Still Fierce,
Still Fighting

A Reproductive Justice Agenda for
Asian Americans and Pacific Islanders

napawf
NATIONAL ASIAN PACIFIC AMERICAN WOMEN’S FORUM
About NAPAWF

The National Asian Pacific American Women’s Forum (NAPAWF) is the only national, multi-issue Asian American and Pacific Islander (AAPI) women’s organization in the country. NAPAWF’s mission is to build a movement to advance social justice and human rights for AAPI women and girls.

Following the 1995 United Nations Fourth World Conference on Women in Beijing, the organization was established by 157 Founding Sisters in September 1996. The Founding Sisters identified six issue areas to serve as the platform and foundation for NAPAWF’s work: civil rights; economic justice; educational access; ending violence against women; health & reproductive freedom; and immigrant and refugee rights. Since then, NAPAWF has grown to a staffed organization with offices in New York, Washington, DC, Chicago, and Atlanta. The organization has a large member base organized into 14 chapters.

For information on NAPAWF, visit www.napawf.org or email info@napawf.org.

National Asian Pacific American Women’s Forum
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In July 2013, an Indian-American woman named Purvi Patel sought medical attention for uninterrupted bleeding due to a miscarriage in her home. Fearing that her conservative Hindu parents would find out she was pregnant, Patel disposed of the fetus in a dumpster. Two years later, after already serving time in jail, she was sentenced to 20 years in prison for fetal homicide, becoming the first woman in the US to be convicted under a feticide law for having an abortion. Despite the fact that no drugs indicating medicated abortion were found in Patel’s system, Patel was criminalized for her miscarriage after being interrogated by doctors and detectives in her hospital room on questions such as the race of the baby’s father. Purvi Patel served two years in Indianapolis Women’s Prison, a center notorious for abuse and violence. Patel suffered a miscarriage and sought medical attention, but instead she faced intense discrimination as a South Asian woman whom her doctors suspected induced an abortion.

Stories like Patel’s are not unheard of: research shows that women of color and low-income women are disproportionately punished in relationship to their pregnancies and the outcome of their pregnancies as compared with white women.1 Patel’s case encapsulates many issues that women of color face but that are obscured behind the traditional “pro-choice” framework; she may have had the legal right to have an abortion, but in practice she was racially scrutinized for her choice of sexual partner, denied due process in a flawed criminal justice system, and shamed and prosecuted for her pregnancy outcome.

The Reproductive Justice Framework

The term “reproductive justice” was first coined in 1994 by a group called Women of African Descent for Reproductive Justice, who believed the mainstream reproductive rights and feminist agendas did not meet their needs.2 The reproductive justice framework adds an intersectional lens to the traditional pro-choice movement by recognizing that each person’s reproductive choices are uniquely affected or limited by the various racial, sexual, physical, economic, social, institutional, and religious factors that surround them.3
Reproductive justice operates under three principles that center and support a woman's decision to:
1. become a parent, along with the conditions under which to give birth;
2. not to become a parent, including access to all of the options for ending or preventing pregnancy and be treated with dignity; and
3. parent a child she already has in safe, supportive communities free from violence and oppression.4

For Asian American and Pacific Islanders (AAPIs), a reproductive justice framework acknowledges the diversity within our community and ensures that different aspects of our identity, such as ethnicity, immigration status, education, sexual orientation, gender identity and access to health are considered in tandem when addressing our social, economic and health needs. The experiences and difficulties that an AAPI woman encounters are as diverse as the community itself. An AAPI woman is the undocumented domestic worker toiling away to care for the families of others, even if her immigration papers say otherwise. She is the Nepalese American employee making 51 cents for every white male dollar earned while raising four children. She is the nail salon worker earning minimum wage while exposing herself to toxic chemicals that can result in miscarriages, infertility, or cancer. She is the working-class green card holder battling breast cancer who is unable to obtain immediate life-saving treatment because she must wait five years to receive Medicaid. She is the mother who lost her sons to detention and deportation simply for being Muslim after September 11th.

While the mainstream reproductive health movement has traditionally prioritized abortion as the singular challenge that all women face, the reproductive justice movement created an advocacy approach that recognizes the complex and lived experiences that impact an AAPI woman's reproductive life and choices.

This report is being written at a time during which the basic rights of AAPI women and other women of color are directly under threat. Xenophobic, anti-immigrant sentiment has driven political agendas at all levels of government. Federal and state policy makers have renewed their attempts to chip away at the reproductive rights of women, disproportionately impacting women of color who experience layers of discrimination and injustice. A century after women earned the right to vote, the country has yet to achieve pay equity or guarantee paid family leave for working parents. Instead, women of color continue to dominate low-wage industries without access to affordable health care for their children or their own reproductive needs.

We believe that reproductive justice will be achieved when all members of the AAPI community have the economic, social, and political power to make decisions regarding their bodies, families and communities. We infuse this vision in all of our reproductive health, economic justice, and immigrant rights work. Reproductive health is an integral component of this vision for reproductive justice. Yet, we recognize many other factors impact accessibility to reproductive health – such as domestic and intimate partner violence, sexual assault, transgender and gender non-conforming discrimination, housing and education access, disability rights, and workplace rights. For example, a low-income woman who lacks access to paid family and medical leave must choose between returning to work a week after childbirth and not starting a family at all. A lawfully present immigrant woman must wait five years before she can access Medicaid, which covers more than half of all births in the U.S. When it comes to reproductive health, simply having rights is not enough; AAPI women experience varying layers of intersectionality that affect their ability to access these services.
Data Equity and Disaggregation for the AAPI Community

A reproductive justice analysis also takes into account the challenges and barriers to building power and visibility among AAPI women and girls. For decades, much of the AAPI community has been overshadowed by the “model minority” myth, or the idea that AAPIs in the US have fared better than other minorities due to their educational attainment and work ethic. This “model minority” myth minimizes the effects of structural racism and sexism that fuel the systematic oppression and discrimination of all women of color. Furthermore, it paints the large and diverse AAPI population with a broad brush and ignores the reality of many struggling AAPIs in the country. Consisting of nearly 50 ethnicities, the experiences of AAPIs differ vastly, from the Indian-American law student to the Bhutanese refugee to the Native Hawaiian.

Data collection has failed to capture these diverse experiences: publicly reported data on the AAPI community is hardly ever disaggregated by ethnicity, much less inclusive of lesbian, gay, bisexual, transgender, queer (LGBTQ) and gender non-conforming (GNC) people. Data disaggregation tends to reveal stark differences among various AAPI populations. For example, while 7.9 percent of adult Japanese Americans do not have a high school diploma, the percentage is much higher for Cambodian Americans: 40.3 percent. While the poverty rate among Asian Americans is approximately the same as the national average (12.4 percent), poverty rates are as high as 37.8 percent, 29.3 percent, and 18.5 percent for Hmong, Cambodian, and Laotian AAPIs respectively. So while stereotypes portray AAPIs as a particularly well off, high achieving population, the data at a closer look tells a different story. Without accurate and disaggregated data, crucial disparities within the AAPI will continue to be masked and resources cannot be allocated to the populations that need them most.

Gender and racial justice for transgender and gender non-conforming people is essential to our vision of reproductive justice. As such, we include information and data about the experiences of AAPI transgender and gender non-conforming people when available, however the lack of comparable data makes consistent reporting throughout this report challenging. While this report focuses primarily on the experiences of cisgender AAPI women it is clear that AAPI transgender and gender non-conforming people experience unique challenges to accessing health care, immigrant rights, and economic justice.

For more information about the experiences, barriers and discrimination transgender and gender non-conforming community members face, please visit www.transequality.org.

Language Access and Cultural Barriers

AAPIs also face significant language and cultural barriers, in large part due to the high percentage of immigrants. In addition to the linguistic challenges that adult AAPIs face, nearly one out of every four AAPI students is Limited English Proficient (LEP) or lives in a household where parents speak little English. This has profound implications for the ability of AAPIs to access a wide range of services and opportunities such as employment, the housing market, and healthcare. In fact, many AAPIs struggle to communicate effectively with their healthcare providers. Moreover, many AAPIs prefer to see doctors that offer traditional medicine from their own culture.

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i. The following are the working definitions of terms we use throughout this report. The term “cisgender” is used to describe a person whose assigned gender at birth is congruent with their current gender identity. The term “transgender” is a broad term we use to describe a person whose assigned gender at birth does not match their current gender identity. The term “gender non-conforming” is a term we use to describe a person whose gender identity or expression does not conform solely to the categories of “man” or “woman.” For more information on these terms and other terms used to describe gender variance, visit www.transstudent.org/definitions.
that may not be covered by insurance plans. Interventions that seek to alleviate issues specifically facing the AAPI population must take into consideration their varied linguistic and cultural needs.

While the current AAPI population is concentrated in California, New York and Texas, an increasing number of states in the South and Southwest are home to the fastest growing population of AAPIs in the nation. Between 2000 and 2012, the population of AAPIs more than doubled in Nevada, Arizona, North Dakota, North Carolina, and Georgia. AAPI communities in these emerging states are often isolated and lack the social, political, or cultural infrastructure of states that have been traditional settlement areas for AAPI populations. Many AAPI women and their families depend on public welfare and education programs to make ends meet, yet may not feel comfortable accessing these services or be aware that such programs exist without the support of community groups that provide culturally and linguistically appropriate services.

This report outlines the issues of concern to NAPAWF through the reproductive justice lens and a vision for social justice for AAPI women and gender-nonconforming people. In addition, it highlights particular issues within the AAPI community that tend to be shielded by the “model minority” myth and the aggregation of AAPI ethnicities in data collection. NAPAWF invites you to join the movement for reproductive health, immigrant rights, and economic justice for AAPI women.
Despite their growing numbers, AAPI women and their histories, contributions, and needs are largely overlooked in national conversations. This has resulted in an ongoing failure to recognize the unique and diverse experiences of AAPI communities and a mismatch between the needs of AAPI women and the policies and systems available to support them. Thus, in order to identify the challenges and potential solutions to gender and racial justice for AAPI women, it is first crucial to understand the diversity and richness of the AAPI community.

AAPI Population and Growth

In 2015, AAPIs comprised over six percent of the total U.S. population, representing over 21 million people.12 Of the 163 million women in the U.S., 10.7 million – or 6.5 percent – are AAPI,13 and over 50 percent of all AAPI women are of reproductive age.14 AAPIs are the fastest-growing racial group in the United States. Between 2000 and 2010, Asian Americans and Pacific Islanders were the two fastest growing communities in the country, growing at a rate of 46 percent and 35 percent respectively, compared to 9.7 percent for the overall U.S. population.15,16 By the year 2060, the AAPI population is estimated to reach over 48 million, representing one out of every ten persons in the United States.17

The AAPI community is extremely diverse. Over 30 countries and ethnic subpopulations speaking more than 100 languages are represented within the AAPI community, and the Pacific Islander community is made up of over 20 distinct ethnic groups.18,19 The significant ethnic and linguistic diversity also reflects the range in English proficiency rates among AAPIs. While the majority of AAPIs speak English well, approximately 70 percent speak a language other than English at home, and 35 percent of AAPIs are limited English proficient (LEP) and experience difficulty speaking, reading, writing or understanding English.20 According to U.S. Census data, 20 percent or more of Vietnamese, Korean, Chinese, Bangladeshi, Laotian, Thai, Hmong, Indonesian, and Cambodian households are linguistically isolated, meaning no one in the household 14 years old and older speaks English very well.21 Approximately six percent of NHPI households are linguistically isolated.22 Language barriers and a lack of quality interpreting and translation services make health care, housing, and job access especially challenging for AAPI communities.

Figure 1: AAPI women (graphic credit: Florence Lee)
Source: U.S. Census Bureau, Population Division.
The majority of AAPIs are from ethnic groups that have resided in the U.S. over several generations, such as Chinese Americans; however, the fastest growing groups are from South and Southeast Asia. The populations of Bhutanese, Nepalese, Burmese, Mongolian, Bangladeshi, Maldivian, Singaporean, and Pakistani Americans have doubled in size since 2000. Each of these subgroups and subpopulations bring their own unique histories, traditions, and cultures.

An Immigrant Community

The dramatic growth of AAPIs has been fueled largely by immigration. Nearly two-thirds of all AAPIs are foreign-born, representing over one-fourth of the nation’s total foreign-born population. Although only 17 percent of Native Hawaiians and Pacific Islanders are foreign-born, the rate at which Pacific Islanders are immigrating to the United States is also rising rapidly. The U.S. Census Bureau estimates that by 2020, the net international migration rate for Pacific Islanders will be five percent, making it the third highest rate of migration after Asians and Latinos.

AAPIs enter the country through a diverse set of pathways, including joining loved ones through family-based visas, as dependents of spouses on temporary worker visas, as refugees and asylum-seekers, and as undocumented individuals. Immigrant women are more likely than immigrant men to enter the country through family immigration channels. Among the over one million immigrants who received green cards in 2014, over 42 percent were from Asian countries and 54 percent were immigrant women. In 2014, over 47.5 percent of all refugees and over 49 percent of all admitted asylees were women.

A significant number of women from Asian countries also live in the shadows as undocumented immigrants. Within the total estimated 11.4 million undocumented individuals in 2012, approximately 1.3 million are of Asian origin and more than 5.3 million are immigrant women. Five Asian countries rank among the top ten countries of origin for those without immigration status – Philippines, India, Korea, China, and Vietnam. Sadly, higher deportation rates have resulted in increased separations between parents and their children. It is estimated that 5.15 million U.S.-born children are living with an undocumented parent. Of these, approximately 416,000 are Asian children.

**AN IMMIGRANT COMMUNITY**

Immigrant women are a large part of the immigrant community and enter the country through a variety of pathways.

- **U.S. Immigrants W/Green Cards**
  - 54% Women

- **Undocumented Individuals**
  - 46.5% Women

- **Refugees**
  - 47.5% Women

- **Asylees**
  - 49% Women

*Figure 2: Immigrant women (graphic credit: Florence Lee) Source: US Department of Homeland Security, 2014*
Historically, threats to reproductive health care and abortion access have been both racialized and gendered. Cultural and legal barriers restrict AAPI women from accessing a full range of reproductive health services, including abortion, contraception, and treatment for sexually transmitted infections (STIs). These barriers disproportionately impact women of color, low-income women, and other marginalized groups. Although the scope of reproductive justice extends beyond reproductive health services, without legal protection and access to basic reproductive health care, many AAPI women and families are left without crucial sexual health and family planning services. Working to ensure that all AAPI women have access to complete and comprehensive reproductive care is a critical step in preserving and expanding our reproductive and sexual rights.

AAPI Young Women

Studies show strong parent-child communication about sexual health and sexuality promotes healthier decision making among teens. However, sex and reproductive health are often considered taboo topics within AAPI communities, and frank discussions about sex do not usually occur in AAPI households. One study found that more than half of the young AAPI women surveyed felt uncomfortable talking to their mothers about reproductive health, and more than one-third never discussed pregnancy, STIs, birth control, and sexuality in their households. Another study documenting South Asian American attitudes towards family planning showed that South Asian American teenagers were significantly less likely to learn about contraception from their parents than other racial and ethnic groups – five percent compared to 18 percent.

As a result, many AAPI teens do not learn about sexual health or reproduction from their families. This leaves AAPI teens to receive their sex education from outside their household, through their school, friends, and the media. Yet the content offered in school sex education programs varies greatly. State laws and local school districts vary significantly in sex education requirements and curricula. One AAPI teen may attend a school that teaches abstinence only curriculum, which does not educate students about safe sex and contraception, while another AAPI teen in a neighboring city may attend a school that provides a limited sex education program. For example, an overwhelming number of participants from a recent survey of 18-35 year old Asians and Asian Americans living in New York City felt the sex education they received from their schools was inadequate and focused too narrowly on heterosexual, reproduction-only sex.

“I just wish my parents, my family, had educated me more. In Asian culture you don’t talk about sex basically until you get married and so I just wish they were more open to talking about what sex is exactly and just how to be careful about having sex – being more aware and knowledgeable.”

– Participant F from NAPAWF Atlanta focus group
Some AAPI parents also do not feel connected to their children’s schools and do not know how to approach teachers and administrators about subjects such as sex education due to language and cultural barriers.42

In addition, the interplay of gender and cultural norms for young AAPI women can lead to troubling outcomes. Studies have shown that the inability to cope with strict cultural expectations for AAPI women and competing social pressures can result in risky behaviors and substance abuse among AAPI teen girls.43

As a group, the rate of teen pregnancies among AAPI adolescents is relatively low.44 Birth rates for AAPI women ages 15 to 19 decreased by five percent from 2011 to 2012.45 However, studies that break down data by ethnic subpopulation show variations. For example, one study found that 50 percent of Hmong girls between the ages 15 and 19 in the Twin Cities area of Minnesota had children or became pregnant before graduating from high school.46 Yet many Hmong teen mothers are married when they become pregnant and consider themselves to be adults who proudly carry the roles of wife, mother, and daughter-in-law.47 Thus, while teen pregnancy is often considered a negative outcome among mainstream health advocates, cultural and social factors such as those within the Hmong community require a much more nuanced understanding of teen motherhood.

Pregnant AAPI teens seeking abortion care face significant challenges. As of 2017, 37 states enforce laws that require a young woman to notify or obtain consent from one or both parents before she can receive abortion care.48 As noted above, a significant proportion of AAPI youth do not talk to their parents about sex. Requiring AAPI women and girls to notify their parents or gain their consent to receiving an abortion may delay their abortion care, which leads to riskier, late-term abortion procedures. In some cases, it may also lead to young women proceeding through an unwanted pregnancy.

### Issues in Reproductive Health

#### Contraception and Family Planning

AAPI women use contraception at rates similar to other women of color. A 2012 report from the Centers for Disease Control (CDC) showed that 58.5 percent of AAPI women use any method of contraception, compared to 54.2 percent of Black women, 59.7 percent of Hispanic women, and 65.6 percent of White women.49 Yet a closer look at these numbers indicates that AAPI women use less effective contraceptive methods at much higher rates compared to women of other races and ethnicities. On average, only ten percent of women report relying on condoms, while AAPI women report using this method at 24 percent.50 One in three AAPI women use the calendar method for pregnancy prevention, a rate approximately double the percentages of other racial and ethnic groups.51

While these methods of contraception are inexpensive, they are also the least effective, placing AAPI women at greater risk of unintended pregnancy. Only 57 percent of AAPI women have reported ever using birth control pills, a more effective pregnancy prevention method, as compared to 68 percent of Hispanic or Latina women, 78 percent of black women, and 89 percent of white women.52 AAPI women’s rates of usage of non-pill hormonal contraception — such as intrauterine devices (IUDs) or implants, considered the most effective forms of contraception — are even lower. Compared to 44 percent of all black women and 38 percent of all Latinas, only 19 percent of AAPI women have ever used a hormonal method of contraception other than the pill.53

Differences in utilization also exist between AAPI subgroups. One study that examined levels of knowledge and usage of emergency contraception (EC) among women in California showed striking differences among AAPI subpopulations. Despite the fact that the level of EC knowledge nearly doubled among Hispanic and South and Southeast Asian women between 1999 and
2004, the overall percentage of these women that have knowledge of EC remains 15–25 percentage points lower than their white, African American, and East Asian counterparts.54

Pregnancy and Childbirth

Reproductive justice extends beyond simply planning if and how AAPI women grow their families; it includes ensuring that AAPI women have the resources, information and support they need throughout their pregnancy, birthing experience, and beyond. AAPI women give birth at a higher rate than all other racial and ethnic groups other than Latinas, and AAPI women tend to be older when they give birth.55 The birth rate was highest for AAPIs aged 30–34 years.56 Asian immigrants comprised approximately 22 percent of births to immigrant women in the U.S.57

Lack of prenatal care can contribute to infant mortality and other birth complications, a significant measure of health and wellness of a population. Unfortunately, some AAPI mothers are less likely than others to receive early and adequate prenatal care. For example, Laotian and Cambodian women have especially low rates of early prenatal care.58 Overall, AAPI women had a lower infant mortality rate than the general population in 2013 at 4.07 compared to 5.06 per 1,000 live births, down 17 percent since 2005.59 However, that rate nearly doubled to 7.4 for AAPI mothers under age 20.60

While there is limited research on U.S. maternal mortality rates for AAPI women, the most recent data found that AAPI women die due to pregnancy-related causes at a rate of 11 deaths per 100,000 births – slightly higher than the rate of white, non-Hispanic women at 10.4.61 According to the Center for American Progress, AAPI women are twice as likely to die from pregnancy-related causes, including embolism and pregnancy-related hypertension.62

With the increase in the Asian immigrants over the past decade, more Asian immigrant women are also giving birth in the U.S. Thus, linguistically and culturally competent prenatal and birthing care is needed as the AAPI population continues to grow in the U.S. This includes maintaining ethnic beliefs and practices around childbirth and postpartum care. A Vietnamese American author, for example, recently published a book of recipes that are a part of many AAPI postpartum traditions for nutritional health.63

Abortion Care and Attitudes

Very few studies report abortion data on AAPI women. While the CDC publishes annual surveillance data on abortion, the reported race/ethnicity data are limited to White, Black, Hispanic and Other, with AAPIs grouped under the “Other” category. The “Other” category provides no information on Asian American abortion rates, let alone ethnic subgroups under the AAPI umbrella.64 The limited reports that do include AAPI data suggest a relatively high use of abortion among AAPI women. One 2008 study found that seven percent of women obtaining abortions identified themselves as AAPI.65 Of the 16 percent of women seeking abortions who were foreign born, 23 percent were Asian or South Asian.66

Public opinion surveys on AAPI attitudes towards abortion are also limited,67 though the data that does exist indicate widespread support among AAPIs. A recent poll from the Center of Reproductive Rights surveyed American views on abortion with results disaggregated by race.iii The results reveal that 74 percent of AAPIs prefer to keep Roe vs. Wade as opposed to overturning it, and 66 percent would support a federal law protecting a woman’s legal right to abortion by preventing restrictions that make it more difficult and expensive for women to access safe

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iii. This survey by the Center for Reproductive Rights was conducted by research firm GfK from June 15-26, 2017. The sample consisted of 1,877 adults (18+) in the United States, and it includes oversamples of communities of color (African Americans, Latinos, and Asian/Pacific Islanders), Floridians, and Texans. GfK fielded the poll using its KnowledgePanel™, a nationally-representative, online probability panel that recruits survey takers using a process called address-based sampling (ABS). The survey was conducted in English and Spanish. The margin of error for the national sample is +/-2.5 percentage points. The margins of error for Florida and Texas are +/-5.7 percentage points. The margin of error is also greater for subgroups compared to the national sample.
abortions. Furthermore, 58 percent of AAPIs consider the drastic increase in state laws restricting women’s access to abortion to be “a step in the wrong direction.”

The poll also solicited views on the role members of Congress should play in women’s health issues and found that 84 percent of AAPIs wanted Congress to be vocal about women’s health issues. Of those who wanted Congress to be more vocal, 66 percent believe that members of Congress should demonstrate how women’s health issues connect with other key issues, such as the economy. This finding supports the need for a reproductive justice framework when discussing abortion, which should not be considered in isolation from other critical policy issues.

**Anti-choice Legislation**

Since 2010, the country has witnessed an unprecedented surge of state and federal anti-choice policies. In 2016, legislatures in 19 states enacted 60 abortion restrictions, and over one-quarter of abortion restrictions since Roe v. Wade have been enacted since 2010. The majority of women now live in states hostile to abortion rights. The number of anti-abortion regulations have especially surged in states in middle America and the South – coincidentally, regions with the fastest growing Asian American and Pacific Islander populations. These restrictions disproportionately affect women of color and low-income women for whom access to health care is already difficult. The discussion below takes a closer look at those policies that most target the reproductive choices of the AAPI community.

**Sex-Selective Abortion Bans**

Legislative proposals seeking to ban sex-selective abortions are premised on misinformation and stereotypes about AAPI women. In theory, the bans would punish doctors and health providers who perform or assist with so-called “sex-selective abortions,” abortions based on the sex of the fetus. Providers could face jail time, fines, or lawsuits from a patient or her family.

In practice, sex-selective abortion bans target and discriminate against AAPI women. Supporters of these bans rely heavily on xenophobic rhetoric suggesting that AAPI immigrants import “backwards,” gender-biased cultures from Asian countries that favor the birth of sons, thus perpetuating anti-immigrant sentiment and negative stereotypes about AAPI women. In many states, doctors and nurses who merely suspect a patient is seeking a sex-selective abortion are required to report them to authorities. Due to fear of criminal or civil penalties, doctors may scrutinize the decision of an AAPI woman to have an abortion in ways they would not scrutinize if the woman was of another racial group. Threatening providers with criminal and civil penalties could decrease the availability of services for communities that are already under-served. Even worse, these bans pose a dangerous risk to the reproductive health of AAPI women, many of whom face language barriers – a simple misunderstanding could result in denial of care.

Sex-selective abortion ban proposals have gained strong momentum in recent years. In 2013 and 2014, it was the second most-proposed abortion restriction. To date, sex-selective abortion bans are in effect in seven states – Pennsylvania, Oklahoma, Kansas, Arizona, North Dakota, South Dakota, and North Carolina. Most of the states where sex-selective abortion bans have passed are among those with the largest or fastest-growing AAPI populations. Twelve of the 15 states with the largest AAPI populations and ten of the 15 states with highest AAPI growth rates have proposed the ban.

At the federal level, Rep. Trent Franks (R-AZ) has introduced House bills banning so-called sex-selective abortions in every Congress since 2008. In 2013 and 2014, Senator Vitter (R-LA) introduced sex-selective abortion bans in the
Senate. To date, there is an active federal sex-selective ban bill in the House of Representatives, H.R. 147, or Prenatal Nondiscrimination Act of 2017.

Proponents of sex-selective abortion bans argue such bans are necessary to protect women and girls. They point to stories of infanticide in India and gender-based abortions in China to justify the need for state surveillance of pregnant Asian women. In reality, legislators supporting these laws have voting records that are hostile towards women’s rights, abortion, health care access, and civil rights. Moreover, while son preference exists to some extent in some Asian cultures, there is no evidence that Asian American women in the U.S. are seeking abortions due to son preference.

In 2014, NAPAWF, along with the University of Chicago Law School International Human Rights Clinic, and Advancing New Standards in Reproductive Health (ANSIRH) at the University of California, San Francisco, released a report called Replacing Myths with Facts: Sex-Selective Abortion Laws in the United States, debunking the myths anti-choice activists most commonly use to support sex-selective abortion bans. Importantly, the report found that on average, foreign-born Chinese, Indian, and Korean Americans have more girls overall than white Americans. Moreover, researchers also demonstrated that laws banning sex-selective abortion are not an effective way of adjusting male-biased sex ratios at birth. Their empirical analysis of the sex ratios at birth five years before and after the enactment of Illinois’ and Pennsylvania’s sex-selective bans concluded that the bans were not associated with changes in sex ratios in those states.

Sex-selective abortion bans, which are guided by misinformation and stereotypes about Asian immigrants, open the door for politicians to further intrude into the personal health decisions of women. Rather than limit access to safe reproductive health care, lawmakers need to support policies that have been shown to decrease discrimination and improve gender equity. These include improved education, health care access, pay equity, and freedom from violence. This approach would eliminate pressures that could encourage son preference and sex selection.

**Figure 3: Sex-selective Abortion Bans** (graphic credit: Florence Lee)
Source: State Legislation, see endnotes 75 and 76
Hyde Amendment
The Hyde Amendment, which denies federal Medicaid coverage of abortion services, makes it difficult and often impossible for many low-income Asian American and Pacific Islander women to exercise their right to make personal decisions about their reproductive health. At minimum, states must cover those abortions that meet the federal exceptions under Hyde: when continuing the pregnancy will endanger the woman’s life, or when the pregnancy results from rape or incest. However, states are also allowed to provide greater coverage than what is required under federal law. As a result, whether a woman is able to afford the abortion care she needs often depends on what state she lives in. As it stands, 17 states provide coverage for all or most medically necessary abortions beyond what is required under federal law. Thirty-two states and the District of Columbia follow the federal standard. Many states with the fastest growing AAPI populations are among those that limit coverage of abortion to the narrowest circumstances.

Women on Medicaid are already struggling to make ends meet. These women should not have limited access to health care services simply because of where they live or how much money they make or be forced to raise a child under harsh economic conditions. Yet restricting Medicaid coverage of abortion forces one in four poor women to carry an unwanted pregnancy to term. Moreover, a woman who wants to get an abortion but is denied one is three times more likely to fall into poverty than a woman who is able to obtain an abortion.

Nearly one in five AAPI women rely on Medicaid. The program is particularly important for Southeast Asian and Pacific Islander women. For example – 62 percent of Bhutanese women, 43 percent of Hmong women, and 32 percent of Pakistani women currently receive their insurance through Medicaid. After the U.S. Supreme Court’s 2012 ruling on the Affordable Care Act in National Federation of Independent Businesses v. Sebelius, many states have expanded Medicaid eligibility for those with an income of up to 133 percent of the Federal Poverty Level and therefore increased the number of people covered under Medicaid. With expanded Medicaid eligibility, it becomes even more critical for abortion and reproductive health services to be covered. For AAPI women struggling to make ends meet, paying for an abortion out of pocket can be an insurmountable barrier to accessing care.

Criminalization of Pregnant AAPI Women
As federal and state lawmakers seek to further restrict abortion rights, laws intended to protect pregnant women have in recent years been used to criminalize them. Couched in the language of “fetal rights,” these laws have been used to punish women for self-induced abortions, miscarriages, and other pregnancy outcomes. These laws are disproportionately enforced against women of color. A study of arrests and forced interventions on pregnant women found that approximately 71 percent were low-income women and 59 percent were women of color.

In 2011, Bei Bei Shuai made headlines when the state of Indiana decided for the first time in the history of the state to charge her with murder and attempted feticide for the outcome of her pregnancy. Shuai, a Chinese immigrant, had attempted suicide when she was 33 weeks pregnant. She survived, however her daughter died two days after giving birth by emergency C-section. Shuai was jailed for over a year, eventually pled guilty to a misdemeanor charge of criminal recklessness, and was released.

Two years later, the state of Indiana prosecuted another immigrant Asian woman, Purvi Patel, for feticide and child neglect. In July 2013, Patel sought treatment at a hospital emergency room for profuse bleeding suffering a miscarriage. Prosecutors alleged that Patel self-induced an abortion, even though no drugs were found in her system. Patel was the first woman in the U.S. to be charged, convicted and sentenced for feticide. However, her conviction and 20-year sentence was later overturned on appeal.
Thirty-eight states have fetal homicide laws.\textsuperscript{97} While they were originally intended to protect pregnant victims of crime, Shuai and Patel’s cases have opened the door for states to criminalize pregnant women for any negative pregnancy outcome. Their cases also reveal broader attempts to restrict the reproductive freedom of women of color and immigrant women. That the only two women prosecuted under Indiana’s feticide law are of Asian descent – when Asian residents are only two percent of the state’s population – is no coincidence.

**Health Care Access**

Access to a full range of reproductive health services is a necessary part of reproductive justice and fits within a broader context of health and wellness for the AAPI community. While this section focuses primarily on physical health needs of AAPI women, NAPAWF recognizes that reproductive justice will only be achieved when each member of the community can nurture their mental and physical health, uncompromised by racial and gender oppression. Working to understand how various intersections of identities impact AAPI women’s health and their use of health care services is vital to creating health care policies that support healthy, sustainable communities.

**Health Insurance Coverage**

The health care landscape has changed dramatically over the past decade. Health care reform under the Patient Protection and Affordable Care Act (ACA) heralded significant improvements to health services and insurance coverage for AAPI women and increased access more broadly for transgender and gender non-conforming communities. Still, NAPAWF continues to advocate for health care reform that removes all barriers to access and ensures that each member of the AAPI community — regardless of gender identity, ethnicity, income, or immigration status — can fully engage in the benefits of the health care system.

**Affordable Care Act**

Enactment of the ACA in 2010 expanded health insurance coverage to an estimated 20 million Americans, including over two million AAPIs.\textsuperscript{98} The ACA also provided millions of AAPIs with access to preventive services at no cost to the patient, such as Pap smears and mammograms.\textsuperscript{99} In fact, an estimated 2.5 million AAPI women gained coverage for services like HPV testing, prenatal care, and breastfeeding support under provisions in the ACA.\textsuperscript{100} The ACA also helped over 50,000 AAPI young women receive coverage through their parents’ insurance and eliminated lifetime or annual coverage limits for approximately 2.1 million AAPI women.\textsuperscript{101}

While the ACA has reduced the number of uninsured AAPIs, many AAPI women, especially Southeast Asian and Pacific Islander women, continue to face barriers to accessing insurance.\textsuperscript{102} The reasons AAPI women lack coverage vary from cost barriers to restrictions on how and which immigrants can access health coverage. Additionally, language and cultural barriers continue to create challenges to health care outreach and accessibility for various AAPI communities.\textsuperscript{103}

The ACA has vastly increased insurance coverage and access to crucial preventive, life-saving services for AAPI women, especially low-income women. However, under the Trump administration and a Republican Congress, the ACA has already faced potential repeal through the American Health Care Act in the House of Representatives and the Better Care Reconciliation Act in the Senate. Though both bills failed, the future of the ACA and the benefits it provides for AAPI women remains tenuous.

**Medicaid and CHIP**

Medicaid is a government program that provides health care coverage for millions of low-income Americans, including pregnant, disabled, and older women. As a group, an estimated 19 percent of AAPI women receive Medicaid coverage.\textsuperscript{104} In the disaggregate, over 60 percent of Bhutanese women rely on Medicaid, while nearly 56 percent of Burmese and more than 40 per-
cent of Hmong and Bangladeshi women were estimated to rely on the program in 2015. Medicaid provides an important safety net for thousands of low-income AAPI women and children who would be otherwise uninsured. It also covers over half of U.S. births and access to prenatal and pregnancy care, thereby decreasing the risk of adverse health outcomes for pregnant women and their babies. Additionally, the Children's Health Insurance Program (CHIP) provides publicly funded coverage for uninsured, lower-income children and pregnant women. Together, Medicaid and CHIP cover one in four Asian American children.

Medicaid is also an important source of funding for reproductive health care services for AAPI women. Medicaid accounts for 75 percent of all public dollars allocated towards family planning services. Thus, attempts to block Medicaid funding to reproductive health clinics like Planned Parenthood would limit the ability of low-income AAPI women to access high-quality primary and preventive health care including STI testing and treatment, birth control and contraceptive counseling and access, and cancer screenings.

Yet even with Medicaid, existing restrictions on federal funding for abortion limit the ability of low-income AAPI women to meaningfully access the full range of reproductive health care options and create an undue financial burden that affects their ability to obtain healthcare.

**Medicare**

Medicare is another publicly funded program that provides health insurance for people aged 65 and older. More than one in ten older AAPIs relies on Medicare for insurance. In fact, older AAPI people are more likely to be uninsured and rely on public insurance compared to the general population. Some AAPI groups rely on Medicare more than others; for instance, nearly 30 percent of Japanese American women enrolled in Medicare in 2015. In order to support AAPI women's reproductive health throughout their lifespan, ensuring health care coverage and Medicare access is imperative.

**Contraceptive Coverage**

Under the Affordable Care Act, all health insurance plans are required to cover the full-range of FDA-approved contraceptive methods without imposing extra charges. While this represents a huge step towards reproductive and health equity for AAPI women, implementation of this policy has met many setbacks. The Supreme Court's 2014 decision in *Burwell v. Hobby Lobby* significantly limited the scope of the ACA's contraceptive mandate by allowing certain religious employers to opt out of providing their employees with contraceptive coverage.

In 2016, the Supreme Court was once again called to decide the fate of contraceptive access in *Zubik v. Burwell*. The case called into question whether religious institutions other than churches should be exempt from the ACA's contraceptive mandate. The Supreme Court vacated the decision to the lower courts, specifying that any religious exemptions would have to ensure that women could receive contraceptive coverage "seamlessly." Reproductive rights advocates must continue to resist attempts to restrict contraceptive access under the Religious Freedom Restoration Act and work alongside allied religious organizations to ensure coverage.

Access to emergency contraception is another essential part of providing women with a full range of contraceptive options and reducing unintended pregnancies. Certain types of emergency contraception, such as Plan B One-Step, are available over-the-counter regardless of a woman's age. While over-the-counter availability of emergency contraception greatly increases its accessibility, low-income women still find it difficult to pay out-of-pocket for emergency contraception that may cost up to 50 dollars.

Despite the ACA's expansive mandate, not all brands or types of contraception are guaranteed to be covered by every plan, especially those that are available over-the-counter (OTC). Consider-
ing the low rates of oral contraceptive use in the AAPI community and barriers to culturally appropriate reproductive health services, OTC contraceptive access could provide relief for those in the AAPI. However, expanding OTC access should not pose age or cost barriers and should be covered by insurance plans.

Reproductive health researchers and policy makers must work to understand the direct and indirect risks and benefits that over-the-counter oral contraception may have on a person’s reproductive health as a whole. Additionally, policy makers and health providers should prioritize ensuring that oral contraceptives remain an affordable method of birth control covered under one’s health insurance. These initiatives occur in tandem with other expansions occurring at the state level, such as policies in Oregon and California that allow pharmacists to prescribe hormonal contraceptives and bills in Oregon and District of Columbia that would require insurance companies to cover 12-month supplies of birth control.116

Barriers to Care

Nearly two-thirds of all Asian Americans are foreign-born, and Asian Americans make up the largest percentage of recent immigrants.117 Data examining both the racial and gender demographics of the foreign-born population are limited; however, estimates from the Census Bureau place approximately 5.6 million women in the U.S. as born in Eastern Asia, South Central Asia, or Southeastern Asia.118 Despite the significant achievements in expanding health care coverage in the past decade, many AAPI women and their families cannot obtain affordable health care due to immigration restrictions and language barriers. Ensuring that AAPI immigrant women and their families have access to health care is essential for AAPI communities in the U.S. to thrive.

Immigration Restrictions

Appropriate access to preventive, routine, and critical health services for AAPI women and their families too often relies on their job status, income, immigration status, or language. Of the over five million foreign-born AAPI women in the U.S., over half a million of them are undocumented.119 Foreign-born women are almost twice as likely as U.S.-born women to lack health insurance.120 Differences in health care coverage for women of reproductive age (ages 15-44) are even more dramatic between native-born citizens and noncitizens: approximately 42 percent are uninsured compared to 13 percent of native-born citizens.121 For noncitizens who live in poverty, approximately 57 percent are uninsured.122 Even worse, undocumented immigrants are prohibited from accessing health services through Medicaid and are not allowed to purchase private health insurance through the ACA health insurance exchanges.

Even lawfully present immigrants face restrictions. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits immigrants from accessing Medicaid and CHIP within the first five years of obtaining lawful immigration status.123 This “five-year bar” can be a matter of life or death for immigrant women and their families waiting to access vital and necessary health care services. Other lawfully present immigrants, like those present under Deferred Action for Childhood Arrivals (DACA), are not only prohibited from accessing Medicaid and CHIP, but are also excluded from ACA marketplaces and subsidies. Compacts of Free Association (COFA) migrants from the Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau, are also excluded from accessing Medicaid and CHIP – despite the fact that many suffer from chronic health conditions due to U.S. nuclear testing.124 Although the ACA allows COFA migrants to participate in the health care marketplace and to benefit from tax subsidies, without Medicaid, many COFA migrants continue to struggle to afford the new plans.

One important advancement under the Children’s Health Insurance Reauthorization Act of 2009 allows states to waive the five-year bar for children and pregnant immigrants who are otherwise eligible for the program.125 Twenty states have taken up this option to expand coverage for pregnant immigrants, and twenty-five have allowed coverage for immigrant children.126 How-
ever, access to vital health care for immigrant communities should not be contingent on where they live.

Moreover, increased criminalization, detention, and deportation of immigrants over the past decade have created fear and distrust within AAPI immigrant communities, resulting in reduced access to health care. For example, following a strict immigration enforcement bill in Arizona, immigrant women reported being discouraged from seeking health care due to the possibility of profiling and deportation. Federal and state laws that encourage local law enforcement to act as immigration enforcement can also cause immigrant women to avoid other public locations including schools, religious institutions, courthouses, and police stations. Such barriers not only jeopardize the health and wellness of AAPI immigrant women, but also the overall health and safety of communities more broadly.

**Language Access**

Language differences compound existing barriers to accessing and receiving appropriate reproductive health care services. The inability to communicate or understand English, particularly health care or medical terminology, makes it difficult for LEP AAPI women to navigate the health care system. Moreover, the barriers faced by LEP women are often compounded by discrimination, which makes accessing basic health care even more difficult. Without adequate interpreting or translation services, women may be forced to seek language assistance from individuals with whom they do not want to share sensitive health information, such as a child or an abusive partner. Furthermore, research has found that even in health care settings that provide a diverse range of interpreters, communication remains a challenge because of the unique dialects, tones, expressions, and terms surrounding reproductive and sexual terminology.

The availability or unavailability of linguistically appropriate outreach and assistance can have a dramatic effect on the ability of AAPIs to access health care even before the point of service. A recent report found that state and federal agencies provided insufficient language assistance during the ACA’s first open enrollment period, leading to confusion among LEP AAPI consumers and, in some instances, deterrence from enrolling in the marketplaces or in Medicaid altogether. Inconsistently translated and delayed in-language assistance materials exacerbated the already low health literacy among LEP AAPI enrollees and made enrollment difficult, if not impossible, for many community members.
**Culturally Appropriate Care**

The concept of culturally competent care includes linguistic competency as well as a provider's ability to recognize and respond to the different values, preferences, beliefs, and needs of an individual patient. Given the diversity of AAPIs and the significant number in our community who are LEP or new to Western systems of health care and medicine, culturally competent care that expands beyond interpretation services is critical to ensuring health equity for AAPI women and their families. For example, in the Hmong community, health is seen as inextricably linked with spiritual factors that Western providers fail to consider. Additionally, the Hmong language has few medical terms, making health care communication even more complex.

Health providers can provide culturally competent care 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 treatments. A recent study found that among all racial groups, AAPIs are the most likely to feel looked down upon by their providers and least likely to perceive their background was understood by their providers. This lack of connection between the AAPI community and providers diminishes the quality of care.

Providing care in a culturally competent manner will create positive outcomes for patients and ultimately improve their health status. Culturally competent care requires incorporating traditional treatments, such as acupuncture, herbal remedies, and traditional birthing practices into Western clinical practices and education. Many times, non-Western remedies and treatments are not covered by health insurance plans, leaving AAPI women with the limited options of either forgoing care altogether or receiving health care in a manner that is disempowering and unfamiliar. The 2007 National Health Interview Survey found that U.S. adults spent an estimated $33.9 billion out-of-pocket on alternative, non-traditional health remedies and treatments.

For AAPI women in particular, cultural stigmas around reproductive health care often influence how AAPI women perceive and utilize these services. AAPI women may avoid seeking care because of the cultural stigma associated with sex or reproductive health and due to misconceptions about what preventive care, such as a Pap smear, entails or is used for. With culturally competent and linguistic translation services, these stigmas and accurate comprehensive sex education can be addressed in the patient’s native language.

**Transgender & Gender Non-Conforming Health Care Access Barriers**

While cisgender and transgender AAPI women face many similar barriers in accessing health care, transgender and gender non-conforming people face unique obstacles when seeking care. The 2015 U.S. Transgender Survey (USTS) found that one in ten Asian American respondents lacked insurance over the past year, and 27 percent of respondents reported not going to a health provider due to financial constraints. Barriers to changing the name or gender identity on government forms can lead to inconsistencies when applying for health care, creating unnecessary complications for transgender and gender non-conforming people trying to navigate the health care system.

In addition, transgender and gender non-conforming AAPI people face significant gender discrimination in the health care field. Nearly one-quarter of AAPI respondents said they avoided going to a health care provider due to fear of discrimination, and 26 percent reported at least one negative experience with a health provider over the past year. While marketplace health plans are required under law to provide preventive health services (such as mammograms or Pap smears) regardless of gender identity, many transgender and gender non-conforming respondents still report discrimination. Additionally, transgender and gender non-conforming people reported experiencing lack of knowledge by health care providers about transgender-specific appropriate care,
unnecessary or invasive questioning by health care providers, harassment at the health care center or by the health care provider, and denial of transition-related treatment.

Many health plans use inconsistencies in interpretations of federal nondiscrimination laws as a way to still enforce discriminatory policies in determining coverage of transition-related care.\textsuperscript{140} The 2015 USTS found that one-quarter of respondents experienced problems with their coverage due to their gender identity, including denial of coverage for surgery and hormone therapy.\textsuperscript{141} While some states have passed protections banning transgender exclusions in private and Medicaid coverage, the majority of states have no explicit protections for transgender or gender non-conforming patients.\textsuperscript{142} For reproductive justice to be actualized in the AAPI community, each person should be able to define and make decisions about their bodies. Transgender and gender non-conforming people must be able to access – free from discrimination and financial burden – a full range of health services, including hormone therapy, puberty-blocking hormones, and transition-related surgeries and procedures.
API immigrant women are integral drivers of this country’s economy. They are entrepreneurs, domestic workers, professionals, and homemakers supporting the next generation of Americans. They are also increasingly becoming a political force by becoming citizens, participating in elections, and seeking elected office.

AAPI immigrant women enter the country through a diverse set of pathways, including those joining loved ones through family-based visas, dependents of spouses on temporary worker visas, refugees and asylum seekers fleeing persecution, and undocumented individuals. They possess a range of immigration statuses and have a considerable stake in immigration policy reform discussions.

AAPI immigrant women, as with all other immigrants, have become an invaluable part of the American fabric, yet they must navigate a convoluted immigration system that devalues their contributions. Moreover, since the 2016 general election, the state of immigration reform has taken a disastrous turn for the worse. President Trump's campaign promises – a wall built along the Mexican border and mass deportations of undocumented immigrants – have materialized into legislation punishing sanctuary cities and increasing penalties for deported criminals.\textsuperscript{iv} It has also resulted in the appointment of known anti-immigration and anti-civil rights leaders such as Jeff Sessions, Steve Bannon, John Kelly, and the implementation of ideas from right-wing leaders such as Kris Kobach, the engineer behind Trump’s proposed “Muslim registry.” The executive order prohibiting people from certain Muslim countries from entering the U.S., otherwise known as the “Muslim ban,”\textsuperscript{v} also targeted people of color while being masked as protection from terrorism. Immigrants, while contributing to the economy and pursuing their equal rights, now live in more fear than ever. Experiencing constant discrimination and injustice, they face the possibility of deportation, lack of access to health services, and multiple forms of violence.

**Path to Citizenship**

**Undocumented Women and Youth**

The United States is premised on the ideal that all individuals are created equal, regardless of gender, race, class, faith, or immigration status. Yet, many AAPI women who lack immigration status are denied the American Dream simply because they do not possess the proper documents. In order to be true to the ideals that have made this country a beacon of hope, and to ensure the success of all Americans, it is imperative that immigration laws include a roadmap for all those seeking to become citizens.

Of particular concern for undocumented AAPI women are any potential requirements that individuals provide proof of current employment in order to be eligible for relief and maintain status. Such prerequisites could pose a significant barrier for many who are employed in informal sectors of the economy and aim to progress towards permanent residency and citizenship.

\textsuperscript{iv} The No Sanctuary for Criminal's Act (H.R. 3003) and Kate’s Law (H.R. 3004) passed the House of Representatives on June 29, 2017.

\textsuperscript{v} On June 26, 2017, the Supreme Court allowed a partial ban to go in effect, under which immigrants from Iran, Libya, Somalia, Sudan, Syria, and Yemen must be able to establish a “bona fide relationship” to a family relative or employment in the US in order to enter. The ban went into effect on June 29, 2017.
Due to various factors, such as limited English proficiency, gendered power dynamics around decision-making within families, and financial constraints, many AAPI women immigrants work in low-wage and informal sectors of the economy, including as domestic workers and beauty and nail salon workers.143

Immigration policies must also protect children of undocumented immigrants, who are also vulnerable to deportation, family separation, and lack access to education and other public services. In 2012, the United States Citizenship and Immigration Services (USCIS) rolled out the Deferred Action for Childhood Arrivals (DACA) program, which provides two years of temporary relief from deportation for eligible undocumented young immigrants and work authorization. These individuals must submit evidence related to date of birth, age upon entry, continuous residency, educational enrollment or military service, absence of certain criminal convictions, and not posing a threat to national security or public safety. As of December 2016, USCIS reported accepting for processing 7,760 applications from South Koreans, 5,015 applications from Filipinos, 3,716 applications from Indians, and 1,906 applications from Pakistanis.144 While AAPI organizations working with undocumented youth know there are sizable populations of eligible applicants from various Asian countries, the application rates for these communities appear to be lower than those eligible. In fact, among applicants eligible for DACA, an estimated six percent are Asian nationals, yet they make up only 4.2 percent of individuals who have sought such relief.145 Unlike youth from other countries with a high number of DACA eligible applicants, only one in three of DACA eligible individuals from South Korea actually apply.146 This indicates that achieving higher rates of DACA application among Asians may require more linguistically and culturally targeted efforts.147

At the time this report is being written, President Trump remains undecided on whether to preserve or eliminate DACA. However, at least ten state governments have written Attorney General Jeff Sessions, a relentless immigration opponent, demanding DACA be immediately terminated.148

While deferred action offers much-needed temporary relief, it does not provide a path to permanent residency or citizenship and cannot be extended to family members. Legislation such as the DREAM Act, reintroduced in July 2017 by Senators Lindsey Graham and Dick Durbin, would further protect DACA recipients. The Act would allow young immigrants at risk of deportation to become lawful permanent residents (LPRs) if they have been longtime residents of the U.S., pass background checks and haven’t committed federal crimes, can show they are proficient in English and know U.S. history, are graduating from school or have a GED, and are pursuing higher education or serving in the military.

Due Process and Immigration Detention

A pathway to citizenship is crucial to ensuring immigrants are able to become full members of American society, yet many are barred from this opportunity due to trivial mistakes made in their past. For individuals who have committed criminal offenses, even for those who have green cards, the roadmap to citizenship becomes virtually non-existent. Much of this stems from provisions within the Antiterrorism and Effective Death Penalty Act (AEDPA) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) enacted in 1996. These policies resulted in the expansion of the definition of criminal offenses, known as “aggravated felonies,” which can trigger mandatory deportation with little relief.
The current list of such offenses includes non-violent and minor crimes, such as possession of more than 30 grams of marijuana or theft where the length of imprisonment is more than one year. In many cases, even if the sentence in the initial criminal case was suspended, deportation consequences may still apply. In addition, immigration judges have also lost considerable power in exercising discretion in sympathetic cases. Despite the fact that these individuals already served time and many have since rehabilitated and established families here, immigration judges can no longer consider these factors in adjudicating their deportation. For AAPI immigrants facing deportation, perhaps one of the biggest challenges is finding lawyers to help individuals understand the legal system and its many layers, especially among a high LEP population.

Southeast Asian immigrants, many of whom obtained green cards after arriving here and seeking safety as refugees, have been among the most affected within the AAPI community by these harsh policies. Over 2.5 million Southeast Asians live in the US, and almost 16,000 of them have received final orders of deportation. Over 12,000 of these deportation orders are based on old criminal records, representing 82 percent of total deportation orders, whereas among all immigrants with deportation orders, only 20 percent are based on old criminal records.149

The threat of deportation among Southeast Asians not only tears families apart but also negatively impacts their economic stability, employment, and reproductive choices. While the majority of deportees consist of men, the struggle that women endure to keep their families together amidst the threat of deportation is often overlooked. In effect, many AAPI women and their families who undergo this process are essentially punished twice for the same crime – once by the criminal justice system and again by the immigration system – and locking them out of a roadmap to citizenship only compounds the severity of deportations. These aspiring citizens include many whose family members are themselves United States citizens or green card holders and consider themselves Americans.
Jenny Srey, a social worker and the wife of a Cambodian detainee, Ched Nin, experienced six traumatizing months while her husband was detained, resulting in financial loss, depression, negative health consequences. After pleading guilty and serving two years in 2010 for an assault with a BB gun, Nin was marked for deportation at a regular ICE checkup. Due to the 1996 immigration laws, immigrants with criminal records must be deported even if they have already served their time. Nin, born to Cambodian refugees in a Thai refugee camp during the Khmer Rouge genocide, has never been to Cambodia. Since childhood, he has been living in the U.S., where he works as a carpenter.

Nin’s six months of detention led to a diagnosis of depression and insomnia for Srey, a first-generation Cambodian herself who continued to care for five children in school. Separated from their father and uncertain of if and when he would get deported, Nin and Srey’s children also sought therapy and saw their grades begin to slip. During his detention, Nin also experienced racist and hostile treatment from guards in Arizona, saying things such as “Ping pan pong, I can’t pronounce your name.” Srey recalls living in “crisis mode” for six months, and though Nin eventually returned home after winning his case, the family continues to struggle to return to normal.

As new homeowners, Srey and Nin suffered financially due to legal fees, transportation costs, losing their health insurance, phone card costs, and more, totaling almost $20,000. Srey lamented how difficult it was to pay their credit card bills on time, and their credit score began to plummet. In addition, Srey had to borrow money from her family and host fundraisers with neighbors and friends.

The financial and health implications of Nin’s detention disrupted the couple’s family planning. Srey and Nin had been trying to have a baby, but six months of detention left the family without paid family leave, the adequate finances to add a family member, and health insurance. Srey had been stress eating and gained weight as a result and didn’t want to have another child while feeling unhealthy. Still recovering from trauma, Srey found it difficult to devote to the children she already had: “It was really hard to get out of crisis mode, even though I had a really happy ending and I had my husband home, we were still traumatized by what we had gone through…. I remember telling the kids ‘I’m sorry, I’m not the same mom and I’m not prioritizing your needs right now.’”

Srey’s experience of her husband’s detention illustrates the various and intersecting layers of issues that women face as a result of unjust immigration policies. Understanding her story through a reproductive justice lens reveals the economic and health impacts of these policies. Not only did Nin’s detention result in devastating financial consequences and family separation, Srey and Nin’s family planning needs were disrupted and their access to affordable healthcare cut off.
Preserving Family Unity

As with all Americans, strong families serve as a much-needed emotional support system for immigrants in this country by providing shelter in times of need and a more stable environment for children to be raised. Encouraging robust family networks also benefits the American economy when family members can pool financial resources to start small businesses and create jobs for both native-born and immigrant workers.

Yet the current immigration system has failed all Americans by tearing families apart and keeping family members separated. Existing channels for family-based immigration have become woefully outdated, resulting in extreme wait times for visas for AAPI women and their families.

Family-based Visa Backlogs

Immigrant women disproportionately rely upon the family-based immigration system to come to the United States: over 70 percent of all immigrant women obtain legal status through family-based visas. As of November 2016, of the over 4.3 million individuals waiting in the family visa backlog, over 40 percent or 1.7 million, are from Asian countries. Moreover, a large proportion of individuals waiting in the categories of family visas that result in the longest wait times (third and fourth preference) are from the Philippines, India, Vietnam, and China. The waiting period of those in the fourth preference category has grown to at least thirteen years and even longer for oversubscribed countries.

The effects of such extreme wait times have repercussions, not only for AAPI women but also for the country as a whole. Many AAPI women must be separated from their spouse or children abroad for years. It is also not uncommon for waits to become so long that sponsored minor children become adults or get married, thus shifting them into a different visa category and lengthening their wait times even further. Those with pending family-based immigration applications also find it nearly impossible to get even tourist visas to visit the United States, as the government fears that these family relationships mean they are likely to overstay. In addition, sponsoring green card holders are required to reside in the United States for a requisite period of time, making travel back home challenging.

Impact of Enforcement Programs

While President Trump's rhetoric on immigration focused on stopping criminals and terrorists, his policies have targeted immigrants with no criminal records such as working mothers. Women who had attained temporary legal relief under the Obama administration suddenly faced direct threats of deportation from ICE. Ramped up detention and deportation of immigrants – including green card holders, temporary workers, refugees, and undocumented immigrants – have harshly impacted AAPI families. India and China ranked among the top ten countries whose nationals were apprehended by immigration authorities during FY2015.

Often, those who suffer the worst are U.S. citizen children in mixed-status families who face no choice but to be left abandoned when a parent is detained or removed from the country. Over
400,000 Asian American children live with at least one undocumented parent in the United States. In 2013, Immigration and Customs Enforcement (ICE) deported over 70,000 parents to U.S. born children, and it is estimated that over 90 percent of deportees are men. Children with a deportable parent sometimes leave with the parent, but the Urban Institute found that most families surveyed chose to stay in the U.S. following parental deportation. According to the study, when fathers were deported, the family was usually met with financial hardship. In many of these families, mothers were called upon to take over family caregiving responsibilities. If they are also detained, other relatives, such as siblings or aunts, may be called to care for the children left behind. Without appropriate protections, these sudden shifts in caretaking responsibilities can have long-term impacts on the career trajectories and income potential of Asian immigrant women.

ICE also uses detainers, or “immigration holds,” to apprehend individuals and their families when they come in contact with local or state law enforcement agencies. ICE agents use detainers to request that law enforcement detain an individual for an additional 48 hours so that they can decide if an individual is deportable without probable cause, which raises constitutional concerns. While detainers were designed for law enforcement agencies to hold immigrants who committed crimes, the vast majority of those subject to detainers actually have no criminal record. In fact, between 2007 and 2011, over 17,000 ICE detainers were issued against citizens of Asian countries; yet, in almost half (44 percent) of the cases, the individual had not been convicted of any crime.

Despite the establishment of “sanctuary cities” protecting undocumented immigrants from harmful immigration policies at the federal level, the Trump administration and ICE have issued orders to crack down on undocumented immigrants in such cities. Other federal agencies such as the Department of Justice have also been reviewing policies in order to determine if sanctuary cities should lose federal money for failing to share information with the federal government on the immigration status of undocumented individuals. Through ICE’s Criminal Alien Program (CAP), local enforcement can use identification methods such as fingerprinting to immediately coordinate with ICE the monitoring and deportation of individuals, despite the fact that ICE is a federal, not local, agency. In addition, in 2017 alone, ICE has requested multiple times to increase funds for the detention of undocumented immigrants. As a result, AAPI women and their families live in constant fear of detention and deportation, forcing them to take low-paying jobs that offer little security or preventing them from seeking the health care necessary to raise sustainable families.

Access to Public Health Benefits and Programs

Medicaid

The AAPI community heavily relies upon accessible and affordable health insurance programs. Nearly one in five AAPI women are enrolled in the Medicaid program, with certain AAPI ethnicities – particularly those with high refugee populations – relying heavily on Medicaid: 62 percent of Bhutanese women, 43 percent of Hmong women, and 32 percent of Pakistani women receive their health insurance through Medicaid. Yet many more immigrant AAPI women and girls are unable to obtain affordable health care due to restrictions resulting from their immigration status. These include the current five-year bar on Medicare and Medicaid for LPRs, the exclusion of undocumented immigrants from the health insurance marketplaces, and bars on access to ACA programs for DACA recipients. Such policies deny basic rights to individuals who consider the U.S. their home but live in constant fear for their health. It also sends mixed messages to DACA recipients, who are granted legal status in the U.S. but still barred from accessing care that helps them go to school or work to fulfill their dreams.

For undocumented AAPI women, the situation is even more dire. Undocumented immigrants are ineligible for Medicaid, CHIP and Medicare and...
prohibited from purchasing affordable private insurance plans through the health insurance marketplaces. Instead, they must rely on the limited number of community health clinics and safety-net providers for their care.

The HEAL for Immigrant Women and Families Act, re-introduced in 2017, alleviates many of the obstacles preventing immigrant families from accessing affordable health care. It ensures access to health coverage for immigrants by restoring Medicaid and CHIP eligibility to lawfully present immigrants regardless of their date of entry, grants DACA recipients access to public and affordable health coverage, reinstates Medicaid eligibility for COFA migrants, and enables immigrants to purchase coverage through the health insurance marketplaces. The bill takes a reproductive justice approach to removing the legal and policy barriers to affordable health care that disproportionately harm women. restoring access to basic health care for immigrant women enables them to continue contributing to our communities and our economy.

**Health Care for Women in Detention**

Detention of immigrants in the United States continues to happen at astounding rates. In FY2015, an estimated 307,000 immigrants from all countries were admitted into immigration detention.\(^1\) During FY2015, India ranked sixth among the countries whose nationals were admitted to detention facilities.\(^1\) Immigrants in detention often face deplorable conditions including limited access to adequate health care. This has particular ramifications for women held in confinement given the unique health care needs of women, including cancer screenings, gynecological services, pregnancy care, family planning services, and mental health services for survivors of gender-based violence.\(^1\) Yet current detention policies only ensure access to emergency care and fail to guarantee women detainees’ access to life-saving preventive care and treatment solutions. The reality is that ICE agents are essentially gatekeepers who determine whether women detainees are able to obtain basic medical care, such as Pap smears, mammograms, or prenatal care, and often leave requests for medical assistance unheeded.\(^1\) In addition, frequent transfers of detainees to remote detention facilities and separation from family members can result in gaps in care that can have devastating consequences on women detainees’ health.

Women in detention also lack access to safe abortion. Legislators have attempted to impose, through Department of Homeland Security (DHS) appropriations bills, a ban on coverage and provision of abortion for women in ICE custody except in the cases of rape, incest, and a very narrow definition of life endangerment. Pregnant women in detention, already separated from their families and communities, are denied the ability to make crucial decisions about their reproductive health and have children on their own terms. Many have been forced to live in inhumane conditions, sometimes being forced to give birth in shackles, denied their HIV medication, or sexually assaulted by guards. Such proposals to restrict abortion access to women in detention not only represent yet another politicized attack on the reproductive rights of women, they also target vulnerable women of color and highlight an intersectional challenge often overlooked by the traditional movements for both criminal justice and reproductive health.

**Freedom From Violence**

For many AAPI immigrant women, violence takes many forms, often manifesting itself in domestic violence, persecution in their home countries, or labor and sex trafficking. Economic disempowerment entrenched by immigration laws often prevent women from leaving unsafe situations, such as for dependent visa holders who cannot work due to the terms of their visas or trafficking survivors who are subjected to immigration-related, economic, and physical abuse. While numerous policy protections are in place to assist survivors of violence, the road to security can be harrowing and fraught with difficulties, such as stringent requirements imposed on trafficking survivors seeking immigration relief, decreases in support services and financial assistance for re-
settled refugees, and increased power for police to enforce immigration laws rather than protecting the vulnerable.

Immigration and Domestic Violence

Domestic violence is a devastating reality for many women in the AAPI community: approximately 40 to 60 percent experience physical or sexual violence by an intimate partner in their lifetime.176 Local surveys and studies of specific populations further reveal the severity of the issue. For example, among Korean American women in Chicago, one study revealed that 60 percent of those interviewed experienced physical abuse by an intimate partner sometime in their lives.177 According to a study of Vietnamese women in Boston, 47 percent reported enduring physical violence by an intimate partner during their lives and 30 percent indicated it occurred during the prior year.178 One study of South Asian women in the Greater Boston area found that over 40 percent of participants reported being physically and/or sexually abused by their current male partners in their lifetime; 65 percent of women reporting physical abuse also reported sexual abuse.179

For many immigrant AAPI women trapped in violent marriages, securing their stay in the United States can be challenging, since maintaining legal status often requires cooperation from the abusive spouse. This dependency allows batterers to exact control over women, for example, by not filing immigration papers or even threatening deportation. In fact, one study found that one-fifth of immigrant women surveyed reported their spouses had used such immigration-related abuse tactics, and a quarter of participants stated immigration status prevented them from leaving abusive relationships.180 Another study bolsters this, revealing that 75 percent of abused immigrant women reported that their spouses never filed immigration applications for them.181 This reality forces many women to choose between two equally disempowering options: remaining in a violent situation or losing their immigration status. Severe power disparities resulting from dependent visa statuses can also prevent women from obtaining protection orders, accessing domestic violence services, obtaining custody of children, calling law enforcement for help, or participating in abusers’ prosecutions. Moreover, victims without legal immigration status can be half as likely to call the police and report crimes committed against them.182

Protections through the Violence Against Women Act

In 2013, Congress reauthorized the Violence Against Women Act (VAWA), preserving the community violence prevention programs, victim assistance services, and legal aid that the Act had established. VAWA provides federal assistance to programs and services available to U.S. citizens in addition to offering certain protections to immigrants: the U-visa provides a pathway to permanent residency for immigrants who are victims of a serious crime if they assist law enforcement or government officials in investigating or prosecuting the perpetrator.183 Through the U-visa, survivors can file petitions without the knowledge of the perpetrator, who may use the survivor’s immigration status to manipulate them into silence. Nearly half of the cases reported for U-visas resulted from domestic violence, with sexual assault and rape being the next most common cases.184 In 2013, stalking was added to the list of crimes that could provide basis for a U-visa application. The 2013 reauthorization of VAWA also ensured that LGBTQ survivors of violence can access the services established by the law by barring discrimination based on perceived or actual gender identity or sexual orientation.185

U-visas are capped at 10,000 per fiscal year. Since the program began in 2009, USCIS has distributed more than 100,000 U-visas to survivors and their family members.186 The annual cap and thousands more pending petitions have led to a significant backlog in the processing of U-visas, prolonging the time survivors remain exposed to violence and delaying the processing of new cases.

vi. The U-visa was created in 2000 with the passage of the Victims of Trafficking and Violence Protection Act, the entirety of which later became an amendment to the 2013 reauthorization of the Violence Against Women Act.
Under the Trump administration, these protections are currently under threat. President Trump’s orders to detain and deport immigrants, including immigrant women, have undermined provisions of VAWA; although VAWA stipulates that courthouses where domestic violence survivors obtain a protective order cannot be used for immigration enforcement, survivors have been detained nevertheless. Under the supervision of Attorney General Jeff Sessions, who opposed VAWA reauthorization as Senator, immigrant survivors of violence find it more difficult to seek the protections guaranteed to them. Current threats to VAWA and the protections it provides represent yet another set of intersectional challenges facing immigrant women and the unique obstacles they face in achieving reproductive justice.

Refugee and Asylum Issues

For over fifty years, the United States has long welcomed individuals and families from Asia and other parts of the world fleeing persecution in their home countries. This population includes refugees who apply for immigration status from outside the United States and asylum seekers who apply while here or at a port of entry. Historically, the United States has admitted refugees from Southeast Asia and today, the incoming refugee population is rapidly evolving. During FY2015, at least 35 percent, or 24,515 individuals, of all refugees arriving to the United States were from Asian countries. In fact, Burma and Bhutan were among the top five leading countries of nationality for all refugees admitted in FY2013, FY2014, and FY 2015. During FY2011, at least 4,000 individuals from Asian countries were granted asylum in the United States, making up over 50 percent of all asylees granted relief that year.

For women from Asian countries seeking asylum in the United States, numerous challenges prevent them from securing safety in the country. Asylum seekers are required to file their application within one year of arrival; consequently, many have been barred from asylum relief despite demonstrating evidence they will face harm if returned to their home country. Asylum seekers face numerous challenges that may prevent them from filing within the one-year deadline. In some cases, DHS fails to notify asylum seekers of the one-year deadline, and immigration courts often fail to adopt procedures that assist them in filing in time. Until recently, applications also had to be filed before judges in immigration courts, which are notoriously backlogged and often cause severe delays. In addition to these bureaucratic challenges, asylees often face intense language and cultural barriers with little assistance in helping them understand the system. While those who demonstrate a fear of persecution can obtain an alternate form of relief, known as withholding of removal, these individuals are unable to apply for green cards and cannot seek to bring over family members who are abroad. This option results in interminable separation from loved ones often leaving children and spouses abroad in dangerous and life-threatening situations.

Another obstacle facing many asylum seekers is the risk of expedited removal, often without counsel or having their case heard in court, if they lack proper travel documents when entering the country. Under the current Muslim ban enacted since June 2017, in which immigrants must establish an existing “bona fide relationship” in the U.S., refugees seeking entry from countries such as Syria and Iraq have even more diminished hopes of escaping persistent conflict.

Human Trafficking

Some women living in the United States arrived from Asia as a result of human trafficking, defined as the movement of people that generally involves recruitment, coercion, forced labor, systems of bondage, and fraud. East Asians and Pacific Islanders comprise the largest group of people trafficked to the US at approximately 5,000 to 7,000 people out of a total of 14,500 to 16,500 total. Women, including those from Bangladesh, China, India, Nepal, the Philippines, and Vietnam, trafficked into the United States are often employed in the garment industry or as domestic workers. Many trafficked women endure workplace abuse, including underpayment, long work hours, unsafe working conditions, forced labor without pay, physical violence,
and withholding of immigration documentation. For many, the situation is exacerbated by immigration policies that tie a woman’s stay to her employer, thus making her more reluctant to leave and report abuse. AAPI women enduring labor and sex trafficking are denied reproductive justice in the form of sexual coercion and violence in addition to economic oppression.

In recent years, there have also been several high-profile cases of AAPI women forced to work as domestic workers for diplomats and employees of international organizations. In one case, a Filipina domestic worker earned 69 cents an hour in New York City working for a Kuwaiti diplomat. In 2013, an Indian diplomat was charged with visa fraud for lying to the U.S. Department of State about the immigration visa under which she employed a woman to be her grossly underpaid nanny. These employers are often protected from prosecution due to diplomatic immunity, though recent lawsuits have effectively chipped away at this legal defense. In addition, through international marriage brokers, AAPI women are also brought into the country as brides only to find that they are placed into servitude by their husbands after they arrive.

Under the Trafficking Victims Protection Act (TVPA), various immigration-related protections exist for survivors. The T-visa allows survivors to obtain lawful immigration status if they meet various requirements, including proving they are victims of “severe forms of trafficking,” being willing to cooperate with law enforcement in the investigation or prosecution of a trafficker, and showing they would suffer “extreme hardship” if returned to their home country.

Even seeking these visas, however, can be a risk for many AAPI women who may be hesitant to cooperate with law enforcement or, under the T-visa, fear being unable to meet the stringent definition of “severe trafficking.” Language barriers may also prevent AAPI from confidently seeking help amidst bureaucratic red tape and legal jargon. Furthermore, federal government agencies, such as the Human Smuggling and Trafficking Center, have a combined mission of addressing smuggling and trafficking as well as “clandestine terrorist travel.” As a result, law enforcement adopts approaches that can treat trafficking survivors as potential terrorist threats as opposed to victims in need of assistance. In addition, annual caps of 5,000 T-visas issued to principal applicants by the government can delay justice and safety for many women.
ECONOMIC JUSTICE

AAPI Women: An Economic Profile

The economic status of women has shifted dramatically as more women have entered the workforce. In 1967, approximately one-third of U.S. mothers with children under 18 were employed in the formal work sector. In 2015, nearly 70 percent of mothers with children under the age of 18 were working or actively looking for work, including 58 percent of Asian American and 63 percent of Native Hawaiian and Pacific Islander women.

Of the 129 million women of working age in the United States, 7.6 million are AAPI. AAPI women are employed across a variety of sectors, ranging from the managerial and professional to the informal, where they occupy positions as caretakers, domestic workers, housecleaners, and garment workers. LEP women are much more likely than their English-proficient counterparts to work in service occupations at 45 percent vs. 20 percent. Although AAPI women make up 2.9 percent of the overall workforce, they comprise a disproportionately high share of the low-wage workforce at 4.4 percent. In 2015, 11.7 percent of all Asian women live in poverty, compared to 9.6 percent of non-Hispanic white women.

While there is limited data on transgender and gender non-conforming individuals, the 2015 national U.S. Transgender Survey (USTS) revealed significant economic disparities among AAPI respondents. 15 percent of AAPI transgender and gender non-conforming respondents reported a household income of less than $10,000 (higher than the overall sample), only 5 percent reported receiving food stamps or WIC assistance. Nearly one-third (32 percent) of all AAPI respondents reported living in poverty compared to white respondents (24 percent). This is in part due to employment discrimination; 8 percent of AAPIs reported losing a job due to their gender identity and 11 percent reported quitting their job to avoid discrimination.

As the U.S. population becomes more diverse, so too will its workforce. Yet AAPI women in the workplace often face the double negative effect of the “glass ceiling” – used to describe barriers to women’s career advancement due to sex-based discrimination – and the “bamboo ceiling” – a similar advancement barrier experienced by Asian Americans due to race- and national origin-based biases.

vii. In this report, statistics on transgender and gender non-conforming communities are predominantly reported through the National Nondiscrimination Survey (NTDS) and the U.S. Trans Survey (USTS). NTDS was done in collaboration between the National Center for Transgender Equality (NCTE) and the National Gay and Lesbian Task Force. Originally published in 2008, it includes a sample of 6,456 participants from all 50 states, including a subsample of 212 AAPI transgender and gender non-conforming respondents. In 2015, NCTE released another report, the USTS that included a sample of 27,715 respondents over the age of 18 from all 50 states.
# Earnings for AAPI Women Subgroups Compared to White, Non-Hispanic Men’s Earnings

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>118%</td>
</tr>
<tr>
<td>Taiwanese</td>
<td>109%</td>
</tr>
<tr>
<td>Chinese</td>
<td>100%</td>
</tr>
<tr>
<td>Japanese</td>
<td>93%</td>
</tr>
<tr>
<td>Korean</td>
<td>85%</td>
</tr>
<tr>
<td>Filipino</td>
<td>82%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>76%</td>
</tr>
<tr>
<td>Burmese</td>
<td>71%</td>
</tr>
<tr>
<td>Nepalese</td>
<td>71%</td>
</tr>
<tr>
<td>Hmong</td>
<td>66%</td>
</tr>
<tr>
<td>Cambodian</td>
<td>65%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>64%</td>
</tr>
<tr>
<td>Laotian</td>
<td>63%</td>
</tr>
<tr>
<td>Mongolian</td>
<td>63%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>63%</td>
</tr>
<tr>
<td>Samoan</td>
<td>63%</td>
</tr>
<tr>
<td>Tongan</td>
<td>58%</td>
</tr>
<tr>
<td>Taiwanese</td>
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<td>Nepalese</td>
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<tr>
<td>Fijian</td>
<td>45%</td>
</tr>
<tr>
<td>Burmese</td>
<td>44%</td>
</tr>
</tbody>
</table>

**Earnings for Marshallese and Bhutanese Women – Compared to White, Non Hispanic Men’s Earnings**

- Marshallese: 44%
- Bhutanese: 38%

Source: U.S. Census Bureau, 2013 American Community Survey 3-Year Estimates, reported in the U.S. Department of Labor, Selected Population Profile in the United States, Table S0201.

Note: Based on median annual earnings for full-time wage and salary workers, ages 25 and older.

*Marshallese and Bhutanese median annual earnings not reported in ACS 2015, 1-Year Estimates.

**Figure 5**

Source: NAPAWF calculations based on 2015 American Community Survey 1-Year Estimates using IPUMS-USA available at https://usa.ipums.org/usa/ (IPUMS). Figures are based on women’s and men’s median earnings for full-time, year-round workers. The typical white, non-Hispanic man earned $55,000 in 2015.
AAPI Women and The Wage Gap

The wage gap is detrimental to the autonomy and advancement of all women. Following the 2016 election, 87 percent of AAPI people polled agreed that employers should pay women and men equal wages for equal work. Non-Hispanic white men are the largest demographic in the U.S. labor force and earn higher wages than other gender and ethnic groups; therefore, they are often used as a benchmark to assess gender wage disparities between groups. Women make roughly 80 cents for every dollar that a man earns. The wage gap widens for women of color: African American women are paid 63 cents and Latina women 54 cents for every dollar a white man earns.

AAPI women, on the other hand, earn more than the average women at 85 cents for every dollar a white man earns. While some AAPI women experience economic prosperity, the success of high-earning AAPI women contributes to the myth of the "model minority," which minimizes the effects of structural racism and sexism and reinforces existing patterns of discrimination. The myth further marginalizes the experiences of AAPI women whose work does not fit the stereotype, stigmatizes their experiences of economic insecurity, and continues to devalue their work in both the formal and informal sectors. Ultimately, their invisibility disenfranchises AAPI people from social and political advocacy aimed at closing the gender and racial wage gap.

AAPI Wage Gap by Ethnicity

While full-time, year round AAPI women workers are some of the highest paid in the U.S., many AAPI women experience wage disparities worse than those of white women – and Bhutanese, Marshallese, and Burmese women experience the highest wage gaps compared to all other ethnicities (Figure 5). Bhutanese women only earn 38 percent of what white men earn annually, while Marshallese and Burmese women earn 44 percent. AAPI women overall experience a loss in wages greater than $6,500 over the course of the year – and it takes approximately 14 months for them to earn what a white, non-Hispanic man earns in 12 months. Bhutanese women, on the other hand, experience a $33,163 loss in wages annually – and what a white man earns in one year, a Bhutanese woman has to work more than 2.5 years to earn.

The pay gap increases for AAPI women even more with age. The National Women’s Law Center estimated that Asian American women ages 45-64 years make just 69 cents to each dollar earned by a white man, while working Asian American women 65 years and older make a mere 58 cents. Over a lifetime, pay inequities accumulate to $349,000 in lost wages for the average Asian American woman in the workforce. This inequity contributes to the higher poverty rates for Asian American women over the age of 65 (16 percent) compared to both white, non-Hispanic men (5.3 percent) and Asian American men (13.1 percent) of the same age. These disparities in earnings have a devastating impact on AAPI women who need financial resources to support their families and save for retirement. It is particularly devastating on AAPI women who are the sole wage earner in their families. For these women and their families, every dollar counts.

Additionally, a significant portion of the U.S. AAPI population live and work in states such as California, Hawaii, New Jersey, and New York – all of which have higher costs of living. In fact, almost one-third of all AAPI people live in California, a state ranked second in the nation in terms of cost of living in 2016. Moreover, the income of AAPI women as compared to other racial and ethnic groups does not take into consideration geographic concentrations. Higher wages could be due in part to the higher cost of living, and not a representation of wealth.
## Earnings for AAPI Women, AAPI Men, and White, Non-Hispanic Men

<table>
<thead>
<tr>
<th></th>
<th>AAPI Women</th>
<th>AAPI Men</th>
<th>White Non-Hispanic Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burmese</td>
<td>$24,000</td>
<td>$25,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>Cambodian</td>
<td>$30,350</td>
<td>$38,100</td>
<td>$55,000</td>
</tr>
<tr>
<td>Chinese</td>
<td>$55,000</td>
<td>$61,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>Fijian</td>
<td>$25,000</td>
<td>$50,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>Filipino</td>
<td>$45,000</td>
<td>$49,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>Guamanian or Chamorro</td>
<td>$35,000</td>
<td>$48,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>Hmong</td>
<td>$30,000</td>
<td>$36,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>Indian</td>
<td>$65,000</td>
<td>$86,000</td>
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</tr>
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<td>Indonesian</td>
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</tr>
<tr>
<td>Japanese</td>
<td>$51,000</td>
<td>$70,000</td>
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</tr>
<tr>
<td>Korean</td>
<td>$47,000</td>
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<td>$55,000</td>
</tr>
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<td>Laotian</td>
<td>$34,600</td>
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<td>Mongolian</td>
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<td>$41,600</td>
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<td>Native Hawaiian</td>
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</tr>
<tr>
<td>Vietnamese</td>
<td>$35,000</td>
<td>$45,000</td>
<td>$55,000</td>
</tr>
</tbody>
</table>

*Figure 6*

Source: NAPAWF calculations based on 2015 American Community Survey 1-Year Estimates using IPUMS-USA available at https://usa.ipums.org/usa/ (IPUMS). Figures are based on women's and men's median earnings for full time, year-round workers. The typical white, non-Hispanic man earned $55,000 in 2015.
**Within-Ethnicity Wage Disparities**

While wages earned between AAPI men and women of the same ethnic background reveal different patterns, AAPI women overall experience one of the widest within-ethnicity wage gaps compared to other racial and ethnic groups. Asian women earn roughly 78 percent of what Asian men earn. This trend has been consistent over time.

An examination of disaggregated data reveals a more nuanced and authentic portrayal of income disparities within the AAPI community. For some Asian subgroups, the wage gap increases when comparing the within-ethnicity wages of men and women, while others subgroups see a decrease (Figure 6). For example, the median salary for an Indian woman is on average more than the median salary of white, non-Hispanic men – $62,389 and $55,166, respectively. However, Indian women only earn 73 percent of what Indian men earn on average, disproportionately less than what white women earn in comparison to white men. Bangladeshi women, however, earn nearly the same as Bangladeshi men – $36,888 and $36,920 respectively.

**Short- and Long-term Implications of the Wage Gap**

The immediate consequences of the pay gap are obvious: women earn less money for the same work that white, non-Hispanic men do. Even based on conservative estimates of the wage gap, the loss of income for AAPI women adds up to $133 per day and over $6,000 per year. The income disparity is even more astounding for Burmese and Bhutanese women workers, whose loss in wages due to the pay gap each year adds up to more than their annual income. Even groups that experience a modest annual wage gap, such as the $4,000 that Japanese women lose each year, ultimately suffer a devastating loss of $160,000 over the course of a 40-year career.

While this loss of income contributes to the overall economic insecurity of women, the implications extend past immediate concerns of income and wealth. For example, retirement savings are often generated as a percentage of income, meaning that the wage gap translates into less retirement savings and less in Social Security. One study found that the retirement income for women was over 55 percent less than men in the same age group. This contributes to the high rates of poverty for women of color, which is 16 percent for older AAPI women compared to 5.3 percent of non-Hispanic men age 65 and older. Women also tend to live longer than men in the United States, meaning women must make their already limited income stretch even further.

In order to make up for the loss in wages, AAPI women have no choice but to work longer hours, multiple jobs, and past retirement age. For those taking care of children, family members, and loved ones, the extra burden posed by the wage gap creates additional barriers for those workers to provide emotional and economic support to their families and communities. Economic insecurity impacts the safety and wellbeing of already vulnerable workers – including low-wage and immigrant workers – who are prone to workplace violations, employer retaliation, and compensation violations. Because the wage gap disproportionately impacts the overall economic security of low-income women of color and other marginalized communities, advocating for better workplace policies is a key aspect of addressing the wage gap. Such policies include increasing the minimum wage, overtime hours, access to workplace compensation, and paid leave. We strongly believe in the principle that in order to achieve reproductive justice, policies must continue to center the most marginalized people so that they have the self-determination and freedom to care for themselves and their families.

**AAPIs and Occupational Gender Segregation**

Occupational segregation accounts for some but not all of the variance in wages between men and women. Overall, a greater percentage of women work in service, sales and office jobs
compared to men in the same ethnic group. These occupations, particularly those in the service industry, tend to be low-paying jobs, and include food prep, waitressing, housekeeping, dishwashing, childcare, and personal aid. In many cases, LEP and lack of language access severely limits the type of occupations AAPI women can take on. In 2016, approximately 20 percent of Asian women worked in the service industry, compared to 12 percent of Asian men.

Disaggregated AAPI data reveals that women in certain AAPI ethnic communities are even more disproportionately represented in low-wage industries that have a median income below $30,000 per year. For example, Thai, Mongolian, Malaysian, Indonesian, Laotian, and Micronesian women are more likely than the average woman worker to be employed in the restaurant industry. Vietnamese, Bhutanese, Fijian and Cambodian women are overrepresented in personal care and service occupations, which include manicurists, hairstylists, childcare workers and personal care aides. Bangladeshi, Pakistani, Nepalese, and Korean women occupy retail jobs at higher rates than other racial and ethnic groups.

Additionally, foreign-born women are more likely to work in the service industry, as well as production, transportation, and material moving occupations compared to native-born workers. As we promote policies that support equal pay and opportunity for AAPI women, we must first understand why they dominate certain sectors and how that impacts equity and opportunity in that field. Countering modern preconceptions of the typical AAPI worker and recognizing the diversity of AAPI women in the workforce are key components of our vision of reproductive justice to ensure that all – not some – of AAPI women can access their rights.

Minimum Wage

The gender wage gap and exploitative employment practices already put working AAPI women at a disadvantage. Yet even if the workplace was level for AAPI women, current minimum wage rates make it difficult for AAPI women to be financially secure. American wages have remained largely stagnant over the past 40 years, while basic living costs have skyrocketed. If the minimum wage had increased at the same rate as productivity – the rate at which the average worker produces income for the employer – it would be more than $18 per hour today. If the minimum wage increased at the same rate as inflation, it would be over $11 per hour today.

The failure of wages to keep pace with cost of living means wages have declined for most U.S. workers including AAPI women, particularly since the most recent Great Recession ended in 2009. In fact, the proportion of AAPI women living at or below minimum wage more than doubled between 2007 and 2012. The decline in real wages has been the greatest for the lowest paid workers such as restaurant workers, retail workers, and personal care aides. These are occupations that are more likely to be occupied by an AAPI woman than the average woman. They also represent job sectors with some of the highest proportion of workers earning less than $15 per hour: retail (64.3 percent), food services and drinking places (85.3 percent), and personal care and service (77.9 percent).

The median income for full-time workers employed in these industries is less than $30,000. Contrary to popular perception, the majority of workers earning less than $15 an hour are adults. Over one in three sub-$15-wage workers are between the ages of 22-34 years old, one in four are 35-49 years old, and one out of five are 50-64 years old. This means that a high proportion of women earning minimum wage are also of reproductive age – women who aren’t financially prepared to care for a child or who have a child and are struggling to provide for one with low wages.

Decreases in real wages results in a loss in purchasing power for workers and their families. Thus, low-wage AAPI female workers, already faced with the challenge of making ends meet, have less money to spend on the same basic necessities. Fortunately, a movement to increase the minimum wage to $15 is growing across the country. Several states, counties and municipalities have passed laws that would raise the
minimum wage to $15 over time in their juris-
dictions.\textsuperscript{257} In 2017 alone, 19 states passed new
laws for higher minimum wages.\textsuperscript{258} However, of
the top ten states with the fastest-growing AAPI
population,\textsuperscript{259} seven have minimum wage laws
below $10 an hour.\textsuperscript{260} There have also been ef-
forts to increase the minimum wage for certain
industries. In December 2016, New York began
enacting a raised minimum wage to $15 for fast-
food workers.\textsuperscript{261} In Santa Monica, CA, city council
members are expected to pass an ordinance that
would increase the minimum wage to $15.37 for
employees at hotels, motels and associated busi-
nesses located within.\textsuperscript{262}

In addition, many state and local jurisdictions
have approved laws increasing the wage amount
for tipped workers. Often wait staff and bartend-
ers make below minimum wage and rely on cus-
tomer tips to make up the difference.\textsuperscript{263} Tipped
employees are disproportionately women –
about two out of three tipped workers – and one
in three are parents.\textsuperscript{264} They are also less likely to
have health insurance.\textsuperscript{265} AAPIs are also dispro-
portionately represented in this workforce, com-
prising 12.3 percent of tipped workers.\textsuperscript{266} Tipped
workers face numerous challenges. Most tipped
workers earn below or just above the minimum
wage and experience a poverty rate twice that
of other workers.\textsuperscript{267} In addition, tips are often an
unreliable source of income, varying from shift
to shift and season to season. Tipped workers are
especially vulnerable to fluctuations in consumer
spending caused by economic downturns,
when consumers are more likely to cut back on
spending at restaurants.\textsuperscript{268} Thus, AAPI women
employed as tipped workers are often subject to
low wages, unpredictable incomes and long-
term economic insecurity.

Many minimum-wage workers, particularly those
in the retail, restaurant and other service sec-
tors, do not have set working schedules. Instead,
many of these workers are subject to “just-in-
time” scheduling practices, which give employ-
ees only a few days – and sometimes mere hours – notification of their next shift.\textsuperscript{269} Just-in-time
scheduling also allows employers to dismiss staff
early and without pay during slow periods. This
scheduling practice creates an unstable work
environment that can wreak havoc on the lives of
workers, who are disproportionately low-income
women including thousands of AAPI women.

Lastly, the fluctuation in hours creates uncertain-
ty about earnings and complicates childcare and
transportation arrangements, forcing workers
and their families to constantly make last-minute
caretaking arrangements or lose the opportu-
nity for a paycheck if they are unable to do so.\textsuperscript{270}
On top of the costs associated with caring for
children, parents – especially low-wage workers
– should not have to choose between earning
a living wage and being able to support their
families.

### Paid Sick And Family Leave

AAPI households are more likely to include chil-
dren and multigenerational family members.\textsuperscript{272}
Approximately 1.4 million – or 38 percent – of
AAPI households are home to children 18 years
and under.\textsuperscript{273} The percentage of AAPI households
with children is almost ten percent higher than
the national average (38 percent vs. 29 percent),
and increases to nearly half to over three-fourths
of households in several AAPI subgroups.\textsuperscript{274}

Many AAPIs also have different expectations for
family caregiving as compared to white commu-
nities. For example, AAPIs are more likely to take
on the responsibility of taking care of older, adult
family members in the home due to traditions
of filial piety.\textsuperscript{275} AAPI women living in multi-gen-
erational households face the added financial
and social challenges of caring for dependent
children and older adults despite earning smaller
paychecks and fewer employment benefits,
particularly for AAPI female-headed households.
A key tool for working AAPI women to meet their
caretaking and financial responsibilities is to
have paid sick and family leave time.

A recent study by the Institute for Women’s
Policy Research found that 33 percent of Asian
American women and 47 percent of immigrant
women workers overall lacked access to sick days for themselves.\textsuperscript{276,277} Many more do not have paid sick leave to care for family members or loved ones. Even with paid sick leave, many workers may fear retaliation or consequences of taking time off work, forcing them to choose between recovering from an illness and keeping their job.\textsuperscript{278}

In the aggregate, AAPIs are the most likely racial group to have access to paid sick days; however, AAPI women fall ten percentage points below their male counterparts (65 percent vs. 75 percent, respectively) in terms of paid sick day access.\textsuperscript{279} Access to paid sick days decreases for employees in the private sector and drops even more among workers employed by small businesses. Few low-income AAPI women in the workforce have access to paid sick policies, even though they are often the ones that need it the most. Only 19 percent of restaurant workers and 52 percent of retail workers have paid sick days.\textsuperscript{280} In addition, only 25 percent of care workers, which comprise a high proportion of AAPI women, have access to paid sick days.\textsuperscript{281,282}

Stratifying the data by AAPI subgroups reveals certain ethnic groups are disproportionately affected. For example, more than ten percent of Thai, Mongolian and Malaysian women work in the restaurant industry, more than any other racial group. A significant proportion of Vietnamese women – 27 percent – are employed in care work, which includes nail and beauty salons, along with 17 percent of Tongan women. Nearly one-third of Bangladeshi women and one-fifth of Pakistani and Nepalese women work in retail compared to the national average of 12 percent. Such occupations rarely institute paid sick days or paid family leave into their policies, relying instead on other workers who can substitute for sick workers. Often times, workers sacrifice their health by showing up to work while feeling ill in order to earn a day’s worth of pay.

In addition, AAPI women workers are often caregivers for family and community members and therefore need paid sick leave policies with broad and inclusive family definitions. Asian Americans are more likely than whites to live in multigenerational households and are more likely to take care of older, adult family members in the home.\textsuperscript{283,284} Family leave policies should also adopt gender-inclusive definitions of “family” to recognize LGBTQ families, single-parent families, and multi-national families. Fostering healthy communities where AAPI women can thrive means supporting policies that enable AAPI women to care for their health and the health of those they consider family.

Paid sick policies should also be expanded to include “safe days” allowing people impacted by violence – including intimate partner violence (IPV), sexual violence, and stalking – to use paid sick leave for medical and legal appointments. An estimated 40-60 percent of Asian women report physical or sexual violence by an intimate partner in their lifetime.\textsuperscript{285} No one should have to choose between their safety and their job. Expanding paid leave to include safe days would help reduce barriers to reporting and care following sexual and physical violence.

Without access to paid sick days, low-income AAPI working women with caretaking responsibilities are forced to make the impossible choice of caring for a family member or feeding their families. Taking care of a sick family member is even more difficult for female-headed households, who have the added burden of being both the primary breadwinner and caretaker in the family. Furthermore, low-income AAPI women who already lack access to healthcare are sometimes forced to compromise their health and work while they are sick so that they are able to support themselves and their families.
Workplace Harassment

Many AAPI women also experience gender-based sexual harassment and/or harassment based on their sexual orientation or gender identity. A recent survey found that 25 percent of working women experienced sexual harassment on the job, but 70 percent of those women never reported it. Sexual harassment can have a devastating impact on an AAPI woman’s economic security. Women who are harassed at work are often denied or deterred from promotions, fired or forced to leave their jobs.

Immigrant AAPI women employed in low-wage and socially isolated industries such as nannies, caretakers and other types of domestic workers, are especially vulnerable to workplace sexual harassment and violence. In a landmark national survey of live-in domestic workers, 36 percent reported that they had been verbally harassed in the past 12 months, and many others reported they had been threatened, subjected to racial slurs, or sexually abused at the hands of their employers. The majority of domestic workers in the United States are women of color: 38 percent are Latina, ten percent are Black, and six percent are Asian. Almost half are foreign born, and 35 percent are non-citizens. Undocumented women are particularly vulnerable to workplace abuses. Many endure violence, sexual harassment and are fired from their jobs after becoming pregnant because they are unaware of existing employment protections or fear their employers will subject them to deportation proceedings.

Harassment also occurs based on gender identity: the 2015 USTS revealed that 13 percent of AAPI transgender and gender non-conforming respondents reported being harassed or assaulted at work within the past year. NAPAWF strongly believes that reproductive justice cannot be achieved until transgender and gender nonconforming people achieve economic justice, including freedom from harassment and violence.

Women in the restaurant industry are also at greater risk of sexual harassment in the workplace. Two out of three female restaurant workers are tipped workers – employees who are paid a sub-minimum wage and expected to earn the remainder of their wages from customer tips. This arrangement means tipped workers must often tolerate inappropriate advances from customers, co-workers and management in order to earn their incomes. Indeed, while seven percent of the country’s working women (including thousands of AAPI women) are employed in the restaurant industry, 37 percent of all sexual harassment claims reported to the EEOC are from restaurant workers.

While on the surface it appears that AAPI women fare well economically compared to women of other races, dissecting the data further reveals that a disproportionate number of AAPI women live in poverty, occupy the low-wage workforce, and experience unique challenges in caring for their families. Until AAPI women have equitable, fair wages, paid family leave, paid sick days, and protections from workplace harassment, reproductive justice remains unattainable. Economic security should not interfere with a woman’s ability to make reproductive decisions or to raise a child with dignity.

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viii The federal minimum wage for tipped employees is of $2.13 per hour. 17 states follow the federal minimum, while 7 states require employers to pay tipped employees the full minimum wage. The remainder of states have requirements to pay tipped employees above $2.13 but below the state minimum. Department of Labor, Minimum Wages for Tipped Employees, January 1, 2016, http://www.dol.gov/whd/state/tipped.htm.
Reproductive Health

NAPAWF works toward a vision of reproductive justice where each woman has the ability, resources, and support to care for their bodies and communities. NAPAWF also works to prevent major rollbacks to the gains of the past decade. Threats to health care access, affordability, and coverage disproportionately harm the most vulnerable within AAPI communities, including women, immigrants, LGBTQ, and gender non-conforming people. To fulfill NAPAWF’s vision for reproductive justice, it is critical to advocate for policies that allow AAPI women, transgender, and gender non-conforming individuals to define and make decisions about their bodies, free from gender and racial oppression.

To that end, NAPAWF promotes the following policy principles to meet the reproductive health care needs of AAPI women:

- **AAPI women need comprehensive reproductive and sexual health care that supports them throughout their lifetime.** This includes comprehensive sexual health education, access to well-woman exams, a range of contraception options, prenatal and maternal care, and access to affordable and regular STI testing. Moreover, people of all gender identities must have equitable access reproductive and sexual health care access.

- **AAPI women need access to safe and legal abortion.** Despite the fact that a strong majority of AAPI people and people of color believe that women should have access to safe and legal abortion, policy makers at the federal and state levels continue to create anti-choice legislation that shames women and undermines their decision-making abilities. In order for reproductive justice to become a reality for women of color, anti-choice policies such as the Hyde Amendment must be eliminated.

- **Health insurance coverage should be expanded, not restricted.** We believe health care is a human right. AAPI women need health care that is affordable and accessible regardless of race, sex, sexual orientation, gender identity, or immigration status. Current immigration-based restrictions are unnecessary and harmful to AAPI immigrant women and their families, and immigration enforcement actions should not take place at health care centers or other public locations such as schools and courthouses.

- **Health care for AAPI women must be culturally and linguistically appropriate.** A reproductive justice approach to services such as maternal and birthing care would integrate non-Western practices and beliefs and dismiss restrictive policies that rely on racist, sexist, or anti-immigrant stereotypes such as sex-selective abortion bans.

- **Disaggregating reproductive health data for AAPI women helps target resources.** Despite the fact that AAPI women have incredibly varied experiences in accessing reproductive health services, in many surveys and data collection efforts AAPIs are lumped together as a whole or altogether omitted. In order to reach the most marginalized communities, data must be disaggregated by ethnicity and gender identity whenever possible.
Immigrant Rights

In order for our immigration system to live up to the ideals and values of the U.S. Constitution, it is imperative that our immigration laws include a broad and inclusive path to citizenship. Immigration policies that keep families together, ensure that immigrant women have access to crucial health services, and seek justice for survivors of trafficking and domestic violence are crucial for AAPI women’s reproductive freedom. Specifically, we endorse the following policy principles:

- **U.S. immigration policy must include an accessible and timely roadmap to citizenship for all immigrants.** Current immigration policies do not grant enough protections for undocumented youth. Instead of using nonviolent and misdemeanor offenses to trigger deportation, immigration judges should be able to consider factors such as rehabilitation, societal contributions, length of U.S. residency, and best interests of children and dependents for those facing deportation. In addition, AAPI immigrant women, who are often relegated to low-paying occupations must be provided equal employment-based immigration opportunities and workplace protections.

- **Family unity for immigrant families is reproductive justice.** The total number of family-based visas allocated annually as well as per-country caps must be increased in order to shorten current backlogs and ensure that immigrants can reunify and become productive, economically secure families. ICE must also establish enforceable and legally binding detention standards that will increase access to family members and counsel. Lastly, immigration policies must be reformed to prevent criminalization and deportation of immigrants – both LPRs and undocumented individuals – that tears families apart.

- **Immigrant women and families need access to affordable, quality health care.** AAPI immigrant women contribute to the economy in a multitude of ways but must still wait five years in order to access Medicaid for life-saving care. Policies should also ensure that undocumented immigrants can purchase private coverage through the health marketplace established by the ACA. Furthermore, immigration detention facilities must provide medical care that addresses all detainee health needs by maintaining accreditation based on correctional health care standards, having onsite health care providers, and instituting medical and mental health intake screenings.

- **Immigrants need protection from violence, not systems and policies that perpetuate it.** To do so, policy makers should increase the number of U-visas and T-visas available to survivors of violence and strengthen their legal protections for immigrant women and gender non-conforming people. U.S. immigration policy should also be reformed so that an increased number of refugees and asylum seekers can enter the U.S. without discrimination by country of origin or risk of expedited removal.

Economic Justice

Low-income AAPI women, like many other working women, live paycheck-to-paycheck on a shoestring budget. An unexpected expense such as an illness or car accident can instantly trigger a financial crisis. The stress of living with limited financial flexibility continues even after retirement, as AAPI women are at high risk of economic insecurity as they age. New policies are needed for AAPI women to find their economic foothold and care for themselves and their families with fiscal confidence. We uphold the following policy principles in order to achieve economic justice for AAPI women:

- **Employers must adopt policies that protect the dignity, rights and equitable treatment of AAPI women workers.** Equal pay for equal work is a long overdue promise owed to all women of color. Employers and policy makers alike must take responsibility for creating workplace environments that are free from discrimination, harassment and unsafe conditions in order to create a
sustainable and productive workforce. Policy makers should also extend federal and state employment discrimination laws to protect LGBTQ individuals from discrimination and harassment in the workplace.

- **Employment benefits that support women support families.** Paid sick leave, employer-sponsored health coverage and other worker benefits allow workers to take care of their families, which helps put families on the road to success and economic self-sufficiency. Workplace leave policies must also have inclusive family definitions to reflect the diversity of AAPI families and communities.

- **The existing safety net system must be protected and strengthened to assist AAPI women, families, and communities in poverty.** Social welfare programs were designed to help poor and low-income individuals and their families meet their basic needs during times of crisis. These programs were also designed to keep people out of poverty, but have become laden with restrictions and funding decreases over the years making it nearly impossible for families to thrive on their own. AAPI women and their families need programs that boost their economic security, not keep them on the verge of poverty.

- **Data disaggregation reveals the diversity of AAPI women in the workforce.** Aggregating data of up to 50 ethnicities renders the livelihoods and struggles of many low-income AAPI women invisible. Since AAPI people do not live single-issue lives, our communities need data that show how complex intersections of identity impact economic opportunities. As such, government agencies must identify and use current best practices to implement data disaggregation for the broadest number of AAPI subgroups, as well as include transgender and gender non-conforming identities in federal surveys.
COMMUNITY CALL TO ACTION

While the policy principles outlined in this agenda are meant to guide federal and state policy makers, the following are recommendations for NAPAWF’s members, local organizers, activists, and allied organizations to use Still Fierce, Still Fighting to fight for reproductive justice for AAPI women and the broader community.

1 Educate people in your communities about the various and unique issues facing AAPI women when it comes to reproductive health, immigrant rights, and economic justice. Furthermore, we must discuss these issues in tandem – and not as isolated policy areas – because reproductive justice recognizes the multi-issue lives of AAPI women.

2 Contact your local, state, and federal legislators when policies that impact reproductive health, immigrant rights, and economic justice of AAPI women, transgender, and gender non-conforming people are at stake. This can include e-mailing or calling your elected official about a certain issue and organizing a meeting with your elected official. Speak up about policies such as expanded contraception coverage, repealing the Hyde amendment, reforming the 1996 immigration laws, increasing the number of U-visas, and instituting paid family leave, paid sick and safe days, pay equity, and minimum wage.

3 Share stories (including your own) about AAPI reproductive and health care needs. By sharing our stories, we remind people that health care policy has a direct impact on the daily decisions and lives of people in our communities. If you have a health care story you would like to share with us, e-mail info@napawf.org. We will lift up your story in our publications, social media, and meetings with elected officials.

4 Use the local media to speak about issues that impact AAPI women, transgender, and gender non-conforming people. The voices of AAPI women, transgender, and gender non-conforming people, are often missing from media outlets. For our communities to be visible and heard, our stories, experiences, thoughts, and lives need to be represented and shared. For help drafting messaging or guidance on any of the following, contact NAPAWF at info@napawf.org.

5 Challenge stereotypes and stigmas such as the “model minority” myth. Failing to recognize the diversity within the AAPI community and instead aggregating AAPI ethnicities as a whole masks the various and complex barriers that AAPI women face in achieving social justice.

6 Resist immigration policies that threaten family unity and deport immigrants. Current U.S. immigration policy has failed to give families a fair chance at living in the U.S. free from violence. We must continually voice our concerns about a broken immigration system and its impact on women and children.

7 Ensure AAPI communities are represented in research studies and clinical trials. Take steps to ensure there is robust AAPI representation, among participants and research staff, in traditional and community-based research studies.

8 Promote the disaggregation of research data by ethnic subpopulation and by gender identity. While it can be helpful to examine broad trends for the AAPI community, such research can mask gender and ethnic disparities that exist. Encourage researchers and public officials to collect, report, and analyze
Collaborate with organizations to build strong multi-issue partnerships and cross-movement building. We recognize that AAPI women do not live single-issue lives. We engage in multi-issue policy advocacy and grassroots organizing to represent the intersection of identities and needs that exist across AAPI women, transgender, and gender non-conforming folks in our communities. Our ability to effectively create social change relies on working collaboratively across movements.

Create a pipeline for progressive AAPI women leadership. In order to build power for AAPI women, transgender, and gender non-conforming people, we need to build a pipeline of leadership. Organizations should assess their hiring and promotion practices, as well as their overall organizational culture, in order to better recruit, retain, and promote AAPI women, transgender, and gender non-conforming workers. Similarly, we must examine potential pathways to political leadership for progressive AAPI leaders and address the barriers that prevent AAPI women, transgender, and gender non-conforming people from pursuing and accessing positions of political leadership.

The work of NAPAWF is made possible by the tireless work of its staff and volunteers, and the generous support of individual and institutional donors, and foundations.

To learn how you can support NAPAWF, email info@napawf.org or give online at www.napawf.org.
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NAPAWF is a fiscally sponsored project of TIDES
## Relevant Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AAPI</td>
<td>Asian American Pacific Islander</td>
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<tr>
<td>ACA</td>
<td>Affordable Care Act (also known as Obamacare or Patient Protection and Affordable Care Act)</td>
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<td>AEDPA</td>
<td>Antiterrorism and Effective Death Penalty Act</td>
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<td>CAP</td>
<td>Criminal Alien Program</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>COFA</td>
<td>Compacts of Free Association</td>
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<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<td>DACA</td>
<td>Deferred Action for Childhood Arrivals</td>
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<td>DREAM</td>
<td>Development, Relief, and Education for Alien Minors</td>
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<td>EC</td>
<td>Emergency contraception</td>
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<td>EEOC</td>
<td>U.S. Equal Employment Opportunity Commission</td>
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<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
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<td>GNC</td>
<td>Gender Non-conforming</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICE</td>
<td>U.S. Immigration and Customs Enforcement</td>
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<td>IPV</td>
<td>Intimate partner violence</td>
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<td>IIRIRA</td>
<td>Illegal Immigration Reform and Immigrant Responsibility Act</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<tr>
<td>LEP</td>
<td>Limited English Proficient</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, gay, bisexual, transgender, and queer</td>
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<tr>
<td>LPR</td>
<td>Lawful permanent resident</td>
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<tr>
<td>NAPAWF</td>
<td>National Asian Pacific American Women’s Forum</td>
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<td>OTC</td>
<td>Over-the-counter</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>TVPA</td>
<td>Trafficking Victims Protection Act</td>
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<tr>
<td>USCIS</td>
<td>U.S. Citizenship and Immigration Services</td>
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<td>USTS</td>
<td>U.S. Transgender Survey</td>
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<td>VAWA</td>
<td>Violence Against Women Act</td>
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You cannot change any society unless you take responsibility for it, unless you see yourself as belonging to it and responsible for changing it.

— Grace Lee Boggs