

Expanding Options

A Reproductive and Sexual
Health Survey of Asian
American Women

National Asian Women's Health Organization
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Korean American Domestic Violence Program

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Korean Health Education Information and Research Center

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Table of Contents

Foreword	
Introduction	1
Methodology	5
Summary of Key Findings	8
Survey Results	14
Future Directions	27
Conclusion	30
Recommendations	32
Appendices	35
I Bibliography	
II Glossary of Reproductive Health Technologies	
III International Standards for Reproductive Health and Technologies	

Foreword

Expanding Options: A Reproductive and Sexual Health Survey of Asian American Women is a breakthrough study of the knowledge of, attitudes towards, and use of reproductive health technologies by Asian American women. It is a breakthrough because Asian American women have been historically neglected in reproductive and sexual health research, education, and services. More importantly, it demonstrates that we have the power to change this now, and for the future.

Recent United Nations gatherings such as the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women, have underscored the importance of women's rights as human rights, stating that all individuals should be able to enjoy all human rights and fundamental freedoms, and that good sexual and reproductive health are an integral part of those human rights. For the past three years, NAWHO's Asian Women's Reproductive and Sexual Health Project has been striving to make this a reality by conducting health assessments and studies such as this survey; by working in coalition with other health, women's, and Asian American organizations; and by educating the public through seminars, conferences, and workshops.

NAWHO believes that the freedom to fully control one's reproductive life will be realized through education and dialogue that is fostered by equal partnerships between health professionals, advocates, and Asian American women themselves. It is our hope that this study will pave the way for increased investigation into the reproductive and sexual health status of Asian American women, thereby taking further steps to ensure that Asian American women enjoy their fundamental freedoms.

Mary Chung
Executive Director

January 1997

Introduction

As part of its mission to improve the overall health status of Asian American women and girls, the National Asian Women's Health Organization (NAWHO) is committed to addressing gaps in knowledge and awareness about the reproductive and sexual health care needs of Asian American women. NAWHO aims to resolve inequities in access to health education and health promotion activities, as well as in health and social services. One key strategy for addressing and challenging these inequities is gathering baseline data on Asian American women, and sharing and discussing these efforts with health care providers, policy makers, the Asian American community, and the general population at large.

Reproductive and sexual health issues have received little attention as concerns that have a significant impact in the Asian American community. Not surprisingly, reproductive and sexual health issues directly affect the quality of every individual's life, and are influenced by one's cultural background, socio-economic conditions, gender and familial relations, and social environment. This study breaks the long-standing taboo around reproductive and sexual health in the Asian American community by carefully examining these issues in a direct, straightforward manner.

As part of the 1993 Sexuality Research Assessment Project (SRAP), researchers from the Social Science Research Council in New York City interviewed professionals in the reproductive and sexual health field, analyzed databases in social science, education, and public health literature, and held brainstorming sessions with leading researchers. The results of the SRAP revealed the need for an expanded information base on human sexuality. Specifically, the findings of the SRAP pointed to the need for "basic, fundamental research that advances...our understanding of sexuality-related behaviors, attitudes, and structures in populations of varied cultural and social backgrounds."¹ Anecdotal information and traditional stereotypes have led to assumptions and biases about the sexual behavior and sexuality of individuals from varied ethnic, cultural, and social backgrounds.

According to the U.S. Census Bureau, Asian Americans represent the largest growing minority population in the United States.² However, very little information is available on the reproductive health needs and practices of the Asian American population, including Asian American women's contraceptive use and attitudes towards reproductive decisions. Stereotypes about Asian women and sexual behavior, including notions of asexuality, or conversely, exotic male-pleasing, continue to persist, contributing to the lack of research and understanding of this largely neglected group. As American society becomes increasingly multicultural, we must understand what the reproductive health needs and concerns of different groups are in order to allocate resources equitably and appropriately for reproductive and sexual health education and

¹ Di Mauro, Diane. (1995) Sexuality Research in the United States. The Social Science Resource Council. New York, NY.

² U.S. Census Bureau (1990).

other health promotion services. We need a rich database of information on a wide range of topics, including contemporary sexual behaviors, attitudes, and practices, in order to better serve this diverse, unique population of women and their partners.

Many of NAWHO's educational efforts have been directed toward raising awareness and knowledge about the reproductive health status of Asian American women. It is NAWHO's intent to educate our membership and constituency to become more involved in activities that would lead to increased access to reproductive and sexual health care, including family planning services, and encourage Asian American women to expand their reproductive and sexual health options.

In 1995, NAWHO began the *Asian American Women's Reproductive and Sexual Health Empowerment Project*, and conducted interviews and focus groups with health care providers to examine the various factors that influence Asian American women's use of reproductive and sexual health services. One of the major findings of this qualitative-based study was that Asian women tend to view gynecological ailments as important and legitimate only when they directly concern reproductive functioning (i.e., pregnancy and pre-natal care). The assessment found that many Asian American women had a limited understanding of the range of reproductive health technologies available, and felt uncomfortable discussing contraception with their partner(s). The project also found that Asian cultural norms placed many restrictions on Asian American women, in terms of the roles they played within the family structure, as well as their lives outside the family.³

These findings underlined the need for research on the effect of cultural norms on sexual and reproductive health including knowledge and awareness, attitudes and comfort level, and behavior. As sociologist Ruth Dixon-Mueller states: "Women's sexual attitudes and behaviors influence contraceptive adoption, choice, and use effectiveness, and the use of particular methods can affect the way people experience their own and their partners' sexuality in positive or negative ways."⁴

All too often, research on contraceptive knowledge, attitudes, and use has neglected to include Asian Americans. Although some literature on contraceptive behaviors of women does exist, none of this research provides adequate information for understanding the reproductive and sexual health behaviors of Asian American women. There are several community-based studies on contraceptive use by Asians in England that focus mainly on Asian Indians.^{5,6,7} These studies indicate that among Asian Indian women in England, the condom, oral contraceptive,

³ NAWHO. (1995) Perceptions of Risk.

⁴ Dixon-Mueller, R. (1996) "The Sexuality Connection in Reproductive Health", in Learning About Sexuality: A Practical Beginning. Zeidenstein and Moore, eds. New York: The Population Council. Pp. 137-158.

⁵ McAvoy, B.P., and Raza, R. (1988) Asian Women: Contraceptive knowledge, attitudes, and usage. Health Trends. Vol. 20: 11-14.

⁶ Woollett, et al. (1991) Reproductive Decision Making: Asian Women's Ideas About Family Size, and the Gender and Spacing of Children. Journal of Reproductive and Infant Psychology., Vol 9: 237-252.

⁷ Rashid, J. (1983) Contraceptive Use Among Asian Women. British Journal of Family Planning. Vol. 8: 132-5.

and IUD are the most common forms of contraception. Another study reports on the acceptability of Norplant by women in five Asian countries.⁸

Few studies on sexual and reproductive health conducted in North America have included or identified Asian Americans; however a small number have looked specifically at the sexual behavior of Asian college students.^{9, 10, 11} One such study, conducted by Sue, found that the sexual behavior of Asian American students was similar to that of other students¹², while a study conducted by Baldwin et al. found that Asians reported: 1) waiting half a year longer than other groups in having oral sex; 2) waiting to know a new partner before engaging in sex; and 3) using condoms for vaginal intercourse approximately 10% of the time more than Whites did.¹³ In a study conducted in Canada by Meston et al, researchers found that Asian students were significantly more conservative than non-Asian students on interpersonal sexual behavior.¹⁴ NAWHO's 1995 study found that Asian American women generally do not receive much information on their reproductive and sexual health concerns, are reluctant to discuss their reproductive health concerns with family or community members, and often have no other sources of information for their health needs.¹⁵ Based on the limited research that has been conducted to date, it was clear that more extensive studies were needed to not only confirm the findings of these smaller studies, but to expand the current body of information about this population of women.

As part of the second year of the *Asian American Women's Reproductive and Sexual Health Empowerment Project*, NAWHO examined the use of reproductive health technologies * by Asian American women in California through a survey of six California counties with significant populations of Asian Americans. It was our belief that a thorough understanding of the current knowledge levels and patterns of use of various reproductive health technologies, such as Norplant, Depo Provera, "morning after" birth control methods, microbicides, and oral contraceptives, would be the first step to ensuring that Asian American women have access to information about the wide range of safe and effective means for controlling fertility and protecting health. Through this survey, NAWHO expected to identify current contraceptive usage patterns of Asian American women, as well as gaps in knowledge and awareness about reproductive health and contraceptive technologies. Although not necessarily applicable to the entire Asian American women's population, the results of the survey will provide an insight to the reproductive and sexual health knowledge and experiences of a significant number of Asian American women; and assist community organizations, health care providers, and policy makers in addressing the reproductive and sexual health needs of Asian American women. This report

⁸ Krueger, et al. (1994) Norplant Contraceptive Acceptability among Women in Five Asian Countries. Contraception. Vol. 50: 349-361.

⁹ Sue, D. (1982) Sexual experience and attitudes of Asian American students. Psychological Reports, Vol. 51: 401-402.

¹⁰ Baldwin, et al. (1992) The Effect of Ethnic Group on Sexual Activities Related to Contraception and STDs. The Journal of Sex Research. Vol 29(2): 189-205.

¹¹ Meston, et al. (1996) Ethnic and Gender Differences in Sexuality: Variations in Sexual Behavior Between Asian and Non-Asian University Students. Archives of Sexual Behavior. Vol. 25 (1): 33-72.

¹² Sue, D.

¹³ Baldwin, et al.

¹⁴ Meston, et al.

¹⁵ NAWHO.

provides a summary of the research methodology used, the results of the survey, and recommendations on how to use the key findings of the project. A copy of the survey may be obtained by calling the NAWHO office.

* **Terminology** We recognize that the word “technology” denotes several connotations, such as a scientific fix, and a focus on hormonal or provider dependent methods, as opposed to more organic, simpler methods. While we realize the limitations of the word “technology”, for the purposes of this report, we are using the term “reproductive health technology” to mean those methods and behaviors that are used to control fertility and protect reproductive health. This broad definition encompasses the standard and older forms of contraceptives, such as the birth control pill, as well as newer technologies including RU-486 and emergency contraceptives. Please see Appendix I for a glossary of the reproductive health technologies that were included in this study.

Methodology

The results from the first year of the *Asian Women's Reproductive and Sexual Health Empowerment Project* stressed the need for more in-depth research on Asian American women and their reproductive and sexual health behavior. In 1996, NAWHO directed its research efforts to specifically expand upon these findings by studying Asian American women's knowledge of, attitudes towards, and use of reproductive health technologies. Using the following methodologies, NAWHO conducted an extensive reproductive and sexual health survey of Asian American women in six California counties with significant Asian American populations.

Background Review

NAWHO initially reviewed existing data and literature related to Asian American women and reproductive health technologies. (See Appendix II for bibliography) These included both mainstream and Asian American literature and surveys. In addition, NAWHO assessed relevant statistics from the project counties, including the percentage of Asian American women in each county.

NAWHO interviewed a range of reproductive health care providers and researchers including community outreach workers, health educators, family planning specialists, private physicians, and social science researchers, to discuss the current status of Asian American women and their use and understanding of reproductive health technologies. Issues that were discussed included: common sources of reproductive and sexual health information; underutilization of reproductive health services; knowledge and use patterns of specific contraceptives; and common misperceptions by Asian American women regarding reproductive and sexual health.

This initial background review revealed the paucity of information about Asian American women and reproductive health technologies in existing research findings and highlighted the need to collect baseline data on Asian American women and reproductive health technologies. While it also revealed an interest of both providers and researchers in this area, the lack of appropriate services and research tools clearly emerged.

Survey Design

NAWHO used a descriptive, cross-sectional survey design to assess knowledge, attitudes, and behaviors concerning reproductive health technologies. A questionnaire was developed through a consultative process with researchers, health professionals, and Asian American community health workers. During this development phase, the initial scope of the survey was

expanded to include issues such as utilization of reproductive health services and views on abortion, that had been raised as additional areas of concern. The survey was pre-tested with 20 Asian American women of different ages and ethnicities within the study counties. These women were either interviewed or asked to write their comments on the content and wording of survey items. The final version of the survey incorporated these suggestions.

The survey includes a brief description of the purpose of the study, along with a guarantee of confidentiality. It contains questions on demographics, sources of information about reproductive and sexual health, comfort level discussing various topics, such as menstruation and birth control, knowledge and use of reproductive health technologies, and desired qualities in an ideal form of contraception. The prevention of pregnancy and sexually transmitted diseases are separated in several items of the survey, in order to examine if and how Asian American women view these two concerns differently. The questionnaire takes approximately 20 minutes to complete, and includes 264 items. A majority of these (260) are closed-ended, providing response categories. However, four open-ended questions to examine women's attitudes or reasoning behind selected topics such as choice of contraceptive, are included in order to allow respondents to write in their answers.

Data Collection

The target population for this research project was Asian American women between the ages of 18 and 35, living in six California counties with significant Asian American populations: Alameda, Fresno, Los Angeles, Sacramento, San Francisco, and Santa Clara. (See Table 1 on page 12) This age range was chosen because it includes women of reproductive age. Due to logistical considerations, the survey population was not randomly sampled. Instead, a convenience sample was used, with an extensive survey dissemination strategy as described below.

NAWHO utilized many different strategies to ensure that the diversity of the Asian American population was represented in the study population. Main points of distribution included: health centers (including community, reproductive health clinics, private physicians, and health maintenance organizations), cultural organizations and functions, community-based organizations, universities, community colleges, and professional associations. A large number of NAWHO volunteers distributed the surveys to various other localities. The counties with smaller populations, Fresno and Sacramento, required more intensive outreach efforts than the other counties in order to distribute and collect the surveys. These included consultations with community leaders, as well as meetings with political, cultural, and social organizations. Most surveys were returned in self-addressed, stamped envelopes provided by NAWHO, and the remainder were collected by individuals working at the places of distribution or by NAWHO volunteers. Approximately 3,000 surveys were disseminated, and 734 surveys were returned to the NAWHO office. Follow-up phone calls and meetings with community-based organizations, along with the enclosure of self-addressed envelopes helped to secure a high return rate of 24%.

Data Analysis

Sixty of the returned surveys were not analyzed because the respondents did not fall in the age range of 18 to 35, or failed to indicate their age. The responses to questionnaire items for the remaining 674 surveys were coded and then entered by a professional data entry company.¹⁶ Each survey was given an identification number to ensure confidentiality. A word processing, database, and statistics program for public health was used to analyze the quantitative data.¹⁷ Any missing values for each item were omitted during the analysis. The qualitative data was analyzed using content analysis methods of key words analysis and summary.

Limitations of Survey

While every effort was made to ensure the integrity of the research methodology and analysis, a survey of this scope can not claim to be completely representative or exhaustive. A few limitations were inherent in the survey design. The use of a convenience sample certainly limited the generalizability of the data. At the same time, the diversity and sample size of the respondents, while providing an important “big picture” of Asian American women in the counties, precluded the ability to analyze the data more specifically, for example, by country of origin. In many cases, categories were combined to provide significant numbers for analysis. Due to logistical constraints, the questionnaire was only distributed in English, thus limiting the sample.

Additionally, some limitations emerged in the data analysis phase, providing useful lessons for future research efforts. For example, the study sample that emerged was generally well-educated and of middle-to-high socioeconomic status, suggesting the need for even more innovative outreach efforts and participatory research methods when working with Asian American communities. Additionally, while most of the language used in the survey emerged during the pre-test phase, some terms such as “non-vaginal sex” could have included examples for clarification. Some confusion also emerged when answer choices included those which could be subjectively defined, such as “trusting partner”. These linguistic and conceptual difficulties reaffirmed the challenges of doing research in the area of sexuality, and the need for community-based research through methodologies that are participatory and qualitative. This is particularly true when working with the diversity of Asian American communities. Such research could build on base-line data, or provide the basis for collecting quantitative data.

These limitations notwithstanding, the process and findings of the survey provide important lessons learned and information for community activists, health providers and educators, researchers, and policy makers. The knowledge, attitudes, and behaviors of Asian American women with regard to reproductive health technologies undoubtedly affect the health of women and their communities. This survey is an important step in better understanding that impact.

¹⁶ CDS Data Entry Services in San Francisco.

¹⁷ EpiInfo, Version 6.

Summary of Key Findings

This section outlines some of the major findings of NAWHO's Reproductive and Sexual Health Survey of Asian American Women, based on an analysis of 674 surveys collected from Asian American women between the ages of 18 and 35 in six California counties.

1. The **diversity** within the Asian American women's population cannot be underestimated.

- ≡ Over 20 Asian ethnicities were reported, with respondents born in over 30 different countries.
- ≡ The average age of respondents was 24 years old.
- ≡ Two thirds of the respondents (66%) were foreign-born.
- ≡ 81.1% of the sample had at least "some college level education".
- ≡ More than half of the women in the study (57.5%) were working either part-time or full-time. Most of the respondents (78.7%) were single and 90% did not have children.
- ≡ 11.2% of the sample reported an income level less than \$15,000; while 30.2% reported an income level between \$25,000 and \$49,000.
- ≡ The number of individuals providing this income ranged from 1 to 7, and the number of individuals supported by this income ranged from 1 to 13.

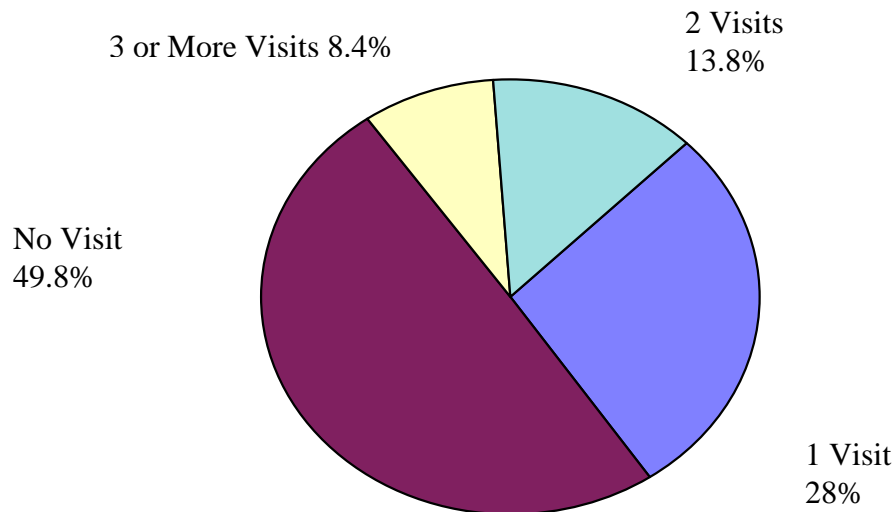
2. Contrary to popular stereotypes, many Asian American women are **sexually active**.

- ≡ Over two-thirds (67.4%) of the sample reported having at least one sexual partner in their lifetime. The average number of sexual partners, for those sexually active, was 4.0, and the average age of first sexual intercourse was 18.5 years old. In terms of sexual orientation, 3.3% of the respondents reported having sex with women only; 91.3% with men only; and 5.4% with men and women. Of the sexually active women surveyed, many appeared to be in monogamous relationships: 36.6% had only one sexual partner in their lifetime, and when asked about sexual partners in the last 6 months, the majority (76.8%) reported having only 1 partner.

3. Many Asian American women have private sources of **health insurance**.

- ≡ A majority of the sample (52.2%) had private insurance, and the most common source of reproductive and sexual health care was a private physician (35.2%). Although 57.5% of the women surveyed were employed, only 30.3% of the sample indicated that they had job/employer based insurance.

4. Asian American women are not utilizing **reproductive and sexual health services**.



- ≡ Half of the women surveyed (49.8%) have not visited a health care provider within the last year for reproductive or sexual health services. In addition, the survey found that one fourth (25.6%) of the sample had never received any reproductive or sexual health services in their lives.

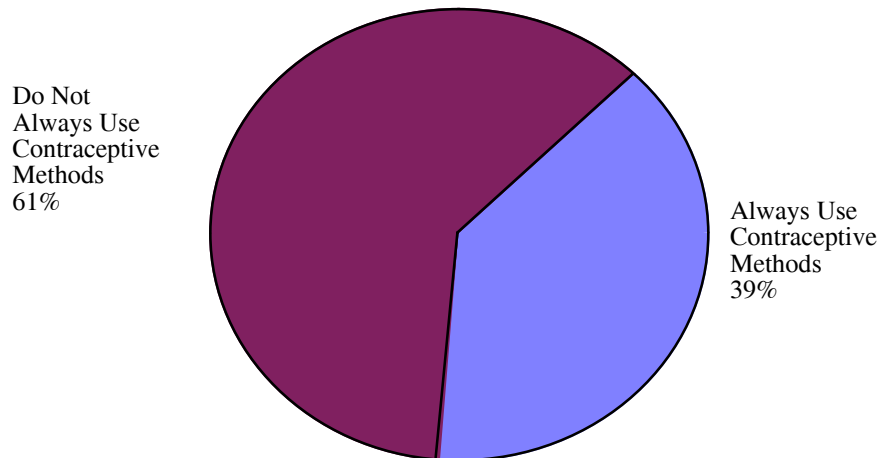
5. Asian American women are not using the full range of **contraceptive technologies** available.

- ≡ Less than 3% of the sample reported ever using Norplant, Depo Provera, or the female condom. Of all forms of contraception, the women surveyed were most aware of the birth control pill and male condom (over 98%).

6. Among the different contraceptives available, Asian American women overwhelmingly feel the most comfortable using **the male condom**.

- ≡ 84% of the sexually active women surveyed had used the condom at some time in their lives. Effectiveness, ease of use and access, affordability, and the lack of side effects were given as reasons for choosing the male condom as a contraceptive. For protection against pregnancy, birth control pills have been used at some time during their lifetime by just over half of the sample, and currently are being used by 28.5% of the sample. Half of the sample (50.5%) have used withdrawal in the past as a method to prevent pregnancy.

7. Asian American women are not adequately protecting themselves against pregnancy.



- ≡ 61% of the sexually active women surveyed stated that they **did not always** use contraceptive methods during sex. The top reason, given by 28.5% of the sample, for not always using contraception was “monogamy/trust of partner”. The next most common answers were “didn’t have it during sex” (16.6%); and “partner doesn’t want to use any” (11.5%).

8. Asian American women are fairly knowledgeable about **certain types** of reproductive health technologies.

- ≡ When asked which types of contraceptive methods or behaviors provide some protection against STDs, most (94.4%) correctly identified condoms. Most women also knew that each contraceptive method offers different levels of protection against STDs, that douching after intercourse is not an effective way to prevent pregnancy, that each woman’s menstrual cycle is different, and that a health provider must be seen to fit a diaphragm to a woman’s vagina size.

9. Asian American women are **not well informed** about other types of reproductive health technologies.

- ≡ The diaphragm, cervical cap, and sponge were correctly identified as providing some protection against STDs by less than 20% of the sample. In addition, some women incorrectly believed that non-vaginal sex, birth control pills, withdrawal, sterilization, IUDs, rhythm method provide some protection against STDs. Two-thirds of the respondents (67%) stated that they did not know whether female condoms could be

inserted a few hours before sex and still be effective, one-fourth (24.9%) incorrectly believed that female sterilization is reversible, and one-third did not know whether sterilization was reversible or not. Slightly more than one-fourth (26.4%) incorrectly believed that Norplant can either be inserted in the arm or taken as a pill. 60.5% of the sample indicated that they could not mark the true items about Depo Provera.

10. Asian American women are unfamiliar with **emerging** reproductive health technologies.

- ≡ Slightly over half of the survey respondents (54.8%) indicated that they were aware of RU-486 (mifepristone). Additionally, there was very little awareness among the sample about the vaginal ring, anti-fertility vaccine, methotrexate, and microbicides, in contrast with the relatively high level of awareness about conventional or established contraceptive methods.

11. **Awareness** of reproductive health technologies is not necessarily correlated with knowledge.

- ≡ Three-fourths (75.9%) of the Asian American women surveyed stated that they were aware of the “morning-after pill.” However, when asked if there is a way to prevent pregnancy if you see a doctor within 3 days of unprotected sex (which are the parameters and purpose of the morning-after pill), only 35.5% answered in the affirmative.

12. Asian American women want more information on contraception and other reproductive health issues from their **doctors**.

- ≡ The study revealed that although 69% of Asian American women are currently receiving information on contraception from their friends, 72% said that they would prefer to receive this information from a physician. In addition, 40% stated that they were very comfortable discussing reproductive health with their doctors. However, when asked how they would prefer to obtain protection against pregnancy, of the women who had a preference, more favored over-the-counter methods (36.8%) than prescription methods (31.9%). Another significant finding was a generational difference: younger Asian American women indicated that they were more likely to receive information from their friends, while older women were more likely to cite their doctor as a source of information.

13. Different forms of **mass media** are important ways through which Asian American women receive information on reproductive and sexual health.

- ≡ Many women identified magazines (63.3%), television (43.1%) and radio (22.3%), as sources they have utilized to get reproductive and sexual health information.

14. Reproductive and sexual health issues are not being addressed in Asian American families.

- ≡ More than one half (52.5%) of the women surveyed were uncomfortable discussing reproductive health with their mother, while they were least comfortable discussing this issue with their father and brother(s). When asked about specific reproductive and sexual health issues, respondents indicated that menstruation was the topic they felt the most comfortable discussing with their parent(s) or caregiver. More than one third of the respondent sample reported never discussing pregnancy, STDs, birth control, and sexuality in their households.

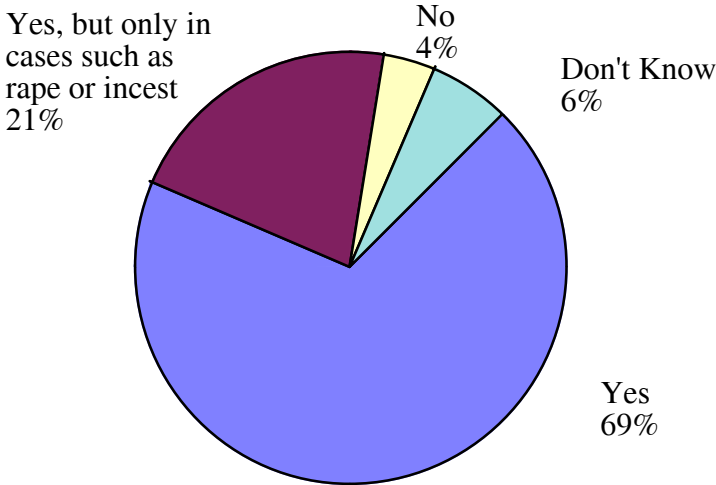
15. Asian American women are not comfortable discussing their reproductive health with their partners.

- ≡ Although a large majority of the sample (90%) wanted their partner to be involved in the contraceptive decision-making process, slightly more than half of the sample (53%) stated that they did not always discuss contraception and “safe sex” with their partner. In addition, a high percentage of the respondents (45.4%) indicated that they were not “very comfortable” discussing their reproductive health with their partner.

16. Asian American women have **clear and specific ideas** of what they want in a form of contraception.

- ≡ Approximately half would prefer a long-term contraceptive. When asked what factors they consider when choosing a form of contraception, the respondents indicated that the following factors were important, in order of preference: effectiveness in preventing pregnancy (94.3%); side effects (74.7%); convenience/easy to use (71.5%); effectiveness in protection against STDs (63.2%); how easy it is to get (45.1%); and cost (44.5%).

17. A majority of Asian American women identify themselves as **pro-choice**.



≡ While 44.6% of the sample were unsure whether they would ever have an abortion, 69.4% indicated that they would support a woman’s decision to have an abortion. In addition, another 20.6% stated that they would support a woman’s decision to have an abortion only in certain cases such as rape or incest. Seventy-one percent (71%) said they would know where to go for an abortion, and 17.3% had already had an abortion.

Survey Results

In the following section, detailed information about the results of the survey is provided. Information is broken down into the following categories: Description of Survey Sample, Health Care Access and Utilization, Sources of Information, Contraceptive Awareness, Sexual Behavior, Contraceptive Use, Knowledge of Reproductive Health Technologies, Comfort Level, and Choosing Contraceptives. The total number of responses reflected in the tables in this report does not always correspond to the total number of surveys analyzed (674) because missing values for each item were omitted during the analysis.

The counties included in the study have large percentages of Asian Americans, according to the 1990 U.S. Census, as indicated in Table 1:

Table 1: Asian Population in 6 Study Counties*

Geographic Area	Asian population (% of total population)	Asian Females 18-35** (% of total Asian females)
California	2,845,659 (9.6%)	316,332 (20%)
Alameda County	192,554 (15.1%)	33,500 (34%)
Fresno County	57,239 (8.6%)	7,399 (25.9%)
Los Angeles County	954,485 (10.8%)	159,922 (32.8%)
Sacramento County	96,344 (9.3%)	14,471 (29.0%)
San Francisco County	210,876 (29.1%)	24,072 (22.0%)
Santa Clara County	261,466 (17.5%)	44,879 (34.9%)

* Source: 1990 U.S. Census, courtesy of Association of Bay Area Governments

** Estimated, based on Census data groupings.

Description of Survey Sample

This section provides detailed demographic information on the Asian American women who participated in the survey. Respondents were asked to provide information on their age, ethnicity, country of origin, education level, employment status, family income, marital status, and number of children in order to provide some descriptive information, as well as to examine the relationship between these variables and knowledge, attitudes, and behavior concerning reproductive health technologies.

County of Residence

Approximately 24% of the respondents were living in Los Angeles County, 23% in Alameda and San Francisco Counties, 13% in Santa Clara County, 8% in Fresno County, 7% in Sacramento, and 2% in other California counties.

Age

As explained in the methodology section, the survey was limited to women between the ages of 18 and 35. The average age of respondents was 24 years old, and the median age was 19 years old. A majority of the women surveyed (86.1%) were under 30 years old.

Ethnicity

In terms of ethnicity, the respondents were very diverse. Over 20 Asian ethnicities were reported. Table 2 summarizes the reported ethnicities of the survey respondents. The proportions correspond somewhat to the ethnicities found in the general Asian American population within California.

Table 2: Reported Ethnicity of Survey Respondents

Ethnicity	Number	Percentage
Chinese	224	33.3%
Filipino	81	12.0%
Korean	75	11.1%
Japanese	49	7.3%
Vietnamese	42	6.2%
South Asian *	41	6.1%
Taiwanese	36	5.4%
Hmong	28	4.2%
Other SE Asian **	35	5.2%
Other Asian ***	15	2.2%
Mixed	48	7.0%
<i>TOTAL</i>	<i>674</i>	<i>100.0%</i>

* South Asian includes Bangladeshi, Indian, Pakistani, and Sri Lankan

** Other SE Asian includes Cambodian, Laotian, Mien, and Thai

*** Other Asian includes Malaysian and Pacific Islander

Country of Origin

Survey respondents were born in 30 different countries. Forty-four percent (44%) of the respondents were born in the United States. The next most common countries of origin were: Vietnam (9.4%), Korea (6.9%), Laos (6.1%), Taiwan (6.0%), and Hong Kong (4.9%). For the 363 respondents born outside the United States, the length of time spent in the US varied greatly, from 1 month to 30 years. The average length of time spent in the US was 14.5 years.

Education Level

As Table 3 indicates, the survey sample was fairly well educated, with only 18.9% having less than “some college level education.”

Table 3: Education Level of Respondents

Level of Schooling	Number	Percent
none / elementary (up to 8th grade)	3	0.4%
high school or equivalent	109	16.2%
some college	208	30.9%
college degree	202	30.0%
some graduate school	61	9.1%
graduate degree	75	11.1%
other (technical school, etc)	16	2.3%
<i>Total</i>	<i>674</i>	<i>100.0%</i>

Health Care Access and Utilization

Respondents were asked about their health insurance and the frequency and types of health care providers they visited for reproductive and sexual health needs, in order to address issues of health care access and utilization. This section provides a summary of the responses given.

Insurance

The type of health insurance a woman has influences her health care utilization greatly. However, possessing health insurance does not guarantee that a woman will see a health care provider more often. In fact, according to a 1992 poll, Asian American women, though the most likely of women of color to have health insurance, are the least likely to have had a pap smear in

the last year.¹⁸ The majority of respondents to this survey (52.2%) indicated that they had private insurance, while 5.5% of the sample was on MediCal or Medicare. The women who had private insurance were generally older, while those on MediCal or Medicare were younger. Of the women who had private insurance, 58.1% had employment-based insurance, 22.7% were covered by their spouse or parent, 10.5% paid premiums themselves, and 8.7% did not indicate the source of their private insurance.

Table 4: Types of Health Insurance

Type of Insurance	Number	Percentage
Private Insurance	344	52.2%
Job/employer based	200	30.3%
You pay premiums	36	5.5%
Spouse/parent	78	11.8%
Didn't indicate type	30	4.6%
Medicare/MediCal	36	5.5%
School-based	106	16.1%
Military/government based	2	0.3%
Self-payment	98	14.9%
No visit	114	17.3%
Other	22	3.3%

Sources of Reproductive and Sexual Health Care

The survey included an item that asked respondents about all of their sources of reproductive and sexual health care, in order to assess Asian American women's utilization of different types of health services. The most common sources of reproductive and sexual health care cited were private doctors and college/school clinics. Health maintenance organizations (HMOs) and community clinics were also important sources of care, while public health departments, STD, and family planning clinics were utilized very little by the respondents. One-fourth of the sample (25.6%) indicated that they have never received any type of reproductive or sexual health care in their lifetime.

¹⁸ The 1991-1992 National Women of Color Reproductive Health Poll. (1992).

Number of Reproductive Health Care Visits

When asked about the number of times they had seen a health care provider for reproductive and/or sexual health needs within the last year, half of the respondents (49.8%) said “none”; 28% had 1 visit; 13.8% had 2; and 8.5% had 3 or more visits within the last year. The number of health care visits was not related to the income level of the respondents.

Sources of Information

Since NAWHO’s 1995 study indicated that Asian American women do not receive much information about reproductive and sexual health from their families, the survey examined the different ways in which Asian American women potentially obtain information about reproductive and sexual health technologies. Respondents were given a list of sources of information about reproductive and sexual health, and asked to indicate the ones they have utilized. The following list shows the percentage of respondents checking each source:

≡ Friends (69.3%)	≡ Community health clinic (28.5%)	≡ Outreach worker (8.2%)
≡ Magazines (63.3%)	≡ Sexual partner (22.6%)	≡ Community center (8.0%)
≡ Doctor (62.4%)	≡ Radio (22.3%)	≡ Church/ religious school (6.5%)
≡ Books (56.6%)	≡ Parents (19.5%)	≡ Other (4.3%)
≡ School (50.2%)	≡ Siblings (17.5%)	≡ None (3.0%)
≡ Brochures (48.6%)	≡ Hospital (17.5%)	
≡ Television (43.1%)		

When asked where they would turn if they had questions about reproductive and sexual health, the responses were slightly different:

≡ Doctor (72%)	≡ Hospital (17.7%)	≡ Television (6.8%)
≡ Friends (59.8%)	≡ Siblings (15.7%)	≡ Radio (4.2%)
≡ Books (43.8%)	≡ Parents (14.8%)	≡ Other (4.0%)
≡ Community health clinic (31.6%)	≡ School (12.5%)	≡ Church/ religious school (1.6%)
≡ Magazines (26.6%)	≡ Outreach worker (9.6%)	≡ None (1.5%)
≡ Sexual partner (26.1%)	≡ Community center (7.4%)	
≡ Brochures (25.7%)		

Almost three fourths of the respondents (72%) indicated that they would ask a doctor if they had any questions about their reproductive and sexual health, although as indicated in the previous question, respondents currently indicated they were more likely to turn to friends for information.

Contraceptive Awareness

Although there are a range of contraceptive methods and risk-reducing behaviors available, women may not be aware of or familiar with their choices. The survey examined Asian American women's familiarity with the different types of contraception currently available, the behaviors which reduce risk of exposure to pregnancy or STDs, as well as technologies that are currently being developed.

The respondents were given a list of contraceptive methods and protective behaviors, and asked to indicate the ones they had heard of. The responses were as follows, with the percentage of respondents who had heard of the contraceptive in parentheses:

≡ Birth control pill (98.8%)	≡ Female condom (85%)	≡ Rhythm method (65.8%)
≡ Male condom (98.1%)	≡ Spermicides (84%)	≡ IUD (64.9%)
≡ Female sterilization (89.9%)	≡ Non-penetrative sex and withdrawal (82.2%)	≡ Cervical cap (62%)
≡ Diaphragm (89.9%)	≡ Sponge (82%)	≡ Depo Provera (59.6%)
≡ Male sterilization (88%)	≡ Non-vaginal sex (71.5%)	≡ Latex barriers for oral sex (58.1%)
≡ Abstinence (86.5%)	≡ Norplant (71%)	≡ Fertility awareness method (26%)

Awareness of the different options varied greatly. Virtually all of the respondents had heard of the birth control pill, while little over one fourth had heard of the fertility awareness method.

Several reproductive health technologies are currently being developed, or are awaiting approval for use by the U.S. government. The availability of these technologies will expand women's reproductive health options. Respondents were asked whether or not they had heard of the following emerging reproductive health technologies. The responses indicate the percentage of respondents who had heard of these technologies:

≡ Morning after pill (75.9%)	≡ Anti-fertility vaccine (10.8%)
≡ RU-486 (54.8%)	≡ Methotrexate (5.2%)
≡ Vaginal ring (18.8%)	≡ Microbicides (3%)

Sexual Behavior

There are many assumptions made about the universality of sexual behavior; however, few studies have researched sexual behavior among different ethnic groups, particularly Asian Americans. In order to examine sexual behavior, this survey contained questions on sexual practices and attitudes.

Of the survey sample, 32.6% (205) reported having no sexual partners in their lifetime. The next section contains responses to the questions asked of the 67.4% who reported having one or more sexual partners. In terms of sexual orientation, 3.3% of the respondents reported having sex with women only; 91.3% with men only; and 5.4% with men and women. The average number of sexual partners, among the sexually active, was 4.0.

Contraceptive Use

The survey asked several questions to examine contraceptive use and the factors that influence contraceptive use, among sexually active Asian American women. Women were asked whether they discussed contraception with their partner, the frequency of contraceptive use, and, for those who did not always use contraception, their reasons for not using contraception.

Table 5: Questions on Contraceptive Use

	Always	Mostly	Sometimes	Occasionally	Never
Do you discuss contraception & “safe sex” with your partner?	47%	26.3%	15.4%	7.6%	3.7%
How often do you use contraceptive methods or behavior when engaging in sexual activity?	39%	34%	11.6%	7.5%	7.9%

Approximately half of the respondents stated that they always discussed contraception with their partner(s). 61% of the sample did not “always” use contraceptive methods or behavior when engaging in sexual activity. Close to eight percent (7.9%) of the respondents replied that they never use contraceptive methods or behaviors. When asked about their reasons for not using contraception, “monogamy / trusting partner”, was the most common response, given by 28.5% of the sample. The next most common reasons for not always using contraception were:

- ≡ Didn’t have it [contraception] during sex (16.6%)
- ≡ Partner doesn’t want to use any (11.5%)
- ≡ Don’t need it (10.8%)
- ≡ Affects sex drive (9.3%)
- ≡ Forgot (6.4%)
- ≡ Want to get pregnant (6%)
- ≡ Too embarrassed to buy it (3.3%)
- ≡ Drunk/high when having sex (3.1%)
- ≡ No available services (2%)

When asked specifically about the types of methods or protective behaviors used in the past, as well as currently, for preventing pregnancy, the following responses were given:

Ever Used Methods/Practices

- | | |
|-----------------------------|-----------------------------------|
| ≡ 84.3% Condom | ≡ 3.7% Fertility awareness method |
| ≡ 51.4% Birth control pill | ≡ 2.2% Depo Provera |
| ≡ 50.5% Withdrawal | ≡ 1.7% Cervical cap |
| ≡ 45.5% Abstinence | ≡ 1.5% Female condom |
| ≡ 36.8% Non-penetrative sex | ≡ 1.1% IUD |
| ≡ 20.3% Spermicides | ≡ 1.1% Norplant |
| ≡ 16.1% Rhythm method | ≡ 0.9% Latex barriers |
| ≡ 15.7% Non-vaginal sex | ≡ 0.7% Male sterilization |
| ≡ 8.5% Sponge | ≡ 0.7% Other |
| ≡ 7.0% Diaphragm | ≡ 0.2% Female sterilization |
| ≡ 4.4% None | |

Currently Using Methods/Practices

- | | |
|-----------------------------------|-----------------------------|
| ≡ 46.0% Condom | ≡ 1.5% Sponge |
| ≡ 28.5% Birth control pill | ≡ 1.3% Depo Provera |
| ≡ 22.9% Withdrawal | ≡ 0.9% Norplant |
| ≡ 21.4% Abstinence | ≡ 0.9% Diaphragm |
| ≡ 13.6% Non-penetrative sex | ≡ 0.7% Latex barriers |
| ≡ 13.5% None | ≡ 0.4% Cervical cap |
| ≡ 7.9% Spermicides | ≡ 0.4% Female condom |
| ≡ 5.3% Rhythm method | ≡ 0.2% IUD |
| ≡ 3.7% Non-vaginal sex | ≡ 0.2% Female sterilization |
| ≡ 2.4% Fertility awareness method | ≡ 0.2% Male sterilization |
| ≡ 1.8% Other | |

Forty-six percent of the sample indicated that they currently use condoms for preventing pregnancy. Birth control pills and withdrawal have been used by approximately one half of the respondents at some time in their lives to prevent pregnancy (51.4% and 50.5%, respectively). Very few have ever used, or are currently using, other types of contraception, including the newer forms of reproductive health technologies, such as Norplant or Depo Provera.

The survey also asked about past and current practices used for protection against STDs. The following responses were given:

Ever Used Methods/Practices

- | | | |
|-----------------------------|-----------------------|----------------------|
| ≡ 82.0% Condom | ≡ 9.4% None | ≡ 2.0% Other |
| ≡ 41.5% Abstinence | ≡ 5.9% Latex barriers | ≡ 1.5% Female condom |
| ≡ 33.0% Non-penetrative sex | ≡ 3.0% Sponge | ≡ 1.1% Cervical cap |
| ≡ 13.5% Spermicides | ≡ 2.2% Diaphragm | |

Currently Using Methods/Practices

≡ 45.0% Condom	≡ 12.1% Not	≡ 1.3% Female
≡ 29.2% None	≡ currently	≡ condom
≡ 15.8% Abstinence	≡ sexually active	≡ 0.9% Cervical cap
≡ 12.9% Non-	≡ 5.7% Other	≡ 0.9% Diaphragm
≡ penetrative sex	≡ 5.3% Spermicides	≡ 0.4% Sponge
	≡ 3.7% Latex barriers	

Condoms are presently used by 45.0% of the sample for protection against STDs. The responses also show that currently 29.2% of the respondents do not use any methods or protective behaviors to prevent STD transmission, although 90% stated that they have used some form of protection for this purpose in the past.

Knowledge of Reproductive Health Technologies

When assessing the effectiveness of contraceptives, there are two types of failure rates which must be considered. The “lowest expected failure rate” is based on consistent and correct use of the method, while the higher “typical failure rate” is based on records of actual use of the method over time.¹⁹ While accidents contribute to the typical failure rate, lack of awareness about the characteristics or correct usage of contraceptive methods greatly influences the effectiveness of the contraception. Moreover, awareness of a reproductive health technology does not necessarily mean that a woman has the knowledge to use it safely and effectively. NAWHO’s survey included several questions assessing knowledge about the properties of different reproductive health technologies.

Respondents were asked to answer true or false questions about specific reproductive health technologies. The following table summarizes their answers, with asterisks indicating the correct answers:

¹⁹ Boston Women’s Health Book Collective. (1992) Our Bodies, Ourselves.

Table 6: Knowledge Of Reproductive Health Technologies

	True	False	Don't Know
Each contraceptive method offers different levels of protection against STDs	80.9%*	11.6%	7.5%
Douching after intercourse is an effective way to prevent pregnancy	1.7%	84.8%*	13.5%
Each woman's menstrual cycle is different	98.4%*	1.0%	0.6%
Female condoms can be inserted a few hours before sex and still be effective	23.1%*	9.9%	67.0%
Female sterilization is reversible for most women	24.9%	41.5%*	33.6%
To have a diaphragm, each woman must see a health provider to fit it to her vagina size	71.5%*	5.8%	22.7%
If you have unprotected sex, there is a way to prevent pregnancy if you see a doctor within 3 days	35.5%*	36.8%	27.7%

As Table 6 shows, less than one half of the sample knew that female sterilization is irreversible. There was also very little understanding of the female condom, with two-thirds of the sample responding with “don’t know” to a knowledge question about that method. Although more than three fourths of the sample had stated earlier that they were aware of the morning after pill, only 35.5% answered the true or false question about the method correctly, illustrating that awareness and knowledge are not always correlated.

Women were then asked about specific characteristics of two fairly new forms of contraception, Norplant and Depo Provera. Respondents were asked to check the items they believed to be true about the technologies. Approximately one third of the sample (31.1%) indicated that they did not know which items were true about Norplant. Sixty-one (61%) correctly identified that Norplant must be removed by health care provider. Slightly over half knew that Norplant can be used for up to 5 years. Just over 25% (26.4%) incorrectly believed that Norplant can either be inserted in the arm or taken as a pill, and only 1.7% incorrectly believed that Norplant can protect against STDs.

Respondents seemed to have less knowledge about Depo Provera than Norplant. A large proportion (60.5%) of the sample indicated that they did not know which survey items were true about Depo Provera. Eighteen percent (18.5%) incorrectly believed that Depo Provera can be taken as either a pill or a shot. Three percent (3.0%) incorrectly believed that Depo Provera causes abortions, rather than preventing pregnancy. One third knew that Depo Provera must be received from a health care provider, and only 26.7% knew that Depo Provera is usually taken every 3 months.

Comfort Level

Parents and/or caregivers²⁰ have an extremely important role in healthy reproductive and sexual development. The level and/or amount of discussion of critical topics such as pregnancy, birth control, and sexuality between parents/caregivers and their children greatly affects the future reproductive and sexual health of women. The survey included questions on comfort level in discussing specific reproductive and sexual health topics with parents or caregivers:

Table 7: Comfort Level When Discussing Specific Topics With Parents/Caregivers

	Very comfortable	Somewhat Comfortable	Uncomfortable	Was never discussed
Menstruation	39.1%	39.4%	14.4%	7.2%
How pregnancy occurs	20.3%	21.8%	23.9%	33.9%
STDs	14.0%	18.2%	24.0%	43.8%
Birth control	12.5%	19.9%	24.0%	43.5%
Sexuality	9.4%	16.8%	32.1%	41.8%

Of the five reproductive health topics, menstruation was the subject respondents felt most comfortable discussing with their parents or caregiver, although only 39.1% felt *very* comfortable with the topic. As illustrated in the table above, respondents were significantly less comfortable discussing the other four topics (pregnancy, STDs, birth control, sexuality) with their parents or caregiver. It appears that these four topics were *never* discussed in more than one third of the respondents' households.

²⁰ For this study, caregivers are defined as the primary individuals who provide care and/or support to youth. In many Asian households, grandparents or extended family members play the role of caregiver.

Choosing Contraceptives

A woman's decision to use a particular type of contraceptive over another can be influenced by a variety of factors. NAWHO's survey sought to examine the factors that play a role in Asian American women's choice of contraceptive. The respondents indicated that they considered the following factors important (listed in order of preference):

1.	Effectiveness in preventing pregnancy	94.3%
2.	Side effects	74.7%
3.	Convenience/easy to use	71.5%
4.	Effectiveness in protection against sexually transmitted diseases	63.2%
5.	How easy it is to get	45.1%
6.	Cost	44.5%
7.	Moral beliefs	13.7%
8.	Whether or not it requires touching body	11.7%
9.	Religious beliefs	9.1%
10.	Cultural beliefs	8.9%
11.	Other	3.5%

Protection against sexually transmitted diseases was significantly less important for the respondents when selecting a form of contraception than preventing pregnancy. This, along with the finding that the number one reason for not using contraception was "monogamy/trust partner", indicates that many women who responded to the survey did not feel that they were at high risk for STDs.

The development of new contraceptives should involve the active participation of women in order to address *their* concerns, and not merely control fertility and population growth. As stated in the Fourth World Conference on Women Platform of Action, reproductive health technology research should: "improve and develop new methods for the sexual and reproductive health of men and women, including methods for the regulation of fertility that meet users' needs and are more safe, effective, affordable, acceptable, easy to use, free of side effects, and suitable for different groups, and for different phases of the reproductive life cycle."²¹

This survey examined the qualities desired in an *ideal* form of protection against STDs and pregnancy by Asian American women, through a series of questions:

²¹ Fourth World Conference on Women Platform. (1995) Beijing, China. 109(h).

**Table 8: Ideal Form of Protection Against STDs and Pregnancy:
(percentages indicate “yes” answers)**

	STDs	Pregnancy
Is it important to you that your partner is involved in deciding to use protection?	90.2%	90.0%
Whom do you prefer uses protection?		
only partner	12.2%	10.6%
only you	1.5%	4.9%
both	57.8%	55.8%
no preference	28.5%	28.7%
What type of protection would you prefer?		
long-term	46.4%	50.9%
used each time you have sex	34.7%	31.2%
no preference	18.9%	17.9%
How would you prefer to obtain protection?		
by prescription		
over the counter	25.0%	31.9%
no preference	42.3%	36.8%
	32.7%	31.4%

Table 8 indicates that there were no significant differences between the qualities women desired in an ideal form of protection against STDs and pregnancy. A large majority of the sample (90%) wanted their partner to be involved in the decision-making process. More than half of the women surveyed wanted to share the responsibility of using protection against pregnancy and STDs with their partner, and approximately half wanted a long-term form of contraception, that they would not have to worry about during each act of intercourse.

Respondents had very specific suggestions for qualities they would like in an “ideal” form of protection against pregnancy. First and foremost was 100% effectiveness in preventing pregnancy. Many also wanted protection against STDs at the same time as preventing pregnancy. Respondents want this form of protection to be low-cost, convenient for both partners, easy to get, easy to use and available in a variety of locations (not just clinics and drug-stores). They also want something that has no (or at least only a few) side effects, both short-term and long-term. Mentioned repeatedly by respondents was the fact that they want something that will in no way affect their ability to get pregnant in the future. This was of considerable concern to a number of respondents. Finally, they want this protection to be safe to use, and to be something that will not interrupt the sex act and will not be messy when used. “Comfortable” was a term used by many respondents in describing the qualities they would like to see in this “ideal” form of protection against pregnancy.

Future Directions

The respondents who completed the question “What are some reproductive health topics you would like to know more about?” provided an array of important issues, topics, and concerns they would like to see discussed and addressed. It is evident from these responses that the survey itself sparked interest in reproductive health technologies (specifically the morning after pill) that respondents may not have heard much about prior to completing the survey. In addition, this list of issues suggests that despite the fact that respondents seemed to have considerable information about contraceptive methods, STD prevention behaviors, and reproductive and sexual health behavior in general, there is still some very basic information about which this group of respondents wants and needs to have more detailed knowledge. Below is a list summarizing the broad topics that respondents listed along with some specific issues that were identified under each topic.

Abortion

- ≡ where to go for abortion, long-term risks of abortion, concerns about future pregnancies

Cancer

- ≡ questions about breast and cervical cancer in particular, and specific interest in the relationship of cancer to use of oral contraceptives

Contraception

- ≡ the need for more specific information in general about all contraceptive methods, concerns about any problems with cancer or effects on fertility of prolonged use of methods, specific comments about the need for more non-chemical or hormonal forms of contraception, plus more information on birth control options for men, and possibilities of long-term birth control methods

Counseling

- ≡ the need for counseling services that will be sensitive to cultural issues for Asian American women

HIV

- ≡ concerns regarding HIV and pregnancy, and more explicit information on how HIV is transmitted, especially during sexual activity

Hot-line

- ≡ proposed for Asian American women to get more detailed information on reproductive and sexual health

Long Term Health Maintenance

- ≡ questions concerning recommended frequency of general check-ups

Menstruation

- ≡ basic information about menstrual cycle and reproductive health examination. In addition, some very specific questions were raised: What is normal menstruation? Can sexual intercourse during menstruation be bad for your reproductive health and your ability to get pregnant? What kind of exercise is okay during menstruation?

Pregnancy

- ≡ specifically prenatal care, staying healthy during pregnancy, also information about infertility

Reproductive and Contraceptive Technologies

- ≡ specific information about the following technologies, as well as detailed information about side effects, health risks, cost, and availability: (RU-486, microbicides, anti-fertility vaccine, vaginal ring, methotrexate, morning after pill, cervical cap, female condom, Norplant, and Depo-Provera)

Self-Esteem and Negotiation Skills

- ≡ how to talk frankly with one's partner in general about sex, contraceptive use, STD protection, and ways to build self-esteem in relationships

Sexuality

- ≡ particular interest in bisexuality and homosexuality, as well as interest in information on different forms of sexual activity

STDs

- ≡ general information about types of STDs and ways in which they are transmitted. In addition, information about women-controlled protection, and how to recognize the signs that one needs to see a doctor

Understanding of Major Health Issues and Health Problems for Asian American Women

- ≡ in particular, respondents wanted to know about menopause and osteoporosis. Several questions were raised: Why do Asian females have premarital sex and how does this affect their relationship with their husbands? Are there any prevailing physical or physiological differences between Asian women and Caucasian women? Would these cultural differences affect the validity of reproductive health related research? How is the health of women of color impacted by the environment?

Understanding One's Body

- ≡ need for basic information that is explicit and thorough

Urinary Tract Infections and Yeast Infections

- ≡ detailed information on how both of these occur, how they affect sex, the ways in which sexual activity can lead to urinary tract infections, general information about preventing vaginal infection after vaginal intercourse

Conclusion

Within the International Conference on Population and Development Programme of Action, **reproductive health** is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”, while **reproductive health care** is defined as “the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes **sexual health**, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.”²²

This unprecedented survey is a first step in understanding the broad range of reproductive and sexual health experiences and needs of Asian American women. It provides the foundation for future examination of sexual knowledge, attitudes, and behaviors, and how these intersect with existing technology, information, services, and advocacy. The survey confirms how, perhaps unlike other clinical technology, the use and impact of reproductive health technologies go far beyond their technical ability to diminish or enhance the occurrence of pregnancy or disease transmission. In fact, the findings indicate that reproductive health technology plays an important role in women’s lives, with regard to our sense of agency, our ability to make and act upon informed decisions, and our ability to protect our reproductive and sexual health and rights.

The survey indicates clearly that Asian American women are sexually active and thus face a number of decisions regarding their sexual and reproductive behavior. Not least of these are related to the use or non-use of protective technologies. Several encouraging findings emerge from the survey. For example, almost all respondents knew about the birth control pill and the male condom, and a high proportion had heard about the morning after pill. Over 70% of the sample knew where they could get an abortion if they needed to, and approximately the same proportion indicated they would support a woman’s decision to have an abortion. Relatively high rates of male condom use indicate an awareness of the risks of unwanted pregnancy and STDs, as well as the existence of heterosexual relationships in which both partners take responsibility for these risks. Similarly, a large majority of the sample (90%) wanted their partner to be involved in the contraceptive decision-making process.

However, while three quarters of the sexually active sample had had at least one sexual partner in the past six months, *half* of them had not visited a health care provider for reproductive and sexual health needs in the past year. Since their health care provider was identified as a preferred source of information, it is likely that these women are missing out on both health care services and information. Lack of access to methods and partner’s objections remain reasons for

²² United Nations International Conference on Population and Development Programme of Action, Cairo, Sept. 23, 1994, paragraph 7.1

why contraception is not always used by women who do not want to get pregnant. Finally, a lack of knowledge about the range of reproductive health technologies could indicate a paucity of information and counseling when women are making decisions about whether to use a protective method.

The need for more information - both for Asian American women, and about Asian American women, is clearly evident. Many respondents requested more information, and the opportunity to process and discuss this information when making sexual and reproductive decisions. *The Reproductive and Sexual Health Survey of Asian American Women* was initiated by the National Asian Women's Health Organization in order to begin gathering the vital information necessary to expand the limited options available to Asian American. The gaps in information about Asian American women and reproductive health technologies revealed by this survey confirm the need for more community-based participatory research on sexual and reproductive health in Asian American communities. NAWHO hopes that this ground-breaking study will serve as a catalyst for health care providers and educators, researchers, policy makers, women's health advocates, the Asian American community, and the general population to proactively address the reproductive and sexual health of Asian American women, and ultimately improve the quality of lives for Asian American women.

Recommendations

In addition to affirming existing international standards on reproductive health and technologies (See Appendix III), the survey identified specific challenges for health educators and providers, community workers and activists and policy makers in the areas of information, services, research and policy.

Increasing Access and Utilization

- ≡ Clear, accessible information on reproductive health technologies (both existing and in development), should be developed in the range of Asian languages and widely distributed in Asian American communities. Asian American communities should be provided with information about the mechanisms and efficacy of technologies for preventing pregnancy and/or the transmission of STDs; risks and potential abuses of reproductive technologies; and referrals on where to obtain the methods.
- ≡ Information should be disseminated through various routes - the media, health services and providers, hot-lines, community and peer organizations, and should be factually correct, accessible and age and language-appropriate.
- ≡ Women should be provided with information and counseling on physiological changes, sexuality and relationships, health concerns and health needs over the span of the lifecycle (including information on adolescence, well-woman care, pregnancy and menopause).
- ≡ Efforts should be made to address the lack of, or mis-, information that exists, particularly with relation to barrier, hormonal and emergency contraceptive methods, sterilization and the impact of other methods on fertility.
- ≡ The base and range of clinicians who provide reproductive and sexual health care services for Asian American women must be expanded to improve access for this population.
- ≡ Since many Asian American women reported receiving reproductive and sexual health information from mass media sources, private physicians, community-based clinics, and other health care providers should build partnerships with ethnic and mainstream media to advertise their services.
- ≡ Health care providers, educators, counselors, and advocates should make no assumptions about Asian American woman's knowledge and understanding of contraceptive methods based on the woman's education and income level. Instead, particular attention needs to

be paid to ensuring that this population of women have access to thorough and detailed information about contraception in both written and verbal forms.

- ≡ Health care providers should work to increase awareness that, although Asian American women do not perceive themselves to be at risk for reproductive and sexual health problems, the survey results indicate that they are at risk for these problems.
- ≡ Services should provide information and access (direct or referral) to the full range of reproductive technologies.
- ≡ Counseling should be available to help women, (and when requested, their partners), to assess which technologies may be useful and appropriate for them, based on their health history, relationships, reproductive and sexual decisions, access to health services and personal preferences.
- ≡ Contraceptive and STD services should be coordinated, so that clients receive consistent information on the (sometimes conflicting) efficacy of technologies with regard to preventing unwanted pregnancy and STDs.
- ≡ Health care services and providers should develop strategies to include women's partners in clinical and counseling services, when women request it. These strategies should be developed to enhance mutual responsibility, without diminishing women's decision-making capacity.

Improving Health Education

- ≡ Health care providers, educators, and counselors must identify strategies for involving partners of Asian American women in the health education and counseling aspects of a health care visit. Women indicated that they wanted their partners more involved in pregnancy and STD prevention, however as indicated in the survey results, respondents were not always comfortable talking with their partner on their own about these subjects.
- ≡ Education and training must be provided to Asian American parents and caregivers on how to talk with children, adolescents, and young adults about issues of reproductive and sexual health.
- ≡ Educators must be aware of and sensitive to the assumption made by some Asian American women that if one is in a monogamous relationship, one is protected from STD and HIV infection.
- ≡ Asian American women must be provided with detailed and explicit information about contraception, especially with regard to what works to prevent pregnancy, the effectiveness of available methods, and specific short-and-long term side effects of different methods.
- ≡ Since awareness of particular reproductive health technologies and actual knowledge of their mechanism of action, availability, side effects, etc. are not always correlated, health care providers and health educators must identify effective strategies to ensure that clients are fully informed and can demonstrate their understanding.

Expanding Research Efforts

- ≡ More concerted efforts need to be made to reach a more diverse population of Asian American women, from different socio-economic and educational backgrounds to compare and contrast the findings of this research project
- ≡ Participatory research methods - both qualitative and quantitative - should be developed and used with diverse Asian American communities to develop a better understanding of the reproductive and sexual health attitudes and behaviors and technological needs and resources that should be addressed within the range of communities.
- ≡ Researchers should work closely with community activists to ensure that: the concerns of Asian American women are addressed in research; ethical standards are adhered to; research findings are disseminated for use within communities as a catalyst to improve development, access to and use of information, service and technologies.
- ≡ More research is needed to better understand: the factors that affect Asian American women's assessment of risk and their health seeking behavior and use of reproductive health technologies; the role of gender and partners in sexual and reproductive decision-making; and the factors that women identify to improve existing and developing technologies.

Policy and Advocacy

- ≡ Asian American and other women of color should be involved at the national and international level in policy decisions about reproductive health technologies to ensure that their perspectives and concerns are taken into account; that their communities are informed of recent developments; and that ethical standards in technology development are adhered to.
- ≡ All political and community leaders are urged to play a strong, sustained and highly visible role in reframing the discussion on reproductive health rights issues in this country to include Asian American women.
- ≡ Establish high-level focal points in federal government agencies that are responsible for monitoring to ensure that Asian American women's health concerns are mainstreamed in all relevant government agencies and programs.
- ≡ Strengthen mechanisms at all levels to ensure that the accountability of national programs and policies to the public, in particular to underserved women.
- ≡ In collaboration with community-based health organizations, women's rights organizations and other institutions, we need to develop a comprehensive national strategy for providing universal access for all to primary health care including reproductive health without distinction to race, national origin, socio-economic class, immigration or other status.

Appendix I

Glossary of Reproductive Health Technologies *

The following list provides a definition of the reproductive health technologies that were cited in the report. This glossary is for definition purposes only. For further inquiries regarding the status or availability of a particular contraceptive, check with a clinician or health care practitioner.

- ≡ **Abstinence:** Refraining from sexual intercourse.
- ≡ **Anti-fertility Vaccine:** Method of contraception that treats a woman's fertility as an illness, and turns the woman's body against itself to fight pregnancy. It is administered in the arm and creates a hormonal disturbance to prevent fertilization and or implantation.
- ≡ **Birth Control Pill:** Birth control pills are made from artificial hormones similar to progesterone and estrogen. They work by stopping the ovaries from releasing an egg every month, and must be prescribed by a clinician.
- ≡ **Cervical Cap:** Small rubber cap which fits tightly over the cervix (opening to the uterus). The cervical cap, which keeps sperm from entering the uterus (womb) and fertilizing an egg, should be used with spermicidal jelly or cream. It comes in four sizes and must be carefully fit by a clinician.
- ≡ **Condom (male):** A rubber or animal skin that fits over the erect penis during sex, and stops sperm from getting into the vagina.
- ≡ **Depo Provera (injection/shot):** Depo-medroxy progesterone acetate (DMPA), known as Depo Provera, is a synthetic female hormone, progestin. The 3-month injectable contraceptive works by suppressing ovulation, altering the lining of the uterus, and thickening the cervical mucous to make penetration of the sperm more difficult.
- ≡ **Diaphragm:** Soft rubber cap that is put into the vagina and covers the cervix. The diaphragm holds contraceptive cream or jelly in place, which kills sperm. It comes in a variety of sizes and must be fitted by a clinician.
- ≡ **Female Condom:** Large, thin, (usually) polyurethane sheath about 6 inches long that resemble a large male condom covering most of the vulva and extending to the cervix. The closed end of the female condom is inserted in the vagina like a diaphragm, and the open end remains outside the vagina. Intended for one-time use, the female condom can be inserted long before having intercourse.
- ≡ **Female Sterilization (tubal ligation/tubes tied):** A surgical procedure blocks the fallopian tubes to prevent eggs from passing into the uterus. In many cases the tube is tied and a small section removed; sometimes tubes are closed by electric current or by applying clips, clamps, rings or bands. It is intended to be permanent and irreversible.
- ≡ **Fertility Awareness Method (FAM):** A woman is fertile (able to get pregnant) only for a short time during each menstrual cycle, and for the rest of the cycle she should be infertile (not able to get pregnant). Using the fertility awareness method, a woman or couple may learn how to tell fertile days from infertile days by observing three simple body signs: cervical mucus, basal body temperature, and cephalad shift (cervix changes). Some women may choose to postpone all vagina-to-penis contact when fertile (periodic abstinence), others may choose to use barrier methods at this time. It is recommended for women to learn fertility awareness observation methods directly from other women and to chart their observances daily.
- ≡ **IUD (Intrauterine Device):** A small plastic or metal device, different brands being of different shapes, that is placed in the uterus to prevent pregnancy. It is not exactly known how the IUD works; it is thought that it acts mainly to prevent attachment of the embryo to the lining of the uterus. It is placed inside the uterus by a trained clinician while a woman is having her period.
- ≡ **Latex Barriers for Oral Sex (includes dental dams, plastic wraps):** Rubber barrier used either over the oral cavity, penis or vagina during oral sex to prevent sexually transmitted diseases.

- ≡ **Male Sterilization** (vasectomy): A surgery which makes it impossible for a man to fertilize an egg. A permanent form of birth control in which the tubes that carry sperm to mix with the seminal fluid are blocked.
- ≡ **Methotrexate**: Folic acid antagonist which creates a folic acid deficiency that prevents development of the embryo, thus causing an early abortion.
- ≡ **Microbicides**: Topical substances that kill bacteria and viruses that cause sexually transmitted diseases. Applied prior to having intercourse.
- ≡ **Morning After Pill**: Also referred to as “emergency contraceptives”, prevents pregnancy *after* unprotected sexual intercourse. A woman takes high doses of combined estrogen and progestin oral contraceptives within 3 days (72 hours) of unprotected intercourse. Must be administered by a clinician.
- ≡ **Non-penetrative Sex** (includes masturbation, kissing): Any activity that does not involve penetration of the vagina, rectum, or mouth and in which semen or vaginal fluids do not make contact with the mucous membranes.
- ≡ **Non-vaginal Sex**: Intercourse in which penetration of the vagina does not occur; includes anal sex or oral sex.
- ≡ **Norplant**: Reversible, five-year, low dose, progestin-only contraceptive. It consists of six soft flexible capsules that are placed in a fan-like pattern under the skin of the upper arm or thigh. Thought to prevent pregnancy through a combination of inhibition of ovulation (so eggs are not released by the ovaries) and thickening of the cervical mucus (which impedes sperm activity). Norplant must be placed and removed through a trained clinician.
- ≡ **Rhythm Method**: Estimation of when ovulation will happen, based on a record of how it has happened in the past, also called the calendar method. Its main use is to provide a probable date when fertile days may start.
- ≡ **RU-486** (mifepristone): Birth control drug which acts to interrupt early pregnancy. As an “anti-progestin,” it blocks the action of progesterone, breaking the lining of the uterus and causing the woman to menstruate, expelling any fertilized egg.
- ≡ **Spermicides** (foam, gel, film, suppository): Contraceptives that are made of chemicals that kill sperm. Must be inserted into vagina no more than 20 minutes before intercourse.
- ≡ **Sponge**: Small, soft spongy material made out of polyurethane that is put into the vagina and covers the cervix (opening to the uterus). It blocks, absorbs and destroys sperm with a killing chemical.
- ≡ **Vaginal Ring**: As a form of long-acting steroid contraceptive, progestin-estrogen rings are worn in the vagina for three weeks and then removed for a week to induce menstrual bleeding. The same ring could be used for usually three months.
- ≡ **Withdrawal** (pulling out): Method in which one removes the penis from the vagina just before ejaculation.

* Definitions obtained from the following sources:

The New Our Bodies, Ourselves

“New Contraceptive Technologies” in Norplant and Poor Women

Planned Parenthood

Reproductive Health Technologies Project

Appendix II

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INTERNATIONAL STANDARDS FOR REPRODUCTIVE HEALTH AND TECHNOLOGIES

Recent international conferences have reaffirmed the need for standard guidelines to assure the reproductive freedom of women throughout the world. The following section cites a few important recommendations from the International Conference on Population and Development (ICPD, Cairo, 1994), and the Fourth World Conference on Women (FWCW, Beijing, 1995):

ICPD 12.12 Governments, assisted by the international community and donor agencies, the private sector, non-governmental organizations and the academic community, should increase support for basic and applied biomedical, technological, clinical, epidemiological and social science research to strengthen reproductive health services, including the improvement of existing and the development of new methods for regulation of fertility that meet users' needs and are acceptable, easy to use, safe, free of long- and short-term side-effects and second-generation effects, effective, affordable and suitable for different age and cultural groups and for different phases of the reproductive cycle. Testing and introduction of all new technologies should be continually monitored to avoid potential abuse. Specifically, areas that need increased attention should include barrier methods, both male and female, for fertility control and the prevention of sexually transmitted diseases, including HIV/AIDS, as well as microbicides and virucides, which may or may not prevent pregnancy.

12.16 All research on products for regulation of fertility and sexual and reproductive health must be carried out in adherence to internationally accepted ethical and technical standards and cultural conditions for biomedical research. Special attention needs to be given to the continuous surveillance of contraceptive safety and side-effects. Users', in particular women's, perspectives and women's organizations should be incorporated into all stages of the research and development process.

FWCW 109(h) Provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for reproductive and sexual health of women and men, including more effective, affordable and acceptable methods for the regulation of fertility, including natural family planning for both sexes, methods to protect against HIV/AIDS and other sexually transmitted diseases and simple and inexpensive methods of diagnosing such diseases, among others; this research needs to be guided at all stages by users and from the perspective of gender, particularly the perspective of women, and should be carried out in strict conformity with internationally accepted legal, ethical, medical and scientific standards for biomedical research

108(o) Support and expedite action-oriented research on affordable methods, controlled by women, to prevent HIV and other sexually transmitted diseases, on strategies empowering women to protect themselves from sexually transmitted diseases, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research;

108(p) Support and initiate research which addresses women's needs and situations, including research on HIV infection and other sexually transmitted diseases in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female risk-taking attitudes and practices.

106(U) Rationalize drug procurement and ensure a reliable, continuous supply of high-quality pharmaceutical, contraceptive and other supplies and equipment, using the WHO Model List of Essential Drugs as a guide, and ensure the safety of drugs and devices through national regulatory drug approval processes.

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