RECLAIMING CHOICE, BROADENING THE MOVEMENT:

Sexual and Reproductive Justice and Asian Pacific American Women

A NATIONAL AGENDA FOR ACTION

national asian pacific american women's forum

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Principal Author
Courtney Chappell
Policy Director
national asian pacific american women's forum

national asian pacific american women's forum
1050 17th Street, NW Suite 250
Washington, DC 20036
www.napawf.org

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EXECUTIVE SUMMARY

"Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women, A National Agenda for Action" is the summation of a body of work by people who believe that the sexual and reproductive lives of Asian Pacific American (APA) women matter. APA women have been organizing around reproductive justice for several decades, yet their voices have been largely ignored or marginalized at the national level. With the publication of this Agenda for Action, NAPAWF hopes to reinsert APA women and girls into the national dialogue about abortion rights, health care, welfare reform, and violence against women.

The Agenda for Action is divided into four parts. The first section includes an overview of the current economic and political profile of APA women. Part II discusses the reproductive and sexual health trends that APA women and girls encounter including the prevalence of cancer and HIV/AIDS, abortion rates, violence against women, and mental health issues. Part III highlights the barriers that prevent APA women and girls from accessing the health care system and receiving appropriate reproductive and sexual health care services. Finally, this document concludes with **A Call to Action** that presents NAPAWF's eight priority areas and offers recommendations for policymakers, advocates, allied organizations, and community leaders to address these issues. Over time, these recommendations will likely change based on the political and policy landscapes and input from community members.

Our eight areas of action include:

- ✓ Providing access to health care for all
- ✓ Promoting linguistic and cultural competence in health and human services
- ✓ Demanding community-relevant sexual and reproductive health data and research
- ✓ Protecting and expanding sexual and reproductive rights
- ✓ Eliminating all forms of violence against women
- ✓ Increasing comprehensive sexuality education
- ✓ Linking women's reproductive health to environmental justice
- ✓ Ending gender discrimination and the promotion of sex selection technologies

NAPAWF believes that sexual and reproductive justice includes the fundamental right of women to have sovereignty over one's sexuality, gender identity, and reproduction. This report is being written at a time in United States history that looks bleak for all forms of civil and human rights. The right to have an abortion in particular is vulnerable; thus the mainstream reproductive rights/"pro-choice" movement is necessarily focused on ensuring that "pro-choice" legislators are elected and fair-minded judges are appointed. At the same time advocates are fighting battles state by state, school board by school board as the opposition chips away at sexual and reproductive rights through state parental notification and consent laws, school district abstinence-education-only policies, and anti-gay initiatives. At all levels of government the stakes have never been higher to protect sexual and reproductive freedom. Yet, the focus on abortion access solely has made it difficult to promote a broader framework of sexual and reproductive justice. Abortion rights need not and should not be isolated from other areas of human rights. In fact, the movement becomes broader and stronger when we can place abortion access in context with the many issues that affect women's sexual and reproductive health and overall well-being including issues related to gender, race, class, sexual orientation, and all struggles for human dignity.

> "WITH THE PUBLICATION OF THIS AGENDA FOR ACTION, NAPAWF HOPES TO REINSERT APA WOMEN AND GIRLS INTO THE NATIONAL DIALOGUE ABOUT ABORTION RIGHTS, HEALTH CARE, WELFARE REFORM, AND VIOLENCE AGAINST WOMEN."

This report is an open invitation for all policymakers, advocates, health care providers, community-based and national organizations to join with NAPAWF to create community and policy changes so that every woman and girl's life, including Asian and Pacific Islanders, is lived in dignity and equality.

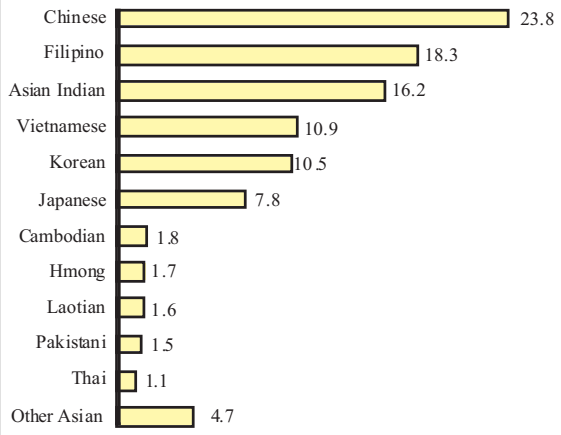
1 ASIAN PACIFIC AMERICAN WOMEN: A DEMOGRAPHIC PROFILE

Overview

Asian Americans and Pacific Islanders[1] represent over 4% of the total U.S. population, or nearly 12 million people, an increase of 52% since 1990.[2] By the year 2050, it is estimated that 33.4 million, or 8% of the total population, will be APA.[3] The APA population is extremely diverse, comprising over 30 ethnic subpopulations and more than 200 languages and dialects. Approximately 60% of Asian Pacific Americans, or 8.7 million, are foreign-born, representing one-fourth of the nation's total foreign-born population.[4] In addition, the population is relatively young, with a median age of 33 years, two years younger than the national median age.[5] Of the 139 million females in the U.S., 4% are APA women.[6] And, 50% of APA women are of reproductive age.[7] Because of the diversity of the APA population, and the limited research that often represents the APA community as one homogenous group, it is difficult to generalize about the specific socioeconomic, health, and cultural concerns of APA women.

"BY THE YEAR 2050, IT IS ESTIMATED THAT 33.4 MILLION, OR 8% OF THE TOTAL POPULATION, WILL BE APA."

Figure 1: Ethnic Distribution of APA Population in U.S., 2000
(*percentage of the total U.S. APA population*)

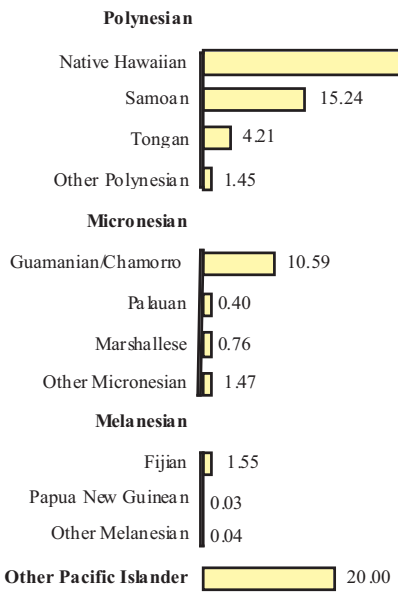


Source: U.S. Census Bureau, Census 2000 special tabulation

Geography

According to the U.S. Census Bureau, one-half of all Asian and Pacific Islanders lived in the West, 19% lived in the South, 12% lived in the Midwest, and 19% in the Northeast. Ninety-five percent of all Asian and Pacific Islanders lived in metropolitan areas, a much higher percent than non-Hispanic whites.[8] And, over half of the APA population lived in just three states: California, New York, and Hawaii.[9]

Figure 2: Ethnic Distribution of Pacific Islander Population in U.S., 2000
(*percentage of the total U.S. Pacific Islander population*)



Source: U.S. Census Bureau, Census 2000 special tabulation

Economic Profile

Asian Pacific American women contribute significantly to the American economy in managerial, specialty, professional, and technical positions and in the labor sector. Despite their gains and achievements, the gap between the wealthy Asian Pacific Americans and those living in poverty remains substantial. For instance, although statistical data reveals that APA women were more likely than non-Hispanic white women to have earned at least a bachelor's degree (44% compared to

27%, respectively), APA women were also more likely to have only a high school diploma than non-Hispanic white women.[10] Similarly, while APA families are more likely than white families to have household incomes of $75,000 or higher, they are also more likely than white families to have incomes of less than $25,000.[11] Overall, the most recent Census data found that Asian Pacific Americans are more likely to live in poverty than their white counterparts.[12]

"One explanation for the disparity in household incomes and higher poverty rates is that many APA women are concentrated in low-wage employment. . . . where workers are paid below the minimum wage and often endure unsafe working conditions."

One explanation for the disparity in household incomes and higher poverty rates is that many APA women are concentrated in low-wage employment. The garment and cosmetology industries, for instance, continue to be dominated by low-income immigrant women of color, where workers are paid below the minimum wage and often endure unsafe working conditions. In California, close to 30,000 garment workers are Asian.[13] Of the 65,000 garment workers in New York, approximately half are Asian.[14] Similarly, Vietnamese Americans alone make up 37% of licensed nail salon technicians nationwide and represent 80% of the industry in California.[15]

Wage Disparities

A wage gap continues to persist between APA women and white men, although studies have found that some APA ethnic subpopulations are more likely to earn higher salaries than white women. In 1999, APA women earned an average annual salary of $33,100, compared to $44,200 for white men and $30,900 for white women. African American women made $27,600, while Native American women made $25,500, and Latinas had the lowest earnings of $23,300. A more detailed study that disaggregated the data collection by ethnicity, however, revealed salary variations among ethnic subpopulations within the APA community. Vietnamese American women, for instance, earned $26,500, compared to Japanese American women who made $39,300. APA immigrant women also tended to earn less because of educational levels and language skills.[16]

Political and Civic Involvement

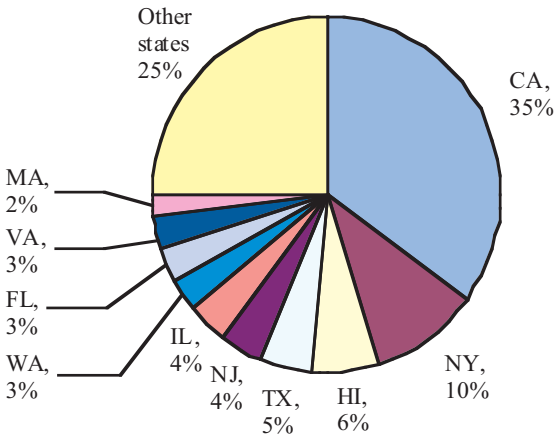
Asian Pacific American women are recognizing their political power and influence. On November 2, 2004, the Asian American Legal Defense and Education Fund (AALDEF) conducted the nation's largest nonpartisan, multilingual exit poll of almost 11,000 Asian American voters. The poll found that 40% of all Asian American women were first-time voters, with 46% of South Asian and 47% of Southeast Asian women turning out to vote for the first time. The poll also found that more than half (51%) of all respondents received news about politics and their communities from ethnic media, rather than from mainstream media outlets.[17]

In addition, according to the report, 41% of all respondents were limited English proficient, and Korean and Vietnamese Americans were the most limited English proficient (LEP) of all Asian ethnic groups.[18] Another exit poll report, sponsored by the National Asian Pacific American Legal Consortium (NAPALC), found similar utilization rates of bilingual voter assistance.[19] Although many counties surveyed made efforts and developed practices to respond to the needs of their LEP voters, Asian American voters continued to face barriers at the polls. For instance, poll workers and/or interpreters were reluctant to provide assistance, or were unaware of how to provide help, poll workers were often unaware of what the law required, and many polling sites failed to provide bilingual written materials or translated instructions.[20]

"Asian Pacific American women are recognizing their political power and influence. . . . Although many counties surveyed made efforts and developed practices to respond to the needs of their LEP [limited English proficient] voters, Asian American voters continued to face barriers at the polls."

The AALDEF report also found that a majority of Asian American voters were registered as Democrats (57%), 15% were registered as Republicans, 2% were enrolled in other parties, and 26% were not affiliated with any political party. Asian American women were registered in the Democratic Party in greater numbers than their male counterparts (59% compared to 55%, respectively). A breakdown by ethnic subpopulation revealed that South Asian voters, particularly Bangladeshi and Indo-Caribbean, were registered as Democrats, as were a majority of Southeast Asian voters of Laotian and Cambodian descent. By contrast, nearly half (48%) of surveyed Vietnamese voters were registered as Republicans.[21]

Figure 3: Geographical Distribution of APA Population in U.S. by State, 2000
(*as a percentage of the total APA population* in U.S.*)



The ten states with the highest APA populations are shown to the left. They account for 75% of the APA population in the U.S.

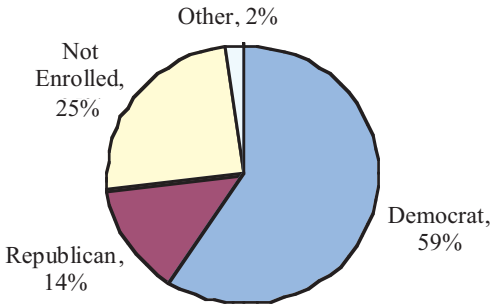
Although it only represents 6% of the entire APA population in the U.S., Hawaii (HI) has the largest percentage of APA residents relative to its *state* population. APAs account for 58% of the Hawaiian population.

*Includes bi- and multi-racial APAs.

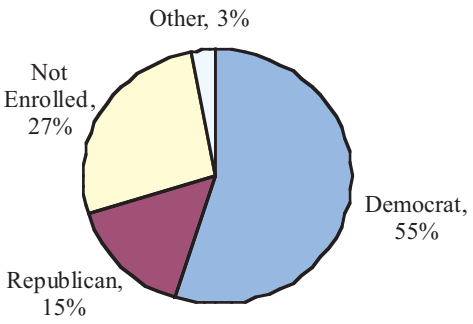
Source: U.S. Census Bureau, Census 2000 Brief, *The Asian Population: 2000* (February 2002)

Figure 4: Party Enrollment by Gender

Asian American Women



Asian American Men



Source: The Asian American Vote, *A Report on the AALDEF Multilingual Exit Poll in the 2004 Presidential Election*, AALDEF

2 Reproductive and Sexual Health Trends Among Asian Pacific American Women

There are few studies that specifically document the reproductive and sexual health trends of APA women and girls, and even fewer that disaggregate the data collection by ethnic subpopulation. The lack of research masks the different socioeconomic, immigration, and education statuses among these various groups. Those rare studies that do exist reveal dangerous reproductive and sexual health trends, gaps in services and programs targeted at APA women, and emerging areas of need.

"Studies. . .reveal dangerous reproductive and sexual health trends, gaps in services and programs targeted at APA women, and emerging areas of need."

Elevated Prevalence of Cancer and Mortality

The cancer screening rates for many APA women are very low, and the incidence of cancer is steadily increasing for particular ethnic subgroups. For instance, the rate of cervical cancer among Vietnamese Americans is five times higher than that for white women, representing the highest rate for any racial or ethnic group.[22] One study found that 53% of the surveyed Vietnamese American women had never had a Pap smear, compared to 6% of women in the general population.[23] Another study found that invasive cervical cancer rates were much higher in Hmong women than other ethnic groups, and that diagnosis occurred at advanced stages, indicating low participation in screening programs.[24] Cervical cancer is one of the most preventable types of cancer, yet treatment relies heavily on early detection and screenings.

In addition, although APA women have the lowest rate of breast cancer and mortality of all women in the U.S., the rate for Japanese and Chinese American women is significantly higher than for women in Japan and China.[25] Furthermore, the risk of death for APA women with breast cancer is 1.5 to 1.7 times that of white women.[26] Similarly, studies have found that once cancer is diagnosed among Native Hawaiians, they have a 5-year survival rate, which is 18% lower than their white counterparts.[27] The higher rate of death associated with breast cancer for APA women stems in part from their lower rates of mammography and clinical breast examinations than other racial or ethnic populations.[28]

APA women are increasingly being diagnosed with other forms of cancer as well. Pacific Islander women who have relocated to California are confronting the long-term consequences of exposure to radiation from nuclear bomb testing conducted in the 1950s and waste dumping by the U.S. The rates of radiation related cancer diagnoses from this exposure are now estimated to reach epidemic proportions among Marshalese Islander women.[29]

Maternal and Child Health

Studies indicate that many APA women have lower rates of prenatal care than the general population. Delaying prenatal care increases the risk of delivering low-birth weight infants, infant mortality, maternal mortality, and other pregnancy related complications. Fifty-two percent of Samoan mothers, representing the lowest percentage of all racial or ethnic groups, 64% of Cambodian American women, and 76% of Native Hawaiian women receive prenatal care during the first trimester, compared to 82% of white women.[30] Furthermore, Native Hawaiian women comprise one-third of all women in Hawaii who do not receive prenatal care until the third trimester.

"There are a variety of reasons explaining why many APA women delay prenatal care . . . interviews with pregnant Hmong women in Wisconsin reveal that many delay prenatal visits because they fear that a doctor's or nurse's touch will result in miscarriage."

There are a variety of reasons explaining why many APA women delay prenatal care, such as lack of health insurance coverage, cultural beliefs, misconceptions about Western clinical practices, lack of transportation, and lack of child care. For instance, interviews with pregnant Hmong women in Wisconsin reveal that many delay prenatal visits because they fear that a doctor's or nurse's touch will result in miscarriage.[31]

Abortion Access and Contraception

Abortion is critically important for APA women. Although very few reports exist on the rate at which APA women are utilizing abortion services, those that do exist suggest a relatively high use of abortion among specific ethnic subpopulations, most notably Chinese American, Korean American, and Thai women.[32] One study found that between 1994 and 2000, abortion rates fell in the United States for all groups except Asian and Pacific Islanders.[33] Researchers infer that the attitudes and rates of abortion may be largely shaped by the abortion practices in those countries from which APA women immigrated. Thus, APA women who immigrated from countries with legalized abortion, such as China, Hong Kong, and Korea, are more likely to view abortion as an acceptable method of family planning than APA women who immigrated from countries where abortion is illegal, such as the Philippines.[34]

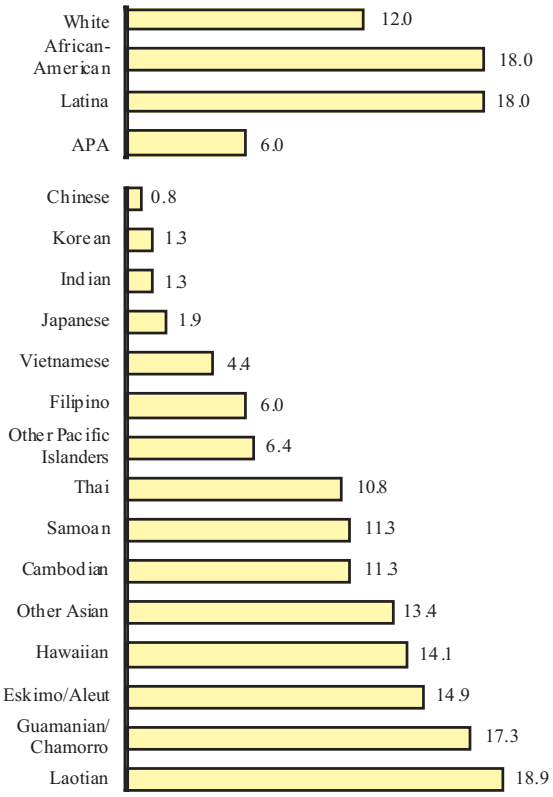
"[B]etween 1994 and 2000, abortion rates fell in the United States for all groups except Asian and Pacific Islanders."

One reason for APA women's high rates of unintended pregnancies and abortion may be related to their contraceptive preferences and use. One study documenting the reproductive health practices of Chinese and Filipina American college women found that Chinese American women were four times less likely to use hormonal methods of birth control than white women.[35] The study further indicated that both Chinese and Filipina American women were more likely to use the withdrawal method compared to their white counterparts, increasing their likelihood of getting pregnant, and making them more vulnerable to sexually transmitted diseases.[36] Moreover, national data reveals that 35% of pregnancies end in abortion for APA women, the second highest percentage for all racial/ethnic groups, compared to 18% for white women, further suggesting that APA women may not be engaging in effective contraceptive usage.[37]

Comprehensive Sexuality Education and Teen Sexuality

Studies reveal that many young APA women and girls are not comfortable discussing issues related to sexuality, pregnancy, and birth control in their families or even with their doctors. One survey of high school students in Los Angeles found that APA teens were less likely to communicate with their physicians about sexual activity and risk prevention than other ethnic groups.[38] Another study found that young Chinese American women were less comfortable discussing sexuality with physicians and peer counselors than young Filipina American or white women.[39] Finally, a focus group involving South Asian women revealed discomfort in asking South Asian providers for reproductive health guidance, for fear that the doctors brought cultural biases to their practice or would violate confidentiality.[40]

Figure 5: Percentage of All Births by Ethnicity to Teens in California, 1989-1998



Source: Weitz, T.A., Harpger, C., & Mohllajee, A.P., *Teen Pregnancy Among Asians and Pacific Islanders in California: A Final Report* (2001).

In recent years, policymakers and reproductive rights advocates have focused significant attention on the issues of teen pregnancy and sexually transmitted diseases. The debate has largely ignored the concerns of APA women. For instance, many teen pregnancy studies fail to disaggregate rates by ethnic subpopulation, creating the public perception that teen pregnancy is not an issue for the APA community. By contrast, one study found that over half of all births to teen mothers under the age of 19 in Hawaii were among Native Hawaiians.[41] Another teen pregnancy study in California, which broke down the data collection by ethnic subpopulation, revealed that Laotian Americans had the highest teen birth rate in the state.[42] The same study found that close to 60% of teen Laotian girls were married at the time they give birth, indicating that promotion of abstinence-only programs may not fully address the needs and concerns of many young APA women.[43]

Similarly, while the prevalence of some sexually transmitted diseases (STDs) is decreasing for the general population, the rate of chlamydia and gonorrhea is actually increasing for Asian Americans and Pacific Islanders, particularly among APA women under age 25.[44] One study found that over two-thirds of APA women are sexually active, yet less than 40% regularly use condoms or other contraceptive barrier methods to protect themselves from sexually transmitted diseases.[45] Another survey found that APA women had lower rates of STD screening than other groups, which may suggest their discomfort with seeking reproductive and sexual health care services.[46]

Emergency Contraception

Access to emergency contraception (EC) is essential to providing women with the full range of contraceptive options, and helping reduce the number of unintended pregnancies. One study found that most young APA women surveyed were aware of emergency contraception, yet over 60% of those same women were confused as to the purpose or parameters of the pills.[47] Another study found that over 50% of South and Southeast Asian women between the ages of 18-44 in California lacked knowledge of EC.[48] Lack of knowledge prevents many APA women from accessing EC in a timely manner.

In addition, EC is available in the United States only by a doctor's prescription. Approximately 36% of APA women and girls under age 65 lack health insurance and do not have a regular source of health care, which can create a critical delay in obtaining the product. Moreover, in recent months there has been a surge in the number of pharmacists who refuse to dispense EC or other contraception because of religious or moral objections, further delaying access to the time-sensitive pills.

Sex Selection: An Old and New Challenge for APA Women[49]

Studies have found that many APA women continue to face intense cultural and societal pressures around pregnancy and childbearing decisions. For instance, one study found that South Asian women were concerned that the preference for boys dominant in Indian culture was contributing to an increase in the number of abortions for sex selection.[50] In fact, the lowered costs and the rise of the use of prenatal screenings, such as amniocentesis and ultrasounds, have led to abortions of female fetuses and abandonment of baby girls throughout Asia. As a result, sex ratios in some districts of India are as low as 766 girls per 1000 male children. In China in 1996, there were 121 boys ages 1 to 4 for every 100 girls in the same age range. Given these cultural patterns, as the biotechnology industry within the United States continues to develop and market more prenatal and pre-implantation selection technologies, the development of sophisticated reproductive genetic technologies could have a dramatic impact on APA women.

Unlike in Asia, sex selection in the U.S. as a whole seems to be driven less by cultural norms and economic need, such as a preference for boys, population control and dowry, and more by a combination of technology and marketing. The assisted reproduction industry in the United States markets sex selection under the rubric of "family balancing" or "gender balance." The reproductive genetic technologies currently in use include social sex selection, embryo screening (i.e. pre-implantation genetic diagnosis), and prenatal screening (e.g., ultrasound, amniocentesis, used for sex selection and disability de-selection). Newer pre-pregnancy technology is currently being used and involves sorting sperm for sex selection prior to fertilization. The newest sex selection technology, introduced in the United States in June 2005, determines the sex of the embryo at five weeks through a simple maternal blood test.

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Sex selection and other genetic technologies on the horizon have important implications for women's reproductive health and rights. Women, particularly APA women who already experience cultural pressures when deciding to start a family, may experience social pressures to produce certain kinds of children, which could lead to less control over their reproductive decisions and experiences.

Occupational and Environmental Toxins and Reproductive Health

For many APA women, reproductive justice also includes the ability to live and work in environments that are free from toxins and other dangerous chemicals and conditions. For instance, a large number of APA women are employed in high-tech manufacturing environments where they are more exposed than the mainstream population to chemical and heavy metal exposures that can lead to miscarriages or birth defects.[51] One study found that 38% of pregnant semiconductor production workers, who worked in the "clean rooms," had spontaneous abortions.[52]

In addition, many Southeast Asian women refugees, who fled from conflicts in their countries, resettle in the U.S. in low-rent housing neighborhoods that are located near refineries and chemical manufacturing plants that produce or had once produced dangerous toxins, exposing themselves and their families to health risks.[53]

The garment industry is also dominated by low-income women of color, particularly Asian and Pacific Islander and Latina immigrants, many of whom are undocumented. Asian Pacific American women comprise approximately 100,000 garment workers in California and nearly 32,000 workers in New York.[54] Because of their immigration status, garment workers are often forced to work below the federal minimum wage and under dangerous and unhealthy conditions such as unsanitary restroom facilities and in rooms with poor ventilation. These poor work conditions have profound implications for the overall health and reproductive health care status of APA women.

"Industry estimates reveal that over 95% of nail salon workers are female, and that 80% of the industry workers in California are Vietnamese immigrants."

Studies have also found that prolonged exposure to phthalates, chemicals used in many cosmetics with the highest concentration found in nail polish, poses a serious occupational hazard to workers. Industry estimates reveal that over 95% of nail salon workers are female, and that 80% of the industry workers in California are Vietnamese immigrants.[55] Nail salon workers typically work long hours and suffer prolonged exposure to occupational chemicals that can increase their risks for adverse health consequences. For instance, phthalates have been linked to both cancer and birth defects and can be found in a variety of everyday cosmetic products such as nail polish, body lotions, and eye mascara. Not only do women of childbearing age frequently use products containing phthalates, but they also transfer many of these chemicals across the placental barrier to the developing fetus.

In addition to workplace toxins, many APA women and their families suffer environmentally from extensive pollution by the military. For instance, Pacific Islanders have been suffering the long-term consequences from nuclear bomb testing in the Pacific. South East Asian people still suffer from the long-term effects of Agent Orange exposure from the Vietnam War. Communities in the Philippines are forced to contend with the decades of military toxics left-over from abandoned military bases. Communities in Hawaii, Guam, Korea and Okinawa suffer from the presence of operating military bases that not only have military toxics but also create an environment where there is a higher rate of violence against women.

HIV/AIDS

Asian and Pacific Islanders comprise less than 1% of all reported HIV-positive cases in the U.S., the lowest rate among all racial or ethnic groups.[56] Yet, in recent years, the number of reported cases has steadily increased, particularly among certain ethnic subpopulations. The estimated number of AIDS cases diagnosed among Asians Americans and Pacific Islanders in the U.S. increased from 346 in 1998 to 478 in 2002.[57] Moreover, a lack of medical data collection by ethnicity or national origin, combined with underreporting and misclassification, often distort the real impact of the disease in the APA community.[58]

"APA women represent 13% of all cumulative AIDS cases within the APA population."

APA women represent 13% of all cumulative AIDS cases within the APA population.[59] One study found that AIDS cases among APA women in California have increased more than 150% in the past few years,[60] and Native Hawaiians have the highest number of AIDS cases among all women in Hawaii.[61] Another study found that 49% of adult and adolescent APA women reported having heterosexual sex with an HIV positive or high-risk partner, compared to 37% for Native Americans/Alaska Natives, 40% for White women, 47% for Latinas, and 39% for African American women.[62] Immigration status, poverty, and language barriers prevent many APA women from accessing government services that include HIV screening and preventive health care. In addition, cultural taboos and the reluctance to discuss issues related to sexuality create further obstacles to accessing and receiving necessary information about HIV/AIDS and treatments.

Over the past few decades, several national and local organizations have been founded to provide linguistically and culturally appropriate services to APA men and women living with HIV/AIDS and to forge partnerships with other groups working on health care issues.[63] These programs and services aim to increase public awareness about HIV/AIDS within the APA community and dispel myths, stereotypes, and cultural taboos about sexuality, homosexuality, and health care.

Violence Against Women and Reproductive Health

Only within the past few decades have researchers started to document the extent of sexual and domestic violence within the Asian Pacific American community. Those studies found that APA women experience a vari-

ety of emotional and physical abuse by intimate partners, and they continue to confront barriers in seeking help. One survey found that 61% of Japanese immigrant and Japanese American women experienced some form of physical, emotional, or sexual violence that they classified as abusive.[64] Another study of South Asian women in heterosexual relationships revealed that 40% of the participants had been physically and/or sexually abused by their current male partners.[65] Available research also suggests that APA women are at a higher risk for fatalities than other groups. For instance, a 1997 study in Massachusetts found that, although Asian women represented 3% of the state's total population, they comprised 18% of all Massachusetts residents killed as a result of domestic violence.[66]

"WOMEN WHO EXPERIENCE VIOLENCE ARE MORE LIKELY THAN OTHER WOMEN TO DELAY PRENATAL CARE, SUFFER FROM SEVERE POSTPARTUM DEPRESSION, AND ENGAGE IN RISKY SEXUAL BEHAVIOR, DRUGS, OR ALCOHOL."

Additional studies have found that APA women are likely to underreport domestic violence, stalking, and sexual assault, and less likely to characterize particular interactions as domestic violence than women of other ethnic groups.[67] Limited shelter services, lack of bilingual staff and service providers, and current immigration restrictions prevent many battered APA women from seeking necessary support systems. In particular, queer APA women feel unsafe in reporting relationship violence to the police because of fear of further abuse. They also face additional barriers to accessing service providers because of homophobia and disbelief.[68]

Violence and abuse are likely to occur in relationships where there is a power imbalance between the two individuals. For instance, a 1999 study conducted by the Immigration and Naturalization Service (INS) estimated that over 200 international marriage brokers (IMBs) operated in the U.S., and arranged approximately 4,000 to 6,000 marriages a year between American men and foreign women. Today, it is estimated that more than 400 IMBs arrange upwards of 8,000-12,000 marriages a year. Although IMBs operate worldwide, a significant proportion of the women they recruit come from Asian countries, including the Philippines and Thailand. It is difficult to document the prevalence of violence within these relationships because of underreporting, lack of bilingual services, and fear of deportation, but the stark power imbalance, anecdotal evidence, and other reports conclude that the incidence of abuse is likely higher within these relationships than in other relationships and marriages.

The intersection of domestic violence, stalking, and sexual assault and reproductive health care is profound. Women who experience violence are more likely than other women to delay prenatal care, suffer from severe postpartum depression, and engage in risky sexual behavior, drugs, or alcohol.[69] They are also three times more likely to have gynecological problems than non-abused women, such as chronic pelvic pain, vaginal bleeding, fibroids, pelvic inflammatory disease, and infertility.[70] Reproductive health care providers are uniquely situated to screen for domestic and sexual violence, yet less than half of providers routinely do so.[71]

Human Trafficking, Modern Day Slavery, and Reproductive Health

Human trafficking is one of the three largest criminal industries in the world and is the fastest growing. Between 600,000 to 800,000 persons annually are trafficked across international borders worldwide.[72] The State Department estimates that of that number, approximately 18,000 persons are trafficked into the U.S. each year, and many of these victims are women from Southeast Asia.[73] Once victims are brought to the U.S., many are forced to work in sweatshops, farms, residences, and in the commercial sex industries, where they are extremely vulnerable to abuse and violence. Trafficking occurs in at least 90 cities in the U.S., but is concentrated in California, Florida, New York, and Texas. For instance, because of its significant immigrant population, manufacturing and agricultural industries, and geographical location, California has become one of the major destinations for human trafficking.

"HUMAN TRAFFICKING IS ONE OF THE THREE LARGEST CRIMINAL INDUSTRIES IN THE WORLD AND IS THE FASTEST GROWING."

Trafficked persons are often isolated from the outside world, and lack access to basic health care and reproductive health care services. As a result, they have few options for birth control, contraception, and other reproductive and sexual health services. Several reports have found that female survivors of trafficking have undergone forced abortions, carried to term unwanted pregnancies, and contracted sexually transmitted diseases and HIV/AIDS. Because of their lack of health care, untreated STDs have been known to result in infertility. In addition to physical trauma, a trafficked woman also suffers from a decline in her mental health status, particularly after undergoing a forced abortion. Finally, prenatal care is minimal for those who are pregnant.

Lesbian, Transgendered, and Queer Health and the APA Community

APA lesbians, gay, bisexual, transgendered, and queer persons (LGBTQ) often face discrimination and oppression based on the intersection of race, ethnicity, gender, and sexual orientation. For immigrant APA LGBTQs, the additional barrier of immigration status and language differences further isolate them from mainstream society. For these reasons, APA LGBTQs are perhaps one of the most marginalized groups within the APA and mainstream LGBTQ communities.

While there are few studies on the reproductive and sexual health needs of APA women generally, APA LGBTQs are virtually absent in research on women's health, studies on people of color, lesbian health, and bisexual and transgender health research. For instance, in 1983-1988, in a National Lesbian Health Care Survey, only 0.8% of the 1,917 surveyed participants were API lesbians. This number increased only slightly in subsequent reports. In a 1995 Lesbian Wellness Survey, only 3% of the 2,393 surveyed participants were API, compared to 76% of Whites, 9% of African Americans, 7% of Latinas, and 3% of Native Americans. And, in a 1999-2001 Lesbian Health Survey in Los Angeles County, 5.2% of the 1,398 surveyed participants were APA lesbians, compared to 73.9% of Whites, 11.8% of Latinas, and 9% of African Americans.[74] In order to properly understand the unique health care needs of APA LGBTQs, it is imperative that they are adequately represented in national and regional research reports.

"Because of the cultural stigma and shame associated with homosexuality within the APA community. . .many APA LGBTQs find it difficult to come out to their parents and families."

Anecdotal evidence has found that lesbians continue to face discrimination by health care providers. As a result, one study found that the majority of lesbians choose not to disclose their sexual orientation during medical check-ups, which prevents doctors from providing individualized and adequate care to every patient. Without the knowledge of a person's sexual orientation, a doctor cannot properly advise a patient on contraception or screen her for particular sexually transmitted diseases or other illnesses.[75] For instance, a physician may not ask direct questions to learn more about a patient's family history for breast cancer, given the fact that women who do not have children may be at an increased risk for that disease, nor can a doctor properly advise a patient on safe sexual practices.[76]

Because of the cultural stigma and shame associated with homosexuality within the APA community, the lack of visible APA LGBTQ role models, and potential emotional and financial vulnerabilities, many APA LGBTQs find it difficult to come out to their parents and families.[77] A recent study conducted by the Asian Pacific Islander Lesbian, Bisexual, Queer & Transgender Task Force (APLBQT) found that 76% of respondents ranked family acceptance as an overall need, and 40% ranked it as their most important need. In addition to family acceptance, respondents also ranked personal safety (50%) and community building/organizing (48%) as important needs. Unfortunately, no research exists that documents the extent to which the stress of "coming out" affects the particular health care concerns of APA LGBTQs.[78]

"The cultural stigma associated with mental health problems, discomfort with American clinicians and treatments, financial restrictions, and language barriers are among some of the factors that contribute to the underutilization of the mental health care system for many APA women."

Mental Health

APA women have the highest suicide rates among all women over age 65, and the second highest rate among women between ages 15-24 in the U.S.[79] A breakdown of available data reveals that elderly Chinese and Japanese American women have the highest suicide rates of all racial or ethnic groups in California.[80] Several studies that have documented the mental health status of Southeast Asian refugees found that they are at an increased risk for post-traumatic stress disorder (PTSD), depression, and other mental health conditions. And, other studies have found slightly higher rates of depression, attempted suicide, and substance abuse for LGBTQs. Although APA LGBTQs are virtually absent from research on women's health and lesbian health, anecdotal evidence suggests that the social and cultural pressures that many APA LGBTQs face are attributed to their higher than average rates of suicide attempts.[81]

Yet, despite these alarming statistics, APA women are less likely than other racial or ethnic groups to seek mental health care from their doctors or health care providers. The cultural stigma associated with mental health problems, discomfort with American clinicians and treatments, financial restrictions, and language barriers are among some of the factors that contribute to the underutilization of the mental health care system for many APA women.

3 Barriers to Accessing and Receiving Reproductive Health Care Services

Lack of Health Insurance

Studies indicate that having health care coverage makes a significant difference in accessing and utilizing health care services.[82] Currently, 36% of APA women under age 65 lack any form of health insurance, and Korean Americans are the most likely racial or ethnic group to be uninsured.[83] Asian Americans and Pacific Islanders of all ages are less likely than whites to have a regular source of health care, decreasing the chance of detecting and preventing diseases which lead to health disparities and poor health outcomes.[84]

"Under the 1996 welfare reform law, lawfully present immigrants are barred from enrolling in Medicaid for five years. Those who are eligible often refrain from applying for benefits out of fear that enrolling themselves or their children will adversely affect their citizenship status and result in deportation."

There are a number of barriers to health care coverage for APA women. Many APA women are concentrated in low-wage employment such as garment industries, textile industries, restaurants, and private households which do not provide employer-based health insurance. In addition, a high percentage of APA women are self-employed. For instance, Korean Americans are disproportionately self-employed or work in small businesses that lack health benefits, accounting for their higher rates of uninsured statuses and lower rates of job-based coverage. Moreover, financial restrictions prevent many low-income APA women from purchasing expensive private health insurance.

Approximately half of Southeast Asian Americans do not receive health coverage from their employers, and they represent the highest percentage of Asian Pacific Americans enrolled in Medicaid.[85] By contrast, Japanese Americans have the highest rate of job-based coverage within the APA community; 77% receive health benefits from their employers.[86]

Current immigration laws create additional obstacles to accessing the health care system for APA women. Under the 1996 welfare reform law, lawfully present immigrants – including pregnant women and children – are barred from enrolling in Medicaid for five years.[87] Those who are eligible often refrain from applying for benefits out of fear that enrolling themselves or their children will adversely affect their citizenship status and result in deportation. Passage of the law has detrimentally affected the immigrant APA community. For instance, Medicaid coverage for Southeast Asians sharply declined between 1994 and 1997, from 41% to 18%, thereby raising their uninsured rate.[88] Moreover, without health insurance, it is very likely that undocumented pregnant immigrant women will forgo necessary check-ups and prenatal care, increasing their risk and cost of complications during and after childbirth.[89]

Insufficient and Inadequate Research on APA Women

Few research reports and studies that focus on reproductive health include Asian Pacific American women and girls, and even fewer studies break down their data by ethnic subpopulation, immigration and refugee status, acculturation, and socioeconomic statuses. In fact, of the total number of published reproductive and sexual health articles, only 2% focus on Asian Pacific Americans, compared to 4% for Native Americans, 18% for Latinos, 35% for African Americans, and 41% for Whites.[90] A comparison of these figures to data from the most recent Census reveals that Asian Pacific Americans, who comprise 4% of the total population, are the only ethnic minority group that is underrepresented in reproductive health research efforts in relation to their overall percentage in society: Native Americans comprise 1% of the total population, Latinos are 13%, African Americans are 13%, and Whites are 77%.[91]

As the previous section illustrated, many APA women have a greater prevalence of certain cancers than the general population, increasing rates of STDs and HIV/AIDS, and high utilization of abortion services. Yet, there are few documented reports, for instance, on the relationship between environmental toxins and breast cancer among APA women, or abortion studies that collect data by ethnic subpopulation. In addition, only one HIV/AIDS intervention study has been conducted for APA women, despite the fact that the rate of HIV/AIDS is steadily increasing.

Finally, certain ethnic subpopulations within the APA community experience high teen pregnancy and birth rates, yet national studies rarely disaggregate data collection and surveys by ethnicity, creating the false perception that teen pregnancy is not a concern for APA women. By contrast, one California study revealed that Laotians have the highest teen birth rate in the state, 18.9%.[92]

The lack of research generally, gaps in data, and failure of studies to collect data by ethnic subpopulation and immigration and refugee status can have detrimental consequences for the reproductive health care of APA women and girls. If the public health and medical communities are unaware that APA women, and certain subpopulations within the APA community, are at a heightened risk for certain reproductive and sexual health conditions because they are not included in published reports, then health care providers are less likely to train their staff and educate APA patients and communities of the need for early detection, intervention, or education, nor can they provide appropriate care to this population. As a result, many APA women are left without the information and education necessary to make well-informed decisions about their overall health, including reproductive health, and could forgo routine check-ups, preventive care, and screenings.

Lack of Culturally Competent Services

Culturally competent care includes taking into consideration, recognizing, and responding to the different values, preferences, beliefs, and needs of an individual patient. Health care providers can do this by creating an environment in which patients from diverse cultural backgrounds feel comfortable discussing their specific health beliefs and practices, being familiar with and respectful of these traditional spiritual and cultural values, and incorporating these practices into their diagnosis and treatment.[93] Providing care in a culturally competent manner will create positive outcomes for patients and improve their health status.

Culturally competent care is an essential component of effective reproductive health care for Asian Pacific American women. Studies have found that many APA women will actually delay or forgo seeking mammograms and clinical breast exams because of the cultural stigmatization of breast cancer as a fatal disease.[94] In one survey, Vietnamese American women reported lower rates of preventive care for breast and cervical cancer because they fear a positive diagnosis or have misconceptions about what a Pap smear entails or is used for.[95] When doctors are aware of these perceptions and beliefs about disease, they will be able to tailor their outreach and treatment in a more appropriate manner.

In addition, delivering culturally competent care also means recognizing that for many APA communities, issues related to sexuality, reproductive choice, and birth control are taboo subjects, leaving many APA women and girls with a limited understanding about their bodies and their reproductive rights. One focus group involving South Asian American women found that many had difficulty communicating with their families or doctors about issues related to sex, sexuality, relationships, and marriage, and that affordable and complete birth control education and information was reported as a serious necessity.[96] Another study on HIV-risk assessment and APA women revealed that virtually all of the respondents agreed that sex was a private subject that is not discussed openly or publicly, and that communicating about sex was tantamount to "airing private laundry."[97]

Furthermore, culturally competent care also requires incorporating traditional treatments, such as acupuncture, herbal remedies, and traditional birthing practices into Western clinical practices and education. Studies reveal that approximately 96% of Cambodian women, 81% of Laotian women, and 54% of Chinese women use traditional health practices, which may help to explain their high rates of non-compliance with Western prescriptions.[98] Another study found that Vietnamese American women rely heavily on herbal medicines, and often use Western clinics as a last resort.[99] Many times, non-Western remedies and treatments are not covered by health insurance plans, leaving APA women with the limited options of either forgoing care altogether or receiving health care in a manner that is disempowering and unfamiliar.

"MANY TIMES, NON-WESTERN REMEDIES AND TREATMENTS ARE NOT COVERED BY HEALTH INSURANCE PLANS, LEAVING APA WOMEN WITH THE LIMITED OPTIONS OF EITHER FORGOING CARE ALTOGETHER OR RECEIVING HEALTH CARE IN A MANNER THAT IS DISEMPOWERING AND UNFAMILIAR."

Language Barriers

Title VI of the Civil Rights Act of 1964 prohibits federally funded entities from discriminating against individuals on the basis of race, color, or national origin in their delivery of services. The Supreme Court has further interpreted this prohibition to include providing adequate services to individuals who do not speak English. Subsequent executive orders have focused on improving language access for limited English proficient individuals by requiring recipients of federal funds and federal agencies to develop guidance policies that describe how they will administer their programs in a non-discriminatory manner.[100] Despite these efforts, language barriers continue to exist in the health care setting.

Linguistically appropriate services are critically important to the Asian and Pacific Islander community, which represents over 30 diverse ethnic groups and over 200 languages and dialects. The 2000 U.S. Census Bureau statistics found that of the nearly 10 million Asian Pacific Americans over age five in this country, 79%, or four-fifths, speak a language other than English at home, and 40% are limited English proficient (LEP) or speak English less than "very well."[101] Disaggregating this data by ethnic subpopulation reveals a significant difference in levels of English proficiency among certain groups. For instance, 95% of Hmong and Bangladeshi Americans speak a language other than English at home, compared to only 38% of Japanese Americans.[102] Similarly, 61% of Vietnamese Americans are LEP, compared to 21% of Filipino Americans.

Figure 6: Limited English Proficiency (LEP) in the U.S.	
United States	8%
White	2%
Black	3%
Native American	8%
Latino	41%
Asian	36%
Native Hawaiian, Other Pacific Islanders	12%
Vietnamese	61%
Hmong	58%
Cambodian	53%
Bangladeshi	52%
Laotian	52%
Taiwanese	51%
Korean	46%
Chinese	45%
Thai	41%
Indonesian	35%
Malaysian	34%
Pakistani	32%
Tongan	29%
Fijian	26%
Asian Indian	23%
Japanese	21%
Filipino	21%
Sri Lankan	18%
Samoan	16%
Guamanian	13%
Native Hawaiian	3%

Source: Asian & Pacific Islander American Health Forum, Diverse Communities, Diverse Experiences, The Status of Asian Americans and Pacific Islanders in the U.S.

Language differences create huge barriers to accessing and receiving appropriate reproductive health care services for APA women. Studies have found that individuals who require interpreters receive fewer preventive services such as mammography, Pap smears, or other important screenings, or leave medical visits without thoroughly understanding the directions for their prescriptions.[103] One study found that language barriers exacerbated misconceptions that Vietnamese American women had about birth control pills, preventing them from receiving accurate information about the full range of contraceptive options.[104] Other stories highlight incidents where health care providers have used a stranger or the daughter of an APA woman to translate during gynecological exams, creating embarrassment and shame.[105] Finally, research has found that even in health care settings that provide a diverse range of interpreters, communication is still challenging because of the unique dialects, tones, expressions, and terms surrounding reproductive and sexual terminology.[106]

Stereotypes and Discrimination

Racial and sexual stereotypes of APA women, both within the Asian Pacific American community as well as mainstream society, continue to have a detrimental impact on their reproductive and sexual health needs. The most pervasive and persistent stereotype is the model minority myth, which creates the public perception that all Asian Pacific Americans are healthy, educated, and economically prosperous. For APA women in particular, the myth presumes that they do not encounter barriers in accessing or receiving reproductive health care services, nor do they suffer from health disparities. As a result, health care providers, policymakers, and the general public will often underestimate or ignore the unique reproductive health issues and overall health care concerns of APA women. The myth further translates into little funding and resources aimed at educating APA women or providing services for APA communities.

"STEREOTYPES OF APA WOMEN AS DOCILE AND SUBMISSIVE "LOTUS BLOSSOMS" HAVE CREATED AN OVERSEXUALIZED AND OVEREXOTICIZED IMAGE OF APA WOMEN, AN IMAGE THAT HAS CONTRIBUTED TO THE GLOBAL TRAFFICKING AND INTERNATIONAL SEX TOURISM INDUSTRIES INVOLVING ASIAN WOMEN."

Additional stereotypes of APA women also contribute to their reproductive and sexual self-images. For instance, within many APA communities and families, issues related to sex, sexual health, and sexuality are not discussed. Sex is viewed as one of the duties

between heterosexual spouses for the sole purpose of procreation.[107] By contrast, other stereotypes of APA women as docile and submissive "lotus blossoms" have created an oversexualized and overexoticized image of APA women, an image that has contributed to the global trafficking and international sex tourism industries involving Asian women.[108] APA women at the national and local levels have worked for decades to challenge these racist and sexist stereotypes and take back power and control over their sexual identity.

Restrictions on APA Women's Access to Reproductive Services

In recent years, there have been trends at both the state and federal levels to restrict access to abortion and other reproductive health care services, especially for minors. Florida and California, for instance, have undergone, or will undergo, attempts to change their state constitutions to require parental notification for minors who wish to have an abortion. New Hampshire passed a similar parental notification law, which was subsequently challenged in a lawsuit by Planned Parenthood; the Supreme Court will hear the case during its 2005-06 term.[109]

Similarly, at the federal level, the Child Custody Protection Act[110]/Child Interstate Abortion Notification Act[111] will require abortion providers to notify a minor's parents before performing an abortion. Other federal legislation, such as the Parents Right to Know Act,[112] would likewise require federally funded health clinics to notify parents of any minors seeking contraceptive services at least five days before dispensing the contraception.

"Approximately 36% of APA women under age 65 have no health insurance."

These state and federal legislative attempts will have devastating consequences for APA minors. As noted above, studies have found that many young APA girls do not discuss issues related to sexuality, birth control, or reproductive health care with their parents or in their households. Thus, requiring parental notification could discourage many APA girls from seeking contraceptive and reproductive services altogether, placing them at an increased risk for unplanned pregnancies, sexually transmitted diseases, and pregnancy-related complications.

In addition, the Hyde Amendment, which prohibits federal funding to cover abortion services, makes it difficult, and often impossible, for many low-income APA women to exercise their right to make personal decisions about their reproductive health. Approximately 36% of APA women under age 65 have no health insurance. Thus, over one-third of APA women are forced to seek their reproductive health care services from Title X clinics,[113] community clinics, and nonprofit and public hospitals.[114] In recent years, the number of nonprofit and public hospitals that have been merged into or are bought by religious hospitals has sharply risen. These religious hospitals impose religious restrictions on which health care services a patient may receive. For instance, religious health restrictions are used to prohibit abortion, birth control, emergency contraception, sterilization, in-vitro and other infertility services, and contraceptive and STD counseling.[115] Low-income APA women who do not have health insurance and who rely on these public hospitals no longer have access to critically important family planning services and abortion.

The Role of the Federal Judiciary

The death of Chief Justice William Rehnquist provided President Bush with the opportunity to nominate Judge John Roberts whose record as Solicitor General and Special Assistant to the Attorney General suggests his hostility to reproductive freedom. In 1990, as Deputy Solicitor General, Judge Roberts co-authored a brief in Rust v. Sullivan[116] where he argued that Roe v. Wade[117] was wrongly decided.[118] Similarly, in Bray v. Alexandria Women's Health Clinic,[119] Judge Roberts again authored a brief on behalf of the government supporting the positions of a radical anti-choice group called Operation Rescue and six individuals who had blocked access to reproductive health care clinics and were harassing patients and doctors. In the brief, Judge Roberts argued that Operation Rescue's conduct did not constitute discrimination against women, even though only women can have abortions.

The resignation of U.S. Supreme Court Justice Sandra Day O'Connor will likewise give President Bush the chance to nominate another individual who shares Judge Roberts' conservative values. Justice O'Connor's replacement is particularly important as she was often the swing vote in many cases of importance to APA women, including sex discrimination, affirmative action, and abortion rights. In particular, the two most recent abortion rights cases, Planned Parenthood v. Casey[120] in 1992 and Stenberg v. Carhart[121] in 2000, were decided by close 5-4 votes, with Justice O'Connor in the majority. In Casey, Justice O'Connor upheld the fundamental premise of Roe v. Wade, holding that governments can regulate abortion services so long as they do not impose an undue burden on the woman's right to choose to have an abortion. In Stenberg, the Court invalidated Nebraska's partial birth abortion ban because it did not include an exception to preserve a woman's health, and because the statutory language defining the procedure was too vague.

Even if the basic principle of Roe v. Wade is upheld, the addition of one conservative Justice to the Supreme Court will likely result in significant restrictions on access to abortion services. For instance, the Court would be more likely to uphold parental notification laws and allow states to ban abortions in the second trimester, even when these laws do not include an exception for the health of the woman. The previous section illustrated the importance of protecting access to abortion services for APA women who have the second highest utilization rate among all racial/ethnic groups. Thus, the judicial nomination and Senate confirmation process will be significant in shaping the legal landscape for APA women's access to reproductive health care services in the years to come.

A Call to Action

Asian Pacific American women's reproductive and sexual health needs, attitudes, and concerns are shaped largely by their diverse historical, cultural, and social experiences. Unfortunately, the lack of research on APA women, combined with misperceptions and stereotypes of the APA community as the model minority, limit the public's and health care providers' understanding of reproductive and sexual health care issues of importance to many APA women and girls. This lack of understanding translates into a paucity of funding designed to break down the barriers that APA women encounter in accessing and receiving important sexual and reproductive health care services. As a result, many APA women suffer from a significant number of health disparities, leading to poorer health outcomes than the general population.

The National Asian Pacific American Women's Forum (NAPAWF) seeks to create partnerships with policymakers, allied groups, advocates, health care providers, and the APA community by presenting a national agenda for action that discusses the reproductive and sexual health issues that APA women encounter today and that provides policy recommendations to address those challenges.

To fully realize sexual and reproductive justice, APA women and their families need to have access to quality health care that is linguistically and culturally appropriate, meaningful research and data, access to a full range of sexual and reproductive health services, comprehensive sexuality education, the ability to live and work in environments free from harmful toxins, and the freedom to make decisions about whether to have a child without cultural and social pressures. Our national agenda "Call to Action" is framed around these issues.

(1) Providing Access to Affordable Health Care for All

Health insurance is a fundamental human right that must be available to all individuals regardless of one's status as a citizen or immigrant, race, or socioeconomic circumstances. Yet, over one-third, or 36%, of APA women under age 65 lack health insurance, creating a significant barrier to accessing and receiving appropriate reproductive health care such as preventive screenings, prenatal care, and early treatment. In fact, Korean Americans are the most likely racial or ethnic group to be uninsured. The rising cost of private insurance, as well as the increase in cost to individuals who have employer-based coverage, further prevents many APA women from seeking timely and necessary reproductive health care services. The lack of health insurance coverage is an enormous contributing factor to the underutilization of the health system for many APA women.

Moreover, current immigration laws, such as the 1996 welfare reform law, that restrict immigrant participation in Medicaid and other health care benefit programs force many immigrant APA women to delay seeking important check-ups and prenatal care, or forgo care altogether. As a result, APA women continue to suffer from disparities in a significant number of health conditions, many of which are preventable and treatable if detected early, leading to poorer health outcomes than the mainstream population.

To provide APA women and their families with affordable and comprehensive health care coverage, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Develop and implement a universal health care system.
- ✓ Restore health care benefits and access to health care services under Medicaid and the State Children's Health Insurance Program (SCHIP) for all immigrants, regardless of immigration status.
- ✓ Support legislation that expands health care coverage and lowers costs for self-employed individuals and small business employees.

For Advocates and Ally Organizations:

- ✓ Develop partnerships and collaborations between APA and health care organizations at both the national and local levels to ensure that APA women's unique health care concerns are part of the ongoing dialogue.
- ✓ Promote the hiring of community leaders in the health care system to better facilitate communication between the health care system and the APA community.
- ✓ Provide bilingual materials about the eligibility of health care benefits for immigrants in clear and unambiguous language.
- ✓ Advocate for health care as a human right.

For Community Leaders:

- ✓ Educate community members about APA women's lack of health insurance and how this prevents them from accessing the health care system.
- ✓ Develop education campaigns within the APA community on the value of preventive screening and health care.
- ✓ Organize and engage in a policy campaign that demands health care coverage for all individuals.
- ✓ Challenge cultural values that reinforce the notion that APA women must subordinate their own health care concerns to those of their family's.

(2) Promoting Linguistic and Cultural Competence in Health and Human Services

Reproductive health care services such as family planning, abortion, counseling, and preventive care must be designed in a culturally and linguistically appropriate way to promote the dignity and equality of all APA women and girls. Providing culturally competent care requires health care providers to understand APA women's perceptions and beliefs about diseases, such as the stigma associated with cancer; recognize that many issues related to sexuality and reproductive health care are not discussed within APA families or communities, leaving many women with a limited understanding of their reproductive and sexual health; and incorporate traditional non-Western treatments into their Western clinical practices. Developing innovative strategies to educate APA women, and the health care system more generally, will provide APA women with sexual and reproductive health care that is sensitive, individualized, and meaningful.

In addition, breaking down language barriers that prevent APA women from accessing and receiving reproductive health care services is a critically important step to ensuring that all Americans have equal access to our health care system. Approximately 79%, or four-fifths, of Asian Pacific Americans speak a language other than English at home, and 40% are limited English proficient (LEP). These numbers increase among certain ethnic subpopulations. Providing appropriate interpreter services and translators will empower APA women to seek necessary reproductive and sexual health care services.

To ensure that the health care system provides adequate and meaningful reproductive health care to APA women, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Expand health insurance coverage for remedies and treatments that are traditional to Asian and Pacific Islander American communities.
- ✓ Oppose any cuts to federally funded programs such as Medicaid that could negatively affect the reimbursement rates for states that offer language services to their LEP patients.
- ✓ Increase resources and funding for appropriate federal and state agencies to monitor enforcement of Title VI and compliance with executive orders.

For Advocates and Ally Organizations:

- ✓ Integrate bilingual health care staff, interpreters, and advocates into all aspects of the health care system.
- ✓ Educate and train health care providers and staff about the particular attitudes, stereotypes, perceptions, and fears that many APA communities face when addressing sexuality, sexual orientation, birth control, and reproductive rights.
- ✓ Ensure that materials on and treatment of reproductive health care conditions, such as breast or cervical cancer, are provided in a culturally sensitive and competent manner so that misconceptions and fears about the Western health care system can be addressed.
- ✓ Build partnerships between health care providers and mainstream and ethnic media to advertise their services to the APA women's community.

For Community Leaders:

- ✓ Break down the taboo and stigma associated with discussing sexuality and reproductive health in APA communities.

(3) Demanding Community-Relevant Sexual and Reproductive Health Data and Research for APA Women

APA women and girls are invisible in the reproductive rights movement and the public health field because of the lack of detailed research on their reproductive and sexual health needs. The dearth of studies also prevents health care providers from adequately treating APA women, and creates the public misperception that the APA community is not susceptible to certain illnesses or diseases. Stereotypes of the APA community as a model minority further contribute to the notion that APA women are healthy, prosperous, and do not suffer from health disparities.

The lack of research also leads to lack of funding, limiting the development of public education programs, allocation of public resources targeted at the APA community, and the ability of health care providers to adequately serve the diverse and unique population of APA women and their families. Improving data collection by including the diverse health needs of APA women will not only broaden the medical community's understanding of the sexual and reproductive health status of this community, but it will also help reduce the number of health disparities and create better health outcomes for all APA women.

To generate a field of research that represents and documents the reproductive and sexual health issues, needs, and concerns of APA women and girls, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Increase public and private funding for data collection and research on the reproductive and sexual health experiences of APA women and girls.
- ✓ Expand data collection systems to take into account race,ethnicity, and immigration status to better capture, among other things, the abortion rates, HIV/AIDS rates, prevalence of domestic violence, and teen pregnancy rates for APA women and girls.

For Advocates and Ally Organizations:

- ✓ Include APA women in data collection, clinical trials, and research.
- ✓ Disaggregate data collection and studies by ethnic subpopulation, immigration and refugee status, language proficiency, and acculturation.
- ✓ Advocate for increased research about Pacific Islander sub-populations and APA LGBTQs in research and surveys on women's health and lesbian health.

For Community Leaders:

- ✓ Engage in community-based participatory action research projects to collect information about the sexual and reproductive health care attitudes, needs, and concerns of the APA community, and develop education and skills-building programs.

(4) Protecting and Expanding Sexual and Reproductive Rights

Reproductive justice includes the fundamental human right to make decisions and have control over one's body and sexuality regardless of one's race, age, socioeconomic, sexual orientation, or immigration status. In Roe v. Wade,[122] the Supreme Court held that the constitutional right of personal privacy includes a woman's decision to terminate her pregnancy. Similarly, in Lawrence v. Texas,[123] the Court extended the fundamental right of privacy to include intimate sexual conduct between two persons of the same sex. The Court recognizes that decisions related to procreation and having a family involve the most intimate and personal choices an individual can make, and are central to personal dignity and autonomy.[124]

Since Roe v. Wade, however, Congress, as well as many states, have enacted certain laws and regulations that make it difficult, and often impossible, for many low-income APA women to exercise their human right to make personal decisions about their reproductive and sexual health. For instance, in 1977, four years after Roe, Congress passed the Hyde Amendment, which prohibits the use of federal funds to pay for abortions except in the case of rape, incest, or when the woman's life is endangered. Similarly, with the increased merger or purchase of nonprofit and public hospitals by religious hospitals in recent years, and their subsequent imposition of religious restrictions on reproductive health care services, many low-income APA women who must rely on these public hospitals no longer have access to critically important family planning services, including abortion.

In addition, the increase in pharmacists who refuse to dispense birth control and emergency contraception (EC) because of moral or ethical objections, the trend among state legislatures to enact parental notification laws, the increasing number of judges who refuse to hear bypass cases because of moral objections, and the growing support of anti-gay initiatives across the country leave many APA women and girls without the ability to take care of their reproductive and sexual health, undercutting the primary purpose of Roe. Moreover, change in the composition of the Supreme Court could permanently alter the legal landscape of reproductive rights.

To preserve and expand the reproductive and sexual rights for all APA women, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Repeal the Hyde Amendment, and ensure public funding for family planning and abortion services.
- ✓ Support federal and state legislation that will expand access to preventive health care services that help reduce unintended pregnancy, reduce the number of abortions, and improve women's health.
- ✓ Oppose provisions that allow health care entities to refuse to deliver reproductive health care services because of moral or religious objections.
- ✓ Oppose federal legislation that will limit minors' access to contraception, STD, and abortion services.
- ✓ Ensure Senate confirmation of only those judicial nominees who will uphold constitutional principles of privacy and equality.
- ✓ Encourage the FDA to grant over-the-counter status to emergency contraception for all women, including teens.
- ✓ Require pharmacies to fill all prescriptions without delay, even if a pharmacist on staff refuses to dispense certain medications, such as contraceptives or EC, because of moral or religious objections.
- ✓ Oppose anti-gay initiatives such as legislation restricting marriage for same-sex couples.

- ✓ Support legislation that protects the equal rights of LGBTQ people in all areas of the law including housing, health care, benefits, property and family law.

For Advocates and Ally Organizations:

- ✓ Advocate for culturally and linguistically accessible reproductive and sexual health care services, including abortion.
- ✓ Include APA women's organizations in national and local coalitions, partnerships, and collaborations that focus on sexual and reproductive justice issues.
- ✓ Partner with other advocacy and community-based health care organizations to create outreach and education programs to educate APA women about their sexual and reproductive health care and rights.
- ✓ Engage in dialogue and education activities within the Asian and Pacific Islander community to confront anti-gay and anti-choice campaigns.
- ✓ Include APA women's sexual and reproductive justice issues as part of the broader struggles for social, economic, and civil rights.

For Community Leaders:

- ✓ Work to create safety for LGBTQ APA women to be full members of their families and communities.
- ✓ Increase programs and awareness that allow APA women to choose from a full range of sexual and reproductive technology, care and services available to them in a culturally and linguistically accessible way.
- ✓ Create sexual and reproductive health educational materials in multiple languages, utilize alternative media outlets such as ethnic media, radio, and bill-boards and partner with existing advocacy and health care organizations in the community.

(5) Eliminating All Forms of Violence Against Women

Framing violence against women within a broader human rights context provides the opportunity to better understand the connection between domestic violence, stalking, sexual assault, reproductive health, and other social justice issues. Violence against women is profoundly linked to reproductive health care. Women who experience violence suffer from chronic illnesses, delay prenatal care, and may often engage in risky sexual and social behaviors that can lead to higher rates of sexually transmitted disease and HIV transmission.

The growing body of data on violence and APA women reveals that intimate partner violence is a significant problem for the APA community, and may be more prevalent within certain ethnic subpopulations. Moreover, APA women have higher rates of fatality associated with domestic violence than any other group. In addition, the significant percentage of Asian women who are trafficked into the U.S. or brought to the country through international marriage brokers are at a heightened risk for violence and abuse, and lack the knowledge and resources to seek outside assistance. Asian and APA women continue to underreport domestic violence and confront economic, cultural, linguistic, and social barriers to accessing and receiving critically important services.

To end all forms of violence against women and increase support services for survivors of domestic violence, sexual assault, and stalking, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Support state and federal policies that will increase language access for bilingual and immigrant survivors of violence through hiring bilingual staff and developing culturally competent programs in police departments, shelters, and among service providers.
- ✓ Eliminate state and federal immigration restrictions that prevent immigrant APA women from accessing and receiving appropriate care and support.
- ✓ Resolve inconsistencies in the eligibility requirements for immigrant victims to receive protection, including the ability to self-petition for lawful permanent residency.
- ✓ Provide funding and education to ensure that health care providers adequately screen for domestic violence during routine check-ups.
- ✓ Advocate for state and federal legislation to provide protections for individuals who are trafficked into the U.S., or are brought into the U.S. through international marriage brokers.

For Advocates and Ally Organizations:

- ✓ Conduct additional research studies on the prevalence of violence and its connection to reproductive health in the APA community.
- ✓ Collaborate with grassroots and national APA and women's organizations to develop educational materials and organize advocacy efforts on the intersection of domestic violence and reproductive health in the immigrant APA women's community.

For Community Leaders:

- ✓ Educate men and mainstream communities about domestic violence, violence against women, and the intersection of race, gender, and class.

(6) Increasing Comprehensive Sexuality Education

Empowering young APA women and girls with knowledge about their bodies, sexuality, birth control, and reproductive health care is central to human dignity, equality, and freedom. Yet, studies have found that many young APA women and girls are not discussing these issues within their families or with their doctors. Instead, many young APA women and girls are left to discover this information from their peers, in their schools, or in their communities. The few teen pregnancy studies that have broken down the data collection by ethnicity reveal that teen pregnancy is an important concern for the APA community. One study found that Laotians had the highest teen pregnancy rate in California. That same study found that Guamanian/Chamorro teens had the third highest pregnancy rate in the state. In addition, while the rate of sexually transmitted diseases is decreasing for the overall population, it is actually increasing among APA women under age 25. These studies illustrate the need to provide young APA women and teens with accurate, comprehensive, and culturally appropriate school-based and community-based abstinence and sexuality education programs that are inclusive of all genders and that create messages to LGBTQ or questioning youth.

To support and empower young APA women and teens about their reproductive and sexual health, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Support comprehensive sexuality education and teen pregnancy programs that include accurate information about abstinence, contraception, and STD prevention, and address the cultural values and beliefs of APA communities.
- ✓ Oppose abstinence-only-until-marriage programs and other scientifically unproven curriculums.
- ✓ Ensure that the above programs are accurate and represent the linguistic needs of the diverse APA subpopulations.

For Advocates and Ally Organizations:

- ✓ Develop creative strategies to capture and understand the teen pregnancy rates among APA subpopulations, such as conducting interviews with community members, workshops, and focus groups.
- ✓ Create partnerships with community-based organizations and representatives to better shape the format, content, messages, and structure of materials, educational programs, and activities that focus on teen pregnancy and sexuality education.

For Community Leaders:

- ✓ Conduct outreach and develop education programs for young APA women and teens to teach them about their bodies, birth control, sexually transmitted diseases, and overall sexual health, and to provide them with a support system to discuss issues of sexuality and gender identity.
- ✓ Develop peer-led workshops and leadership trainings about sexual and reproductive health care in local schools.

(7) Linking Women's Reproductive Health to Environmental Justice

Within the scope of reproductive justice is the inherent principle that all individuals enjoy the basic right to live, work and play in environments that are safe. Yet, studies have found that environmental toxins, past exposure to hazardous military materials and weapons, and workplace exposure to chemical toxins disproportionately affect many APA women and have an adverse impact on their reproductive health. APA women are concentrated in manufacturing, garment, and cosmetology industries where they are more exposed to dangerous chemicals that have been linked to birth defects and other reproductive health problems. In the nail salon industry, for instance, approximately 80% of the industry's workers in California are Vietnamese immigrants.

Compounding these issues is the fact that many APA communities immigrate to the United States and now live in low-rent housing neighborhood in the backyard of refineries or manufacturing plants that produce unsafe chemical toxins. Such cumulative exposure may contribute to the increasing number of health disparities suffered by subpopulations of APA women.

To promote occupational and environmental settings that are free from dangerous toxins and chemicals that adversely impact the reproductive health of APA women and their families, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Adopt the 'Precautionary Principle' related to toxic exposure and pollution. (Precautionary Principle: When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically. In this context the proponent of an activity, rather than the public, should bear the burden of proof.)
- ✓ Increase resources and funding for federal and state agencies to monitor compliance with safety standards in the workplace.
- ✓ Support state and federal policies that regulate use of cosmetic toxins in the nail salon industry.
- ✓ Include advocates from the APA women's community in the decision-making process with respect to environmental issues, policies, licenses, and permits.
- ✓ Promote peace in the Pacific Basin and fully fund the clean up of military toxic pollution in bases overseas and in the U.S.
- ✓ Create long-term monitoring and health treatment programs for all APA populations who were exposed to military related toxins and nuclear bomb testing.

For Advocates and Ally Organizations:

- ✓ Conduct research on the impact of environmental toxins on the reproductive health status of APA women and girls.
- ✓ Create stronger collaborations between reproductive rights, environmental justice, workers' rights, women's health and APA women's organizations to advocate on behalf of APA women in the nail salon industry and other toxic environments.

For Community Leaders:

- ✓ Educate the APA community about the links between environmental justice and women's health.
- ✓ Join and organize campaigns to eliminate polluting facilities, power plants, and landfills in neighborhoods of color.
- ✓ Educate and engage APA workers about their employment and labor rights and the dangers associated with environmental toxins and reproductive health.

(8) Ending Gender Discrimination and the Promotion of Sex Selection Technologies

Reproductive choice for APA women includes the right to establish families in a time and manner which respects women's autonomy. Yet, certain Asian subpopulations including, but not exclusively, South Asian, Chinese, and Korean communities, are disempowered when deciding to have a child because of the lingering cultural and societal preferences for male children.

Today, the marketing and promotion of enhanced reproductive technologies (both pre- and post- pregnancy) poses challenges for ethical reproductive decision-making. In the United States, promotion and marketing of these technologies (for "family balancing" objectives) is growing. At the same time, doctors value patient autonomy to make use of these technologies. Yet it must be understood that in sub-cultures where there is widespread discrimination against female children, there are serious negative social implications.

For instance, countries like India and China now suffer some of the worse sex ratios in the world due to sex-selection related abortions of female fetuses and because of child neglect, abandonment, and infanticide of unwanted female babies. Though use of sex selection technologies for gender preference is banned in these and many European countries, there may be a future of growing "sex selection" tourism in the U.S. where these technologies are unregulated. Already there is evidence of the use of sex selection technologies by immigrant Asian communities.

To eliminate sex discrimination and promote a biotechnology industry that is supportive of APA women, NAPAWF offers the following recommendations for policymakers, advocates and ally organizations, and community leaders:

RECOMMENDATIONS:

For Policymakers:

- ✓ Create regulations and oversight of the sex selection and reproductive genetics technology industry.
- ✓ Ban the marketing and promotion of sex selection technologies.

For Advocates and Ally Organizations:

- ✓ Join in the work to end both the supply and demand for sex selection technologies in all communities in the United States and create international networks to do the same abroad.
- ✓ Participate in grassroots campaigns to remove advertisements, and pressure medical clinics to be socially responsible.
- ✓ Promote a better understanding among reproductive rights, medical professionals, and other human rights advocates about the balance between patient/women's autonomy in reproductive decision-making and the social implications of those decisions.

For Community Leaders:

- ✓ Partner with other community-based organizations and develop education programs about sex selection and reproductive freedom that target both men and women.
- ✓ Promote a better understanding of the dynamics of male child preferences, its relationship to undervaluing females and its contribution to the abuse of women who do not bear male children.
- ✓ Write op-eds about the dangers of sex selection in the U.S. and circulate to mainstream and ethnic media.

[1] "Asian American" refers to Chinese, Filipinos, Japanese, Koreans, South Asians (people from Bangladesh, Bhutan, Myanmar, India, and Maldive Islands, Nepal, Pakistan, and Sri Lanka), and Southeast Asians (people from Cambodia, Indonesia, Laos, Malaysia, Thailand, and Vietnam). "Pacific Islander" refers to people from the thousands of islands in the Pacific Ocean that are classified as Micronesians (Marshal Islands, Kiribati, Guam, and the Federates States of Micronesia), Melanesians (Fiji, the Solomons, Papua New Guinea, and Vanuatu), and Polynesians (Hawaiians, Tongans, Samoans, Cook Islanders, Maoris and Tahitians).
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[17] Asian American Legal Defense and Education Fund, *The Asian American Vote: A Report on the AALDEF Multilingual Exit Poll in the 2004 Presidential Election.*
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[26] Lora Jo Foo, 103 *Asian American Women: Issues, Concerns, and Responsive Human and Civil Rights Advocacy* (2002).
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