized gender, nonjudgmental attitudes, and racial or ethnic similarity in their SRH provider.

Survey participants prioritized gender (42%), nonjudgmental attitudes (41%), and racial/ethnic similarity (37%) when selecting an SRH provider. Most focus group participants felt similarly, with one participant who shared it was easier.

> "I'd prefer if it was a person of color who understands my background and cultural upbringing."
>
> – Ji-ah, Korean participant

> "Personally, I wouldn't love a male to be my healthcare provider… I tend to be very, very conscious of stuff like that."
>
> – Ona, Native Hawaiian participant

> "I usually prefer talking to fellow females… easier to talk to them about issues that we're experiencing as women… It's easier for me to air out my views or my problems to someone of the same gender."
>
> – Kanoa, Native Hawaiian participant

Participants also valued affordability, fair treatment, a suitable physical facility, and the expertise of their SRH provider, sometimes regardless of gender, especially if the provider was a referral.

> "I prefer when I'm being referred [to an SRH provider]… [you are] good at what you do. You [do] not use me as experiments… I prefer someone that knows, that's good at what he or she does."
>
> – Alea, a Samoan participant

A majority of foreign-born AANHPIs perceived less stigma with SRH in the U.S.

Comparing community attitudes towards reproductive healthcare in their birth countries to the U.S., most participants born abroad (64%) perceived less stigma in the U.S. More than half (52%) of participants expressed a desire to continue using or observing SRH practices from their birth countries in the U.S. Only Asian and Mixed Race AANHPI participants shared open-ended responses. Key themes among these responses included reduced cost and improved accessibility for healthcare and OB/GYN services (e.g., "more free access to medical healthcare," "free gynecological examination").

A majority of AANHPIs experienced pressure or judgment about contraception from non-medical sources.

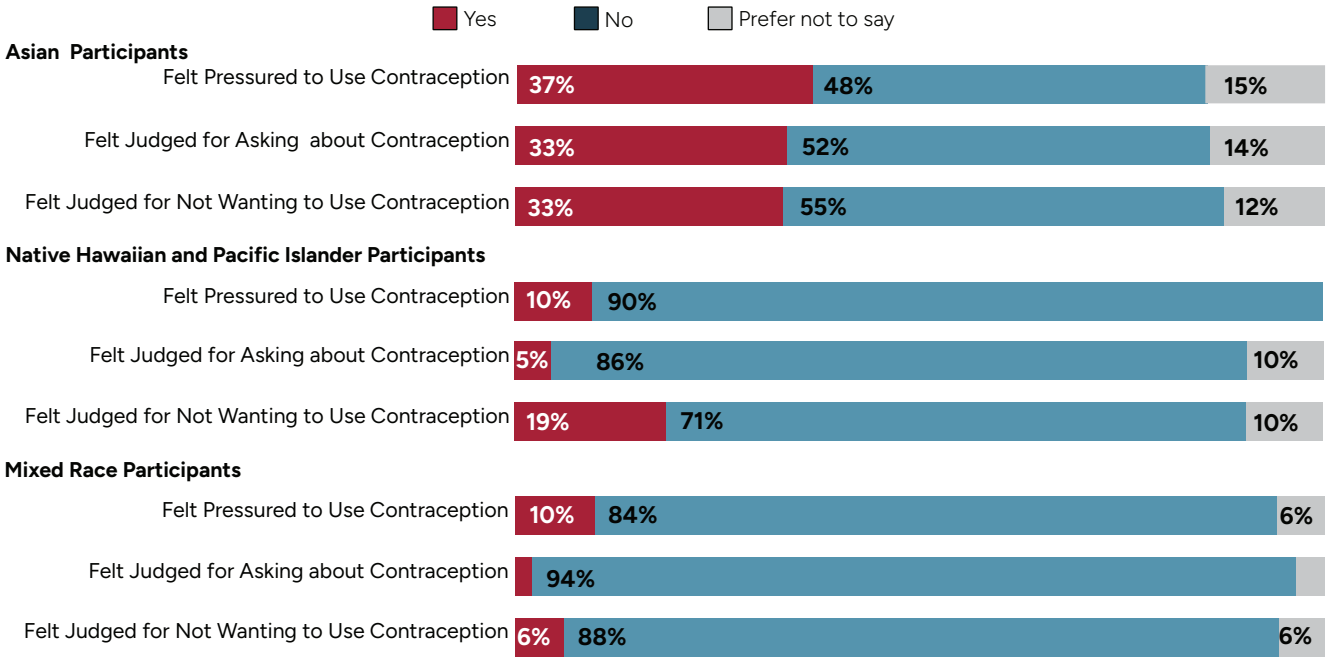
Participants reported pressure or judgment when answering "yes" to any of the following: being pressured to use contraception, being judged when seeking birth control information, or being judged for not desiring birth control (Figure 3). One in three Asian participants felt pressured to use contraception (37%), judged for asking about contraception (33%), and judged for not wanting to use contraception (33%). A higher percentage of NHPI and Mixed Race participants felt judged for not wanting to use contraception than for asking about contraception.

Only 4% of AANHPIs felt this pressure or judgment from doctors, nurses, or counselors. Almost two in ten AANHPIs (18%) experienced this pressure or judgment from their partners, followed by family members (15%), and friends (12%). Over half of AANHPIs felt this pressure or judgment from individuals other than partners, family, friends, or healthcare professionals (57%). Among those who specified "other," only one participant mentioned "religious people."

Figure 3.

One in Three Asian Participants Felt Pressured to Use Contraception, Judged for Asking About Contraception, and Judged for Not Wanting to Use Contraception

Have you ever felt pressured by anyone to use contraception or a birth control method? Have you ever felt judged when asking for birth control information? Have you ever felt judged for not wanting a birth control method?



Note: Result for the individual from the "other" racial subgroup is included in the AANHPI total but not shown separately due to sample size.
Source: Survey conducted July-October 2022.

SRH knowledge varied among AANHPIs, but all racial subgroups felt least knowledgeable about abortion.

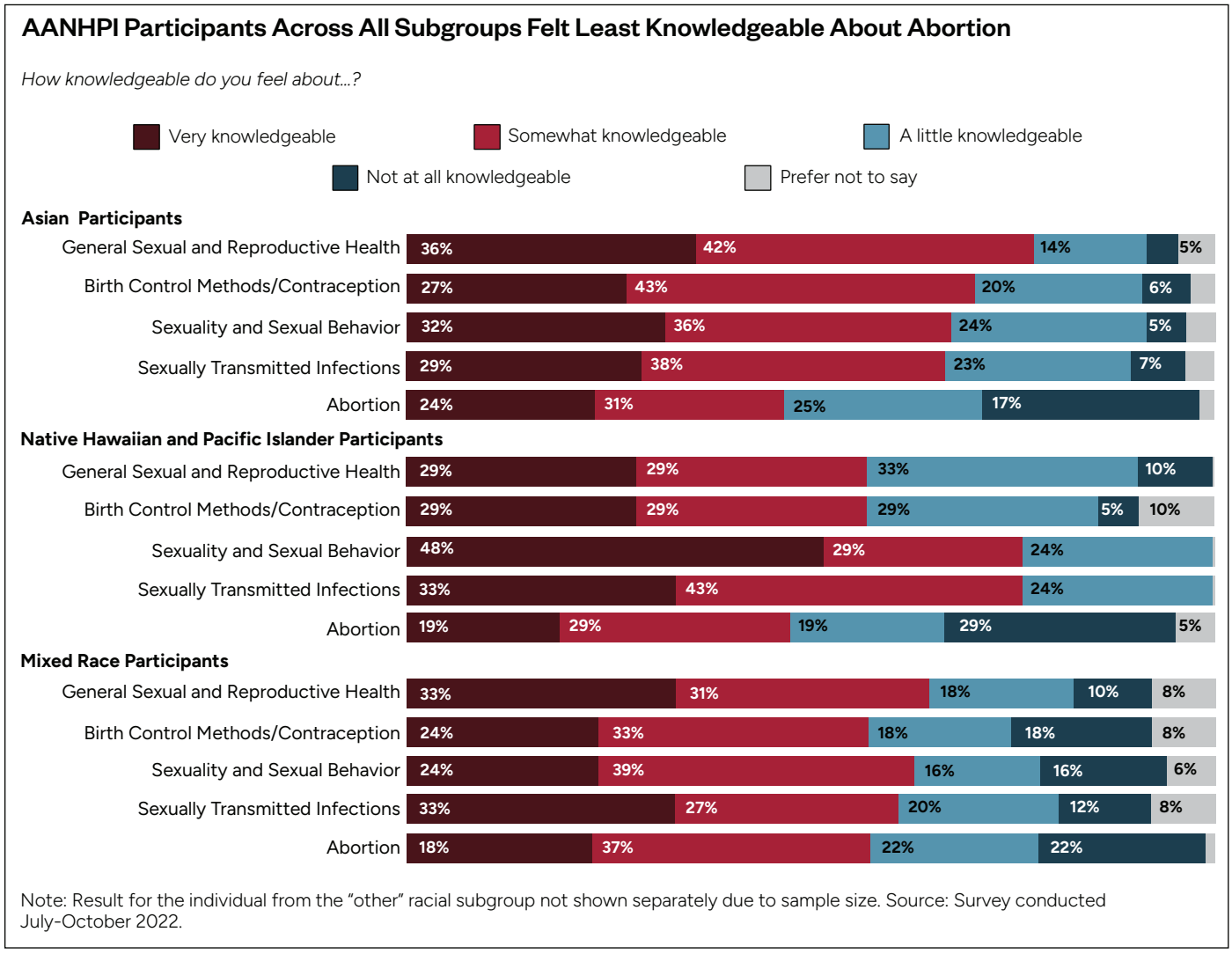
While AANHPI survey participants across all racial subgroups felt least knowledgeable about abortion, knowledge levels on all surveyed topics varied among AANHPIs, underscoring the importance of data disaggregation (Figure 4).

A majority of Asian respondents felt very or somewhat knowledgeable about sexual and reproductive health (78%), contraception (70%), sex (68%), sexually transmitted infections (67%), and abortion (55%). Still, over four in ten Asian respondents felt little or not at all knowledgeable about abortion, and almost three in ten felt similarly about sexually transmitted infections and sex.

More than half of NHPI respondents felt very or somewhat knowledgeable about sex (76%), sexually transmitted infections (76%), sexual and reproductive health (57%), and contraception (57%). Notably, while 48% of NHPI respondents felt very knowledgeable about sex, 43% felt little or not at all knowledgeable about sexual and reproductive health, and 33% felt similarly about contraception. Furthermore, equal shares of NHPI respondents felt very or somewhat knowledgeable (48%) and little or not at all knowledgeable (48%) about abortion. Almost three in ten NHPI respondents felt not at all knowledgeable about abortion, compared to smaller shares for Asian and Mixed Race respondents.

A majority of Mixed Race respondents felt very or somewhat knowledgeable about sexual and reproductive health (65%), sex (63%), sexually transmitted infections (61%), contraception (57%), and abortion (55%). Still, over three in ten Mixed Race respondents felt little or not at all knowledgeable about abortion, contraception, sex, and sexually transmitted infections. Compared to Asian and NHPI respondents, a higher share of Mixed Race respondents also felt not at all knowledgeable about contraception, sex, and sexually transmitted infections.

Figure 4.



Note: Result for the individual from the "other" racial subgroup not shown separately due to sample size. Source: Survey conducted July-October 2022.

AANHPIs primarily sought information from AANHPI-specific community-based resources and healthcare providers.

Focus group participants shared that their first exposure to SRH topics – especially at a young age with peers rather than with family or close friends – often occurred through mandated videos or school-based education. However, not everyone received parental permission to attend sex education classes.

> "My first exposure was through school and mandated videos around fifth grade."
>
> – Lucy, an AANHPI participant

> "Mostly [the] internet, not only family and friends. We can always share information through discussions."
>
> – Elizabeth, a Pacific Islander participant

When asked for their top two information sources about SRH topics, survey participants primarily named AANHPI-specific community-based resources (43%), doctors and healthcare providers (41%), and the pharmacy (36%). Focus group participants regularly sourced SRH information from their doctors or conducted rigorous research on the Internet to seek out trusted information from online platforms or groups.

> "I research a lot. I check things online. I go to platforms where I can get more knowledge… I also go to doctors."
>
> – Alea, a Samoan participant

> "I think most of the information I get is from online sites and online groups… I can usually get from our doctor."
>
> – Kanoa, a Native Hawaiian participant

> "The only person I can feel comfortable confronting or reporting that kind of issue to or seeking advice from could be a doctor or a healthcare worker."
>
> – Alice, an AANHPI participant

AANHPIs had limited family conversations about SRH, contraception, sex, sexually transmitted infections, and abortion.

Family played a unique role as a source of support for participants. Some participants offered their family financial support, provided information in both English and their local language, or developed rapport over time with family, but sometimes there was a lack of communication about SRH topics. Among survey respondents, only one in ten (11%) turned to family as one of their top two resources for SRH information. While some participants felt they lacked family support entirely, some participants would pick and choose what information to share and were more likely to do so with female relatives.

> "They don't know [how] to object to me going. My mom has told me once I shouldn't get a pap smear because it's uncomfortable."
>
> – Cindy, a Vietnamese participant

> "I suffer from PCOS, [and have] dealt with problems with regards to my menstruation and it took me a while to open up to her about it. Anyway, since I started to get treatment for it, she's been a bit supportive."
>
> – Ji-ah, Korean participant

Focus group participants relied on family and friends for simple questions, especially family members who are health professionals.

> "I'd probably say my answer would be the same for low-stakes questions, like females in my family, like my mom or sister, or friends who are females."
>
> – Alana, a Native Hawaiian participant

Survey participants also shared their experiences of discussing sexual and reproductive health topics with family while growing up. Notably, across all racial subgroups, only one in three participants, or fewer, often discussed sexual and reproductive health, contraception, sex, sexually transmitted infections, or abortion with family (Figure 5).

A majority of Asian respondents often or sometimes discussed all topics with family: sexual and reproductive health (67%), contraception (65%), sex (57%), sexually transmitted infections (57%), and abortion (53%). Still, over two in five Asian respondents rarely or never discussed abortion and over one in three recalled similarly about sexually transmitted infections and sex.

For NHPI respondents, the frequency of family discussions varied drastically by topic. A majority of NHPIs often or sometimes discussed sexually transmitted infections (67%), sex (62%), and sexual and reproductive health (57%). In contrast, more than half of NHPI respondents rarely or never discussed abortion (67%) and contraception (57%). Compared to Asian and Mixed Race respondents, a higher share of NHPI respondents also never discussed abortion, contraception, sexually transmitted infections, and sexual and reproductive health.

A majority of Mixed Race respondents often or sometimes discussed sexual and reproductive health (66%), sex (57%), and sexually transmitted infections (55%) with family. Compared to Asian and NHPI respondents, a lower share of Mixed Race respondents often discussed sex and sexually transmitted infections. Less than half of the Mixed Race respondents often or sometimes discussed contraception (47%). Almost equal shares of Mixed Race respondents often or sometimes (41%) and rarely or never (40%) discussed abortion.

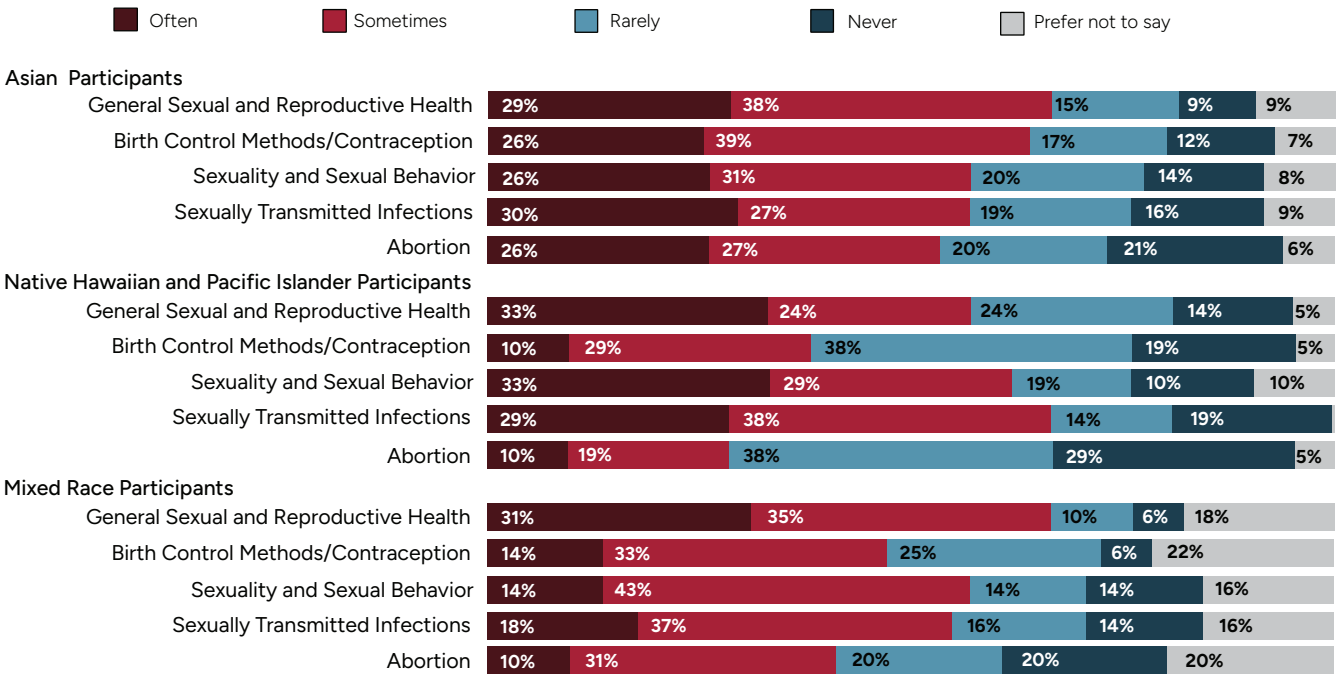
One focus group participant only received limited SRH information from a parent and highlighted that some SRH topics weren't discussed. Consent, in particular, was not considered to be a legitimate concern—a belief that may extend to their specific community.

> "Then with menstruation, when I got it, I knew I was menstruating. Then I went to my mom, and she just told me how to use a pad, and that was it. We've never spoken about pregnancy, STD, STI, anything like that, consent. That's not, like, a thing. I also don't think my mom quite believes in not consent. She doesn't believe that women could be assaulted or anything like that. She just wants to live in this fantasy world that doesn't really happen. People aren't bad. I think that's a weird thing that I feel maybe people in my community also have a similar belief on."
>
> – Aparna, a Bengali participant

Figure 5.

Across All Racial Subgroups, Only One in Three Participants, Or Fewer, Often Discussed Sexual and Reproductive Health, Contraception, Sex, Sexually Transmitted Infections, or Abortion with Family

Thinking about your experiences growing up, how often did your parent(s)/guardian(s) discuss the following topics…?



Note: Result for the individual from the "other" racial subgroup not shown separately due to sample size. Source: Survey conducted July-October 2022.

Insights from AANHPI Community: SRH Access Facilitators and Recommendations.

Focus group participants identified several barriers to accessing SRH services, including financial and accessibility challenges, insufficient advertising, differing beliefs with providers, poor communication, lack of in-language resources, stigma, discomfort, and rushed or delayed healthcare results.

> "I think overall, I've had good experiences, but if I were to say, it probably would be communication, or just not feeling comfortable with the discussion, or if I feel like I'm rushed…yes, things like that, and not providing…sometimes you don't get your results in time."
>
> – Hye-Jung, a Korean participant

However qualitative participants also shared best practices for providing support for someone to access SRH services. Financial and moral support, transportation, anonymous texting service programs, and knowledge exchange based on experience were all identified as facilitators to improve access to SRH care for family and community members.

> "...explain to them about sexual health terms or taking them to Planned Parenthood. I would definitely do that for any of my cousins. I think also financially if any of my close friends need [an] abortion and they were low on money, I wouldn't mind pitching in and then also going with them, driving them to the clinic, and then helping them through the process."
>
> – Aparna, a Bengali participant

Some participants highlighted the connection between their culture and accessing SRH services. One participant described how cultural community centers could serve as safe spaces for the community to discuss SRH issues and address stigma. Others raised concerns about misogyny and divorce as taboo topics in their culture, which may influence other SRH-related discussions.

> "Other facilitators would be like, maybe [if] there was a better transportation or doulas or someone who would be willing to go with them. Because it is scary to go to these places by yourself...I wish we had, each community has its own community center, maybe there's a Vietnamese community center or a Chinese community center. I wish we had like a subsection in these community centers for women or just other people who are interested in sexual reproductive health. Have a safe space and gather information together, that would be really nice. Then it'd be more intersectional within our community and could help defeat the stigma. Obviously, that's a fairytale world. I don't see that happening anytime soon, but it's a possibility."
>
> – Aparna, a Bengali participant

> "I do believe unfortunately a lot of South Asian communities, misogyny is so heavily transpired within generations as a way to keep women apart or just not talking about the things that we should be talking about. I feel like because of systems like that, communities can never grow as they should."
>
> – Jessica, a Bengali participant

> "...bringing up misogyny as well because I know that even in Korean culture, the concept of divorce initiated by a woman is completely taboo. If that's taboo, what is it going to look like for our sexual reproductive rights? That really trickled into the family dynamic for me personally."
>
> – Laura, a Korean participant

Participants offered a range of recommendations for culturally inclusive care to improve access to SRH services for AANHPI communities in Georgia. They suggested that healthcare providers address misconceptions about SRH, use clear and accessible language, treat clients with respect, minimize judgment, maintain professionalism, build trust, and actively listen.

> "Having a provider that was able to myth bust everything that I grew up believing when it came to like sex as a taboo and all the conservative points of views or the mistrust when it comes to birth control and things like that. How they're able to educate me in a proper way without making me feel like it was a debate or argument or something like that, so communication skills."
>
> – Laura, a Korean participant

AANHPI participants also suggested that providers should increase their cultural sensitivity with patients. Participants recommended more translation services, SRH information that is targeted to priority communities, providers who speak a range of languages, services that are sensitive to religion and culture (e.g., Islam and premarital sex), and accessible information at community centers that is sensitive to cultural norms.

To improve healthcare services, participants emphasized the need to train more female doctors, expand SRH information and education, and address discrimination due to race or disability, which may hinder people from seeking SRH services.

AANHPI participants stressed the importance of wraparound support that includes medical and non-medical services and resources to improve their overall well-being and improve access to SRH services–particularly coupons, transportation, affordable care, and more visible SRH services in every community. Participants also recommended broader strategies such as working to reduce the mortality rate and research conservative opinions around SRH, especially among the older generation.

> "I feel a lot of the information especially that my parents and older generation get is from WhatsApp or false Facebook advertisements and they believe that that is what sex health is and I think that's really concerning."
>
> – Aparna, a Bengali participant

Discussion

This research aimed to uncover the barriers that AANHPI communities in Georgia face when accessing sexual and reproductive health (SRH) services at individual, community, and policy levels. The study included surveys and focus groups across four counties, representing a diverse cross-section of AANHPI communities. Alarmingly, survey results reveal that nearly half of the AANHPI respondents lacked health insurance and that less than one-third consistently met their basic needs in the past month, underscoring the urgent need for increased support services.

SRH Access and Experiences

The survey found that many participants who did not have a regular SRH provider cited financial

constraints and infrequent visits. When choosing an SRH provider, the most important factors were gender and a nonjudgmental attitude, with language being the least important—possibly because most participants spoke English. Although most participants had a regular SRH provider, Asian respondents were more likely to see their provider regularly but also experienced higher levels of judgment. In contrast, NHPI and Mixed Race participants visited their providers less frequently but reported fewer instances of judgment or discrimination.

The study also highlighted different SRH topics discussed across racial groups. Asian participants were most likely to talk about STIs, Mixed Race participants were the most vocal about SRH topics in general, and NHPI participants primarily discussed sex and SRH. Abortion was the least discussed topic across all AANHPI communities, reflecting its strong associated stigma. When it came to SRH knowledge, Asian participants felt the most knowledgeable overall, while NHPI participants reported the most knowledge about sex. Mixed Race participants had strong knowledge of both STIs and SRH topics. Abortion, however, remained the area where participants felt the least informed, aligning with the findings that it was rarely discussed.

Cultural Dynamics and Provider Relationships

Focus group findings revealed a wide range of relationships with culture and community among participants—some felt deeply connected to their cultural roots, while others were more distanced. Due to a lack of comprehensive SRH education in schools, some (11%) participants turned to family for basic information and sought more detailed answers from the internet or medical professionals. Family support for SRH issues was mixed, and when participants turned to healthcare providers, they expressed a preference for those who shared their gender or cultural background. Experiences with SRH providers were equally mixed: positive experiences were characterized by transparency, while negative experiences often involved judgment.

Cultural beliefs and norms also played a significant role in shaping access to SRH services. Some cultural practices facilitated access, while others created barriers. Participants recommended that SRH services improve cultural awareness and patient-provider dynamics to foster a sense of being heard and respected. They also emphasized the need for SRH services to expand social support and combat widespread misinformation and conservative opinions that often undermine AANHPI individuals' lived experiences.

Policy Implications

Overall, the survey results and focus group discussions provide valuable insights into the sexual and reproductive health experiences of AANHPI communities in Georgia. The study's findings underscore the complex dynamics surrounding SRH within AANHPI communities and highlight several key barriers to access. The findings also reinforce a recent NAPAWF study which identified various barriers to medication abortion among AANHPIs, including community stigma,

a lack of community support, and limited multilingual resources at abortion clinics.[8] Addressing these challenges requires concerted efforts at individual, community, and policy levels to ensure equitable access to SRH services for all AANHPI individuals.

At the individual level, stigma, misinformation, and cultural norms present significant obstacles. Providers must actively dispel myths about SRH, especially concerning abortion, which remains a taboo topic. Safe spaces for discussing SRH are crucial to overcoming cultural and family pressures. Additionally, with the reliance on digital sources of information, it is important to recognize the legal risks associated with accessing abortion information and services online, especially in legally restrictive states. A recent NAPAWF report highlighted these risks, particularly in the post-Roe era, where accessing information online can lead to significant privacy concerns.

Community-level barriers include a lack of support services and limited access to culturally relevant sexual health information. These challenges are exacerbated by community pressures and judgments related to contraception.

At the policy level, discrimination and inequities in the healthcare system contribute to reduced access to SRH services. The lack of diversity among healthcare providers further limits the cultural sensitivity needed to effectively serve AANHPI communities. Finally, high healthcare costs, especially for those without insurance, present a significant barrier to care.

Policy Recommendations

The research highlights the intersectional barriers AANHPI women face in accessing SRH in Georgia, revealing systemic disparities driven by economic instability, cultural and linguistic challenges, and exclusionary healthcare policies. To address these challenges, the following recommendations focus on actionable steps at the local, state, and federal levels, targeting policymakers, healthcare providers, and community organizations to ensure equitable SRH access for all AANHPI individuals.

Local and State Level

- Georgia legislators must prioritize **Medicaid expansion** to include all immigrants, regardless of immigration status or the current five-year waiting period. This will ensure that AANHPI women, along with other immigrant communities, have access to life-saving healthcare, including reproductive health services.

- Georgia should legislate **culturally competent healthcare mandates** that require comprehensive training for healthcare providers on cultural awareness, language

accessibility, and non-judgmental care, especially in counties with large immigrant populations like Cobb, DeKalb, Fulton, and Gwinnett.

- Fund and support **community health centers** that offer SRH services alongside wraparound support such as language access, social services, and culturally sensitive educational programs. These centers should serve as safe spaces where AANHPI women can access SRH care without fear of stigma or judgment.

- Provide incentives for hospitals and healthcare systems to **hire and train** more diverse AANHPI SRH providers, as well as ensure that all providers have cultural sensitivity training. Having healthcare providers who understand the cultural and linguistic needs of the AANHPI community will significantly improve patient outcomes and trust in the healthcare system.

- Expand Medicaid to include reimbursement for **doula care**, providing additional support for during pregnancy, childbirth, and postpartum care. Doulas play a critical role in supporting pregnant people through childbirth, especially in marginalized communities. Medicaid reimbursement for doula services will improve maternal health outcomes, particularly in communities where healthcare disparities are most pronounced.

Community and Organizational Level

- Support the creation and dissemination of **multilingual and culturally appropriate** SRH materials in formats tailored to AANHPI communities. These materials should be available through ethnic media outlets and include **gender-specific and gender-expansive resources**.

- Partner with community organizations to create and promote culturally sensitive SRH educational campaigns. These campaigns should **normalize conversations** about SRH, **correct misinformation**, and **increase knowledge** of contraception and abortion.

- Fund AANHPI community centers to provide **safe spaces** for open discussions on SRH issues. These spaces should foster cross-cultural collaboration and accommodate the growing needs of mixed-race individuals.

Federal/National Level

- The Health Resources and Services Administration (HRSA) should establish a private, non-federal funding mechanism to support abortion services within **Federally Qualified Health Centers** (FQHCs), ensuring comprehensive reproductive healthcare for low-income women,

including AANHPI individuals.

- **Remove the five-year waiting period** for Medicaid eligibility and extend healthcare coverage to undocumented immigrants.

- Fully enforce **Section 1557 of the Affordable Care Act** to ensure culturally and linguistically competent care across all HRSA programs, especially in FQHCs and community health centers.
  - Mandate language access services at all HRSA-funded facilities.
  - Require training for healthcare providers on cultural competence and non-discriminatory care, with a focus on AANHPI, Black, Indigenous, and other women of color.
  - Monitor compliance with Section 1557 to ensure providers do not discriminate based on race, language, or immigration status.

- Allocate funding for the **collection and disaggregation** of data on AANHPI health outcomes to better understand the unique challenges different subgroups face and use this data to tailor public health interventions and SRH services.

- Increase collaboration between national abortion providers, community health centers, and philanthropic organizations to develop a **repository of translated SRH materials** in multiple AANHPI languages.

- Expand **anti-discrimination training** through partnerships with the HHS Office for Civil Rights (OCR), Centers for Medicaid and Medicare Services (CMS), and insurance carriers to ensure compliance with Title VI of the Civil Rights Act and the ACA.

- Expansion of HHS Office of Minority Health's **Cultural Linguistically Appropriate Standards** (CLAS) training to ensure a wider reach among more diverse SRH providers and community health centers.

- More **proactive anti-discrimination trainings** between OCR and SRH provider affinity groups and associations, in addition to training partnerships with Centers for Medicaid and Medicare Services (CMS) and insurance carriers to ensure anti-discrimination obligations under the Affordable Care Act and Title VI of the Civil Rights Act are met.

- Increased collaboration with **minority health affinity associations**, such as the National Coalition of Asian Pacific Islander Providers (NCAPIP), to inform and build policies that advocate for culturally specific care and clinical protocols.

- Increased **partnerships between national abortion providers and philanthropic organizations** to support the creation of a bank of key translated materials on SRH topics in more AANHPI languages for care providers and community health centers.

Research

To gain a more comprehensive understanding of the SRH experiences and needs of diverse AANHPI communities, future research should be adequately resourced to explore additional factors and perspectives.

- Research should delve deeper into diverse AANHPI communities, including those with varying sexualities and genders, to explore additional intersections and identify further barriers to SRH care. This would enable the development of tailored recommendations for addressing these challenges.

- Expanding outreach into AANHPI communities using their own terminology can foster more open discussions about highly stigmatized SRH issues.

- Further research with AANHPI SRH providers may address the expectations of AANHPI patients and provide opportunities to upskill other SRH providers that are more sensitive to the needs of AANHPI communities.

Conclusion

Sexual and reproductive healthcare is indispensable for AANHPI communities, who confront a complex web of individual, community, and policy-level barriers when accessing SRH services in Georgia. This study, through its diverse range of AANHPI participant voices, offers a nuanced understanding of the context behind these barriers, emphasizing the critical need for disaggregated data on one of the most underrepresented racial groups in research.

Despite persistent threats to SRH care in Georgia, this study underscores the urgent need to support AANHPI communities in improving SRH outcomes, including abortion. By implementing policy and community organizer recommendations, we can advance sexual and reproductive healthcare, rights, and justice, ultimately dismantling the barriers that AANHPI communities face in accessing these essential services.

Resources

To find support for sexual health issues in Georgia: The *Amplify Georgia Collaborative* is comprised of local reproductive health, rights, and justice organizations dedicated to expanding abortion access and advancing reproductive justice in Georgia through policy change, culture shift, and education.

To learn more about sexual and reproductive health topics: The mobile app *Euki* is available for download on the App Store and Google Play. This app is reliable, anonymous, secure, and does not store or track user data.

If you or anyone you know needs an abortion: Head 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*.

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Appendix

Appendix 1

Survey Contents

Screener Questions

I. How old are you? [Eligible= 18-49]

II. In what state or US territory do you live? [Eligible= Georgia]

III. In what Georgia county do you live? [Eligible=Cobb, DeKalb, Fulton, Gwinnett]

IV. How do you identify your race or ethnicity? Please select all that apply. [Eligible=Asian, Native Hawaiian, Pacific Islander or Mixed Race]

- American Indian or Alaskan Native
- Asian (includes having roots in South Asia, Southeast Asia, East Asia, and Middle Eastern countries)
- Black or African-American
- Hispanic, Latina, Latinx, or Spanish origin
- Native Hawaiian
- Pacific Islander
- White
- Mixed race that includes Asian, Native Hawaiian, or Pacific Islander
- Another race, ethnicity, or origin (please specify)

V. [*If selected "Asian"*] Asian Americans have their roots in many different countries and ethnicities. What do you consider your country of origin or Asian ethnic group? (Select all that apply)

- Chinese, except Taiwanese
- Taiwanese
- Thai
- Bangladeshi
- Burmese
- Japanese
- Asian Indian
- Filipino
- Vietnamese
- Korean
- Pakistani
- Hmong
- Cambodian
- Malaysian
- Laotian
- Sri Lankan
- Native Hawaiian
- Pacific Islander
- Other Asian (specify)
- Don't know
- Prefer not to answer

VI. [*If selected Pacific Islander*] You said you identify your race/ethnicity as Pacific Islander. What specific ethnic group do you identify with? (Select all that apply)

- Samoan/American Samoan
- Guamanian
- Tongan
- Fijian
- Other Pacific Islander (specify)

VII. Were you born in the United States, including Puerto Rico, US Virgin Islands, or US-affiliated Pacific Islands? Please remember that your survey responses are confidential and are not linked to your personal information

- Yes
- No
- Prefer not to answer
  - [*If no*] How many years have you lived in the US?

VIII. What best describes your current gender identity? (Select all that apply) [Eligible = anyone except "Man" or "cisgender man"]

- Woman
- Agender
- Cisgender woman (a person that identifies as a woman and was assigned female sex at birth)
- Cisgender man (a person that identifies as a man and was assigned male sex at birth)
- Genderqueer
- Man
- Non-binary
- Transgender Man
- Transgender Woman
- Two-Spirit (feel free to include your tribe's specific language for your identity, if you would like)

Additional gender category, please specify:

Prefer not to say

Survey Questions

Thank you for agreeing to fill out this survey. We would like to ask you some questions about your knowledge, attitudes, and experiences with sexual and reproductive healthcare in Georgia. If you do not want to answer a question, please choose "Prefer not to answer". If you do not want to continue, you can stop the survey at any time.

Section I: Demographic Information
First, we would like to ask some general questions about yourself.

1. What language(s) do you speak at home? (Check all that apply)
- English
- Cantonese
- Vietnamese
- Tagalog
- Mandarin
- Korean
- Hindi
- Urdu
- Other Asian Indian languages
- Japanese
- Arabic
- Not listed Other (Specify)

2. How religious would you consider yourself?
- Very religious
- Somewhat religious
- Not at all religious
- I don't know
- Prefer not to answer

3. Do you consider yourself to be: (select all that apply)
- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Queer
- Questioning
- Same-gender loving
- Straight/heterosexual
- Another sexual orientation (please specify)

- Prefer not to answer

4.Have you given birth to any children?
- Yes
- No
- Prefer not to answer

[*If yes*] How many children have you given birth to?

5. What is the highest grade in school that you have completed?
- No formal education
- Less than high school
- High school degree or GED
- Trade or technical school
- Some college
- College degree
- Some professional school or advanced education
- Professional or advanced degree
- Prefer not to answer

6. How would you describe your employment and student status now? (Select all that apply)
- Working part time or full time
- Student (full or part time)
- Unemployed and not looking for work
- Unemployed and looking for work
- Retired
- Permanently disabled
- Taking care of home or family
- Other (please specify)
- Prefer not to answer

7. How much total combined money did all members of your household earn in 2021?
- Total household income in $:
- I don't know
- Prefer not to answer

8. During the past month, would you say you had enough money to meet your basic living needs such as food, housing, and transportation?
- All the time
- Most of the time
- Some of the time
- Rarely
- Never
- I don't know
- Prefer not to answer

9. Do you currently have health insurance or are covered by someone else's?
- Yes
- No
- Don't know
- Prefer not to answer

[*If yes*] What type of health coverage? (Select all that apply)
- Private health insurance, including insurance that you have through your or your partner's job, your school or college, your parents
- Military insurance (TRICARE)

Indian Health Service
Insurance through Obamacare (Affordable Care Act, ACA)
Medicaid, Medicare, Medi-Cal, Title XIX, or any other state or federal sponsored health plan for low-income families
Any other type of medical coverage or health insurance (please specify)

Section II: General Healthcare Experiences
Next, we would like to ask some questions related to your general healthcare experiences.

10. In general, how would you describe your own health?
Excellent
Very good
Good
Fair
Poor
I don't know
Prefer not to answer

11. Do you have a regular doctor or healthcare provider you usually see when you are sick or need routine care?
Yes
No
Prefer not to answer

[*If no*] What are the reasons you do not have a regular reproductive healthcare provider? (Select all that apply)
I haven't found one that I like
I do not go to a reproductive healthcare provider regularly
I move around frequently
Financial constraints
Challenges related to immigration status or restrictions
I do not have insurance
I haven't found a provider who speaks my preferred language for healthcare related topics
Having the same doctor is not a priority for me
Challenges making an appointment
I do not feel the need to have a regular healthcare provider
Another reason (please specify)
I don't know
Prefer not to answer

12. In the past 2 years, have you seen a doctor or healthcare provider?
Yes
No
Don't know
Prefer not to answer

[if yes] In the past two years, have you talked about any of the following with your doctor or healthcare provider? (Select all that apply)
Diet, exercise and nutrition
Smoking
Alcohol or drug use
Mental health issues, such as anxiety or depression
Domestic violence or dating violence
Your sexual history or relationships
Contraception or birth control
Menopause
HIV
PrEP, the pill to prevent HIV
Another type of sexually transmitted infection, like chlamydia or gonorrhea
Don't know
Prefer not to answer

[If yes to Q12 → Q14]

[If no to Q12 → Q16]

13. In the past two years, have you had a general check-up, sometimes called a "well visit"?
Yes
No
Don't know
Prefer not to answer

14. Thinking about your healthcare visits in the last two years, did you experience any of the following? Your healthcare provider...

	Yes	No	Don't know	Prefer not to answerr
Didn't believe you				
Were telling the truth				
Suggested you were personally to blame for a health problem you were experiencing				
Assumed something about you without asking				
Dismissed your concerns				

[*If "yes" to any items in Q16*]

15. Do you think the healthcare provider treated you this way specifically because of any of the following reasons? (Select all that apply)

- Your race/ethnicity
- Your culture or traditions
- Your religion
- The language you speak
- Your gender/gender presentation
- Your sexual orientation or perceived sexual orientation
- Your age
- Your ability to pay
- The type of health insurance you had
- Because you did not have health insurance
- None of these reasons
- I don't know
- Prefer not to answer
- Not listed/Other (please explain)

Section III: Sexual and Reproductive Health Experiences

Next, we would like to ask you about your experiences related to sexual and reproductive health.

16. Do you have a regular reproductive healthcare provider or a provider you typically go to for reproductive healthcare needs? This could be a visit where you got an annual gynecological exam, birth control method, or a test for STDs or pregnancy.

- Yes
- No
- Prefer not to answer

[*If no*] What are the reasons you do not have a regular reproductive healthcare provider? (Select all that apply)

- I haven't found one that I like
- I do not go to a reproductive healthcare provider regularly
- I move around frequently
- Financial constraints
- Challenges related to immigration status or restrictions
- I do not have insurance
- I haven't found a provider who speaks my preferred language for healthcare related topics
- Challenges related to cultural stigma surrounding sexual and reproductive health
- Having the same doctor is not a priority for me when seeking reproductive healthcare
- Challenges making an appointment
- I do not feel the need to have a regular reproductive healthcare provider
- Another reason (please specify)
- I don't know
- Prefer not to answer

17. When was the last time, if ever, you saw a doctor or nurse for a gynecological or OBGYN exam? These are exams that doctors do to check a person's reproductive organs.

- Within the past 12 months
- More than one year ago but within the past three years
- More than three years ago
- Have never seen a doctor or nurse for an OBGYN exam
- Prefer not to answer

[*If "Have never seen a doctor or nurse for an OBGYN exam" or "Prefer not to answer" → Q21*]

18. In the past two years, have you had the following medical test(s)?

- Pap smear or pap test
- Colon cancer screening, like a colonoscopy or a blood stool test
- Mammogram
- Test for HIV, the virus that causes AIDS
- Test for any other sexually transmitted infection besides HIV/AIDS, such as chlamydia or herpes

19. Have you ever felt that a reproductive health professional you saw judged you unfairly or treated you with disrespect for any reason?

- Yes
- No
- I don't know
- Prefer not to answer

[*If yes] Do you think this was because of any of the following [select all that apply*]

- Your race/ethnicity
- Your culture or traditions
- Your religion
- The language you speak
- Your gender/gender presentation
- Your sexual orientation or perceived sexual orientation
- Your age
- Your ability to pay
- The type of health insurance you had
- Because you did not have health insurance
- None of these reasons
- I don't know
- Prefer not to answer
- Not listed/Other (please explain)

20. Please indicate which of the following are most important to you when you are choosing a reproductive healthcare provider (Select all that apply):

Nonjudgmental
The same gender as me
The same race/ethnicity as me
Speaks and/or works with other clinic staff or offers services my preferred language or in a way that I understand
Shares my religion/beliefs
Able to understand or relate to my culture
Able to explain everything to me in words/ terms that I can understand
Offers information in my preferred language
Offers traditional medicine options/treatments
Is covered by my health insurance provider
From the same country of origin
Other (please specify)

Section IV: Sexual and Reproductive Health Information Sources
Next, we will ask about sexual and reproductive health information sources available to you.

21. Where would you go for information on sexual and reproductive health topics such as contraception, STIs, abortion, etc.? (Please select your top two sources)

Ask at a pharmacy
Ask a doctor or other healthcare provider
AANHPI specific community-based resource such as a community-based provider or other resource specific to AANHPI communities
Call a hotline
Talk or text to a friend or family member
Teacher or counselor at school
Internet (i.e., webpages, videos, online chat, social media platforms such as Facebook, Instagram, etc.)
Other (Please specify)
I don't know
Prefer not to answer

22. Thinking about your experiences growing up, how often did your parent(s)/guardian(s) discuss sexual and reproductive health topics such as sexual activity, birth control methods, sexually transmitted infections, abortion, etc.

Never
Rarely
Sometimes
Often
I don't know
Prefer not to answer

23. Thinking about your experiences growing up, how often did your parent(s)/guardian(s) discuss the following topics...

	Never	Rarely	Sometimes	Often	I don't know	Prefer not to answerr
General sexual and reproductive health						
Birth control methods/ contraception						
Sexuality and sexual behavior						
Sexually transmitted infections						
Abortion						

24. How knowledgeable do you feel about: [sexual and reproductive health; contraception; sex; sexually transmitted infections (STI's); abortion]?

Not at all knowledgeable
A little knowledgeable
Somewhat knowledgeable
Very knowledgeable

25.Have you ever felt:

	Yes	No	Don't know	Prefer not to answerr
Pressured by anyone to use contraception or a birth control method				
Judged when asking for birth control information				
Judged for not wanting a birth control method				

[If yes to any statement above] From whom did you feel pressured or judged? [Select all that apply]

Family members
My partner
Friends
Doctor/nurse/counselor/other clinic staff
Other (please specify):

Section V: Foreign-born Experiences*[For AAPIs born outside the US]*
Next, we will ask you some questions about your experiences with reproductive healthcare in your country of birth...

26. In your opinion, how would you compare community

attitudes about reproductive healthcare in your country of birth to community attitudes in the US?

- People are more stigmatized for seeking reproductive health services in the US as compared to my country of birth
- People are less stigmatized for seeking reproductive health services in the US as compared to my country of birth
- It is about the same
- I don't know
- Prefer not to answer

27. Are there practices related to sexual and/or reproductive health from your country of birth that you continue to use or observe in the United States?

- Yes (please specify:)
- No
- I don't know
- Prefer not to answer

28. Are there aspects of care in your country of birth that you wish you had in the United States?

Appendix 2

Focus Group Discussion Guide

Introduction

Thank you for agreeing to participate in this study. We have developed some questions to help guide our discussion about experiences with accessing sexual and reproductive health services among people in the Asian American, Native Hawaiian, and Pacific Islander community (AANHPI). The focus group should take between 2 and 2.5 hours. Please feel free to share anything you feel comfortable sharing and keep in mind that there are no right or wrong answers to these questions. If I raise an issue or ask a question you don't want to talk about, you do not have to answer that question. Your opinions are so important to understanding the unique and intersectional lived experiences of the AANHPI community.

This conversation will be audio- (and video- if virtual) recorded because we don't want to miss any of your comments. We will only be using first names today and no names will be included in the final report. If you prefer to use a different name for anonymity, please feel free. Please remember you do not need to answer any questions you feel uncomfortable with and you can leave the discussion at any time. When talking about people you know, please do not mention their name as we want all information to remain confidential.

This is a judgment-free safe space, and we should all feel comfortable and make others feel comfortable in sharing their views and experiences. It's also okay to disagree because conversations that emerge from differences in opinion can be quite enriching – we can disagree in a respectful way, and create a space for us all to express our unique perspectives. As a reminder, information discussed during this session is private, and things you hear others say should not be shared outside of this (in some cases, virtual) room. By participating in this focus group you will:

[REVIEW FOCUS GROUP DISCUSSION GUIDELINES]

1. Agree to respect the confidentiality of others in the focus group discussion by being in a room where others are not present (if possible) (Note: Being in a room with someone other than those participating in the study can affect how people respond and can be seen as a breach of confidentiality for other members of the group who share their experiences)
2. Agree to listen to each other, give everyone an opportunity to participate and talk, and avoid cross-talk
3. Agree that notes will be taken by a member of the study team during the discussion (Note: Any information that would identify you will be removed from typed notes and will not be used for public use)
4. Agree to actively participate in the discussion
5. Agree that the discussion will be audio- (and video- if virtual) recorded

6. Agree to pay full attention to the group and minimize anything that may cause distractions, including cell phones, TV's, etc. If for any reason you have to step away, please let me or one of the other researchers know.

Is that okay with everyone? Do you have any questions before we begin the discussion?
Ok, I am going to begin recording the discussion now. **[SAY FGD NUMBER AND DATE AT THE START OF THE RECORDING]**

I. Background

Let's start by getting to know each other better. Tell me a little about yourself.

1. In terms of your identity, how do you view yourself and how do you think others may view you?
   a. How would you describe your community? **[Interviewer: Can provide suggestions such as family, friends, co-workers, ethnic/racial group, etc. to get to differences based on country of origin/nativity status]**
   b. Probe: Are there any specific aspects, qualities, or events that you believe define your culture?

II. SRH Information Sources

Now that we've taken the time to get to know one another, let's start talking about what accessing information about sexual and reproductive healthcare looks like in your community.

2. Talk about how you first learned about sexual and reproductive health topics, this can look like learning about menstruation, pregnancy, STDs/STIs, consent, etc.
   a. Probe: Where did you learn about this? School, the internet, friends, family?
3. Where do you normally go to get information about sexual and reproductive health?
   a. Probe: This could be family members, friends, or the internet.
4. Who would you consult within your family/friends/community to figure out how to access sexual and reproductive healthcare?
   a. Probe: Did your family support you in going to the OBGYN/seeking SRH care?

III. Personal Experiences with SRH Services

Thank you all for sharing your thoughts. Moving on, we're going to talk about any personal experiences you or your family members/members of your household may have had with regard to accessing SRH services.

5. What factors do you think are important when finding a SRH provider in your community?

   a. Probe: Cultural background, gender, etc.?
6. Can you talk about a time when you accessed high quality SRH services?
   a. Probe: OBGYN services, pregnancy care, contraceptive counseling, etc.
   b. Probe: What made this experience high quality?
7. Can you talk about a time when you accessed low quality SRH services?
   a. Probe: What made this experience low quality?
   b. Probe: Did you return to this provider?

IV. Barriers and Facilitators to SRH Access

Thank you all for sharing your personal experiences, I understand that may have been very hard and we can take a moment to pause if needed **[Interviewer: allow for a 2-5 minute break if needed]**. *Moving on, we're going to talk about perceived barriers and facilitators to accessing SRH services.*

8. Imagine a close friend or family member is asking you to help them access SRH care in your community. How would you support them?
   a. Probe: Financially, with transportation, providing information/recommending a provider
9. What might make it difficult for someone in your community to access SRH services?
   a. Probe: stigma, lack of knowledge, transportation
10. What are some facilitators to accessing SRH services in your community?
   a. Probe: Community health centers, translation services

V. Improving access to SRH Services

As we are about to wrap up our focus group, I want to take the time to do a visioning exercise with you all. In this exercise, I will have you all reflect on your or your communities' experience with accessing SRH services and ask you all to provide examples or ideas on how access to services can improve.

11. What would culturally inclusive care look like to you when accessing SRH services?
   a. Probe: How can providers improve their services and counseling to make you more comfortable seeking care?

Additional Comments

Is there anything else that you all would like to share that we have not discussed today?
[TURN OFF TAPE RECORDER]

Thank you so much for sharing your thoughts with us. We appreciate your openness and willingness to participate in this study. This has been incredibly helpful. You will receive your gift

cards via email from Rewards Genius- Tango Card within one week of completing this discussion. If you do not receive it within one week, please contact me.

Appendix 3

Survey Participants: Demographic Characteristics (N=483)

Demographic Characteristics	*N (%)*
Georgia County of Residence	
DeKalb	*136 (28%)*
Fulton	*131 (27%)*
Cobb	*110 (23%)*
Gwinnett	*106 (22%)*
Race	
Asian American	*410 (85%)*
Mixed Race	*51 (11%)*
Native Hawaiian/Pacific Islander	*21 (4%)*
Other	*1 (<1%)*
Gender Identity	
Women	*429 (89%)*
Genderqueer	*23 (5%)*
Nonbinary	*22 (5%)*
Transgender Men	*9 (2%)*
Sexual Orientation	
Heterosexual	*280 (58%)*
Bisexual	*78 (16%)*
Asexual	*49 (10%)*
Queer	*44 (9%)*
Lesbian	*20 (4%)*
Gay	*5 (1%)*
Pansexual	*2 (<1%)*
Prefer Not to Answer	*2 (<1%)*
Questioning	*2 (<1%)*
Same-Gender Loving	*1 (<1%)*
Country of Birth	
USA	*396 (82%)*
Foreign Country	*86 (18%)*
Prefer Not to Answer	*1 (<1%)*

Demographic Characteristics	***N (%)***
Health Insurance	
Yes	*253 (52%)*
No	*219 (45%)*
Prefer Not to Answer	*11 (2%)*
Educational Attainment	
College Degree	*158 (33%)*
Some Professional/Advanced Education	*113 (23%)*
Professional/Advanced Degree	*79 (16%)*
Some College Education	*57 (12%)*
Trade/Technical School Education	*23 (5%)*
High School Diploma	*27 (6%)*
Less than High School level	*16 (3%)*
No Formal Education	*5 (1%)*
Prefer Not to Answer	*5 (1%)*
Language Spoken at Home (Select all that apply.)	
English	*435 (90%)*
Korean	*55 (11%)*
Japanese	*21 (4%)*
Cantonese	*19 (4%)*
Mandarin	*19 (4%)*
Hindi	*16 (3%)*
Urdu	*14 (3%)*
Not Listed/Other	*9 (2%)*
Vietnamese	*8 (2%)*
Tagalog	*7 (1%)*
Other Asian Indian language	*4 (1%)*
Arabic	*2 (<1%)*
Employment or Student Status (Select all that apply.)	
Worked Part-time	*254 (53%)*
Worked Full-time	*139 (29%)*
Student	*42 (9%)*
Unemployed and Looking for Work	*30 (6%)*
Taking Care of Home or Family	*20 (4%)*
Permanently Disabled	*7 (1%)*
Retired	*3 (1%)*
Unemployed and Not Looking for Work	*3 (1%)*
Prefer Not to Answer	*1 (<1%)*

Demographic Characteristics	***N (%)***
Basic Needs Met in the Past Month	
Most of the Time	*142 (29%)*
All of the Time	*136 (28%)*
Some of the Time	*136 (28%)*
Rarely	*54 (11%)*
Prefer Not to Answer	*8 (2%)*
Never	*7 (1%)*

Note: Figures may not add to 100% due to rounding.