Silence, Stigma, and Reproductive Belonging: Contraceptive Knowledge and Sexual Health Communication in an Asian American UC Berkeley-Affiliated Sample

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Abstract

Sexual and reproductive health is often framed as a matter of individual knowledge and choice, but contraceptive decision-making is also shaped by family communication, cultural expectations, stigma, health-system knowledge, and access to trusted information. Asian American young adults remain understudied in reproductive health research, despite evidence that sexuality may be discussed infrequently in some families and communities. This exploratory mixed-methods survey examined contraceptive knowledge, sexual-health communication, stigma, information seeking, and contraceptive experiences among 13 Asian American respondents affiliated with UC Berkeley. The 13-question online survey included multiple-choice, rating-scale, check-all-that-apply, and open-ended items. Although recruitment primarily targeted current students assigned female at birth who self-identified as Asian American, the final sample also included one visiting scholar and two recent graduates. Participants showed high awareness of common contraceptive methods, with all 13 recognizing birth-control pills and condoms, 12 recognizing the arm implant, and nine recognizing both hormonal and copper IUDs. However, broader reproductive-health literacy was less consistent. Ten respondents (76.9%) were unaware of Affordable Care Act contraceptive coverage, nine (69.2%) were unsure whether their insurance covered contraception or believed it did not, and ten (76.9%) reported stigma around discussing sex or contraception in their cultural communities. All respondents selected online sources as a place they would seek abortion information. Open-ended responses highlighted reproductive autonomy, pregnancy prevention, accessibility, side effects, and misinformation. Overall, the findings suggest a gap between recognizing contraceptive methods and having the knowledge, confidence, and support needed to navigate reproductive health care in the Asian American community.

Introduction

Contraception is often discussed as if access begins and ends with knowing that birth control exists. In practice, reproductive autonomy requires more. A person must be able to recognize available methods, understand benefits and side effects, know where services can be obtained, understand how insurance or cost may shape access, and feel sufficiently safe to ask questions. These forms of knowledge develop within social environments. Families, peers, schools, health systems, cultural communities, and online spaces all influence what young adults learn about sexuality and which sources they trust.

For Asian American young adults, these social environments can be especially complex because the category “Asian American” contains substantial ethnic, linguistic, migration, religious, socioeconomic, and generational diversity. At the same time, scholars have repeatedly identified patterns relevant to sexual socialization, including norms of modesty, family reputation, restraint, and the tendency in some families to treat sexuality as private or

inappropriate for open discussion.[1] These patterns should not be treated as fixed cultural traits. Rather, they can interact with immigration histories, gender expectations, generational differences, institutional barriers, and broader U.S. social norms.

The need to examine these dynamics is also connected to a larger problem in reproductive-health research: Asian American, Native Hawaiian, and Pacific Islander populations are frequently aggregated, under-sampled, or excluded from analyses. Heyrana et al. (2023) argue that this lack of data can reinforce the false assumption that these communities experience few reproductive-health needs.[2] Aggregated statistics can also obscure meaningful differences between ethnic groups. A small campus study cannot solve this data-equity problem, but it can contribute to a more specific understanding of how young Asian American respondents describe contraception, stigma, access, and information seeking in a local setting.

Sexual Health Communication in Asian American Families and Communities

Prior research suggests that family communication is an important part of sexual-health education, but Asian American young adults may receive less direct sexual-health information from parents. Lee et al. (2013), in a survey of Chinese, Filipina, Korean, and Vietnamese college women ages 18 to 25, found that parents were the least frequently reported source of sex education across all four groups, while school was the most common source.[3] The authors emphasized the importance of disaggregating Asian ethnic groups because sources and patterns of sexual education were not necessarily uniform.

Research on communication content similarly shows that Asian American students may receive mixed messages from parents and peers. Trinh et al. (2014) surveyed 312 Asian American college students and found gendered differences in sexual messaging, including messages emphasizing abstinence and traditional sexual roles for young women.[4] This matters because contraceptive knowledge does not develop in a vacuum. When sexuality is framed primarily through avoidance, morality, or relationship expectations, young people may have fewer opportunities to ask practical questions about contraceptive methods, side effects, consent, clinical care, or insurance.

Qualitative research provides additional context. Frost et al. (2016) conducted six focus groups with 33 young Asian American women and found that stigma could create barriers to discussing sexual and reproductive health within families and communities.[5] Participants described seeking information and care confidentially, and they differed in whether they wanted more open family communication or preferred private pathways to services. More recently, Ly and Swain (2026) found that Asian American college women in their qualitative sample often

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[1] Okazaki, Sumie. 2002. "Influences of Culture on Asian Americans' Sexuality." Journal of Sex Research 39 (1): 34–41. https://doi.org/10.1080/00224490209552117.

[2] Heyrana, Katrina J., Bliss Kaneshiro, Reni Soon, Brian T. Nguyen, and Melissa F. Natavio. 2023. "Data Equity for Asian American and Native Hawaiian and Other Pacific Islander People in Reproductive Health Research." Obstetrics & Gynecology 142 (4): 787. https://doi.org/10.1097/AOG.0000000000005340.

[3] Lee, Christine, Denise Yen Tran, Deanna Thoi, Melissa Chang, Lisa Wu, and Sang Leng Trieu. 2013. "Sex Education Among Asian American College Females: Who Is Teaching Them and What Is Being Taught." Journal of Immigrant and Minority Health 15 (2): 350–56. https://doi.org/10.1007/s10903-012-9668-5.

[4] Trinh, Sarah L., L. Monique Ward, Kyla Day, Khia Thomas, and Dana Levin. 2014. "Contributions of Divergent Peer and Parent Sexual Messages to Asian American College Students' Sexual Behaviors." The Journal of Sex Research 51 (2): 208–20. https://doi.org/10.1080/00224499.2012.721099.

[5] Frost, Madeline, Alexa Cares, Katie Gelman, and Rita Beam. 2016. "Accessing Sexual and Reproductive Health Care and Information: Perspectives and Recommendations from Young Asian American Women." Sexual & Reproductive Healthcare 10 (December): 9–13. https://doi.org/10.1016/j.srhc.2016.09.007.

relied on online research in the context of limited family communication about sexuality.[6] Together, these studies suggest that silence does not eliminate information seeking. Instead, it may redirect information seeking toward peers, digital sources, and confidential services.

Family communication may also influence health-service use. Gibson et al. (2020) found that Asian American college women in their sample reported less frequent and less open mother-daughter communication about sex than White college women and higher sexual anxiety.[7] Their findings linked communication patterns and anxiety to sexual and reproductive health screening behaviors. Although contraceptive use and screening are distinct outcomes, both require individuals to translate knowledge into health-care engagement.

Contraceptive Knowledge, Side Effects, and Reproductive Autonomy

Knowing the names of contraceptive methods is not equivalent to feeling able to use them. Young adults may understand that hormonal contraception, intrauterine devices, condoms, implants, and emergency contraception exist while still having unanswered questions about side effects, fertility, confidentiality, insurance, or where to obtain care. Recent national research with adolescents and young adults identified perceived harm, stigma, logistical barriers, knowledge barriers, and individual preferences as common explanations for why peers may not use prescribed contraception.[8] These concerns closely reflect the everyday realities of contraceptive decision-making, where health information competes with anecdotes, social media, family stories, and fear.

Side-effect concerns deserve particular attention rather than dismissal as misinformation. In a large U.S. survey of Black, Indigenous, and people of color, including Asian American, Native Hawaiian, and Pacific Islander respondents, Wollum et al. (2025) found that concerns about side effects or health risks were the most commonly reported reasons for not using a preferred contraceptive method.[9] Contraceptive counseling therefore needs to distinguish between unsupported myths and legitimate uncertainty about how a method may affect an individual. High-quality counseling should neither minimize side effects nor imply that a single method is universally best.

This distinction is central to reproductive autonomy. Rao et al. (2023) describe contraceptive agency as the ability to make choices about whether to use contraception and, if so, which method to use.[10] Their Northern California qualitative study found that nonjudgmental

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[6] Ly, Emilee, and Kristen Alley Swain. 2026. "Finding Their Voice: How Cultural Background Shapes Sexual and Reproductive Health Communication among College Women." Journal of American College Health 74 (7): 2118–32. https://doi.org/10.1080/07448481.2026.2640444.

[7] Gibson, Laurel P., Amanda Denes, and John P. Crowley. 2020. "College Women's Sexual and Reproductive Health Screening Behaviors and the Role of Mother–Daughter Communication." Journal of American College Health 68 (4): 357–65. https://doi.org/10.1080/07448481.2018.1549558.

[8] Whitfield, Brooke, Zoe H. Pleasure, Renee M. Odom-Konja, Cambray Smith, Subasri Narasimhan, Tracey A. Wilkinson, and Laura D. Lindberg. 2025. "Young People's Perceptions of Why Sexually Active Peers May Not Use Prescribed Contraception." Journal of Pediatric and Adolescent Gynecology 38 (5): 562–71. https://doi.org/10.1016/j.jpag.2025.04.004.

[9] Wollum, Alexandra, Katherine Key, Carmela Zuniga, Charon Asetoyer, Maricela Cervantes, Sung Yeon Choimorrow, Raquel Z. Rivera, Janette Robinson Flint, and Sarah E. Baum. 2025. "Preferred Use of Contraceptive Methods and Reasons for Non-Use: A Cross-Sectional Survey of a Sample of Black, Indigenous, and People of Colour in the United States." Sexual and Reproductive Health Matters 33 (1). https://doi.org/10.1080/26410397.2025.2494418.

[10] Rao, Lavanya, Corinne H Rocca, Isabel Muñoz, Brittany D Chambers, Sangita Devaskar, Ifeyinwa V Asiodu, Lisa Stern, Maya Blum, Alison B Comfort, and Cynthia C Harper. 2023. "'She Should Support Me, She's My Doctor:'

care supported patient agency, while pressure and unexpected side effects could undermine it. Within a campus context, reproductive autonomy therefore involves more than preventing pregnancy. It includes access to understandable information, the ability to ask questions without shame, awareness of health-system options, and freedom to make decisions consistent with one's own goals.

Health-System Knowledge and the Campus Context

Insurance knowledge is one practical component of access. Under the Affordable Care Act, Marketplace plans generally must cover prescribed contraceptive methods and counseling without copayments or coinsurance when provided in-network, although exemptions and plan-specific rules can apply.[11] For students, knowing that coverage may exist can affect whether they perceive contraception as financially accessible. A person may recognize a method but still avoid seeking it if they believe it is unaffordable or do not know whether their insurance covers it.

UC Berkeley also has campus-specific reproductive-health resources. University Health Services currently offers contraception counseling and access to a range of methods, and Berkeley SHIP covers several prescription-based contraceptive options at 100 percent coverage. Students can request certain methods through MyUCBerkeleyHealth, and UHS describes its clinical services as confidential.[12] These services make the campus an important setting for examining the gap between resources that technically exist and resources that students know about, trust, and use.

Study Purpose and Research Questions

This study began from an interest in the limited discussion of contraception and sexual health within Asian American communities and from a desire to better understand what Asian American people connected to UC Berkeley knew about birth control. The original research question asked: What do female AAPI students at UC Berkeley know about contraception methods, and how does their cultural background impact this knowledge? Because the survey measured cultural communication and stigma more directly than it measured culture itself, the present paper narrows the interpretation of that question.

The analysis focuses on three questions: (1) What contraceptive methods and health-system information were respondents familiar with? (2) How did respondents characterize discussion and stigma related to sex and contraception in their family or cultural communities? and (3) Where did respondents report that they would seek reproductive-health information, and what themes appeared in their descriptions of contraceptive benefits, experiences, and side effects? The study was exploratory and descriptive. It did not test causal relationships between ethnicity, culture, and contraceptive knowledge.

Patient Perceptions of Agency in Contraceptive Decision-Making in the Clinical Encounter in Northern California," Perspectives on Sexual and Reproductive Health 55 (2): 94–103. https://doi.org/10.1363/psrh.12226.

[11] HealthCare.Gov. 2018. "Birth Control Benefits and Reproductive Health Care Options in the Health Insurance Marketplace." HealthCare.Gov. 2018. https://www.healthcare.gov/coverage/birth-control-benefits/.

[12] "Contraception." 2016. University Health Services. March 4, 2016. https://uhs.berkeley.edu/medical/primary-care/gynecology-services/contraception.

Methods

Study Design

A cross-sectional online survey was developed through the Asian American and Pacific Islander Health Research Group (AAPIHRG) at UC Berkeley. The questionnaire contained 13 substantive questions plus an optional field where respondents could provide an email address if they wished to receive research findings. Survey items included multiple-choice questions, 1-to-5 rating scales, check-all-that-apply questions, and open-ended responses. The survey was administered through Google Forms and was designed to take approximately five to ten minutes.

Recruitment and Analytic Sample

Recruitment materials described the intended population as people aged 18 or older who were current UC Berkeley undergraduate or graduate students, self-identified as Asian American, and were assigned female at birth. Recruitment occurred through outreach to UC Berkeley departments and Asian American student/community channels. The survey ultimately received 13 completed responses. Three completed responses fell outside the original current-student wording: one respondent identified as a visiting scholar and two reported having graduated within the previous two years. Because this paper is an exploratory analysis of the complete dataset, all 13 completed responses were retained rather than discarded after data collection. This decision is reported explicitly rather than retroactively redefining the original recruitment criteria. Accordingly, this manuscript refers to the analytic group as a UC Berkeley-affiliated sample and does not claim that all respondents were current students.

Measures

Contraceptive knowledge was assessed in two ways. First, respondents rated their own level of knowledge about contraception or birth control on a scale from 1 to 5. Second, respondents selected all contraceptive methods they recognized from a list that included the arm implant, hormonal and copper IUDs, birth-control shot, pill, vaginal ring, patch, minipill, diaphragm, condoms, internal condoms, spermicide, vaginal gel, tubal ligation, and natural family planning.

Communication and stigma were assessed using a 1-to-5 question asking whether discussions about sex and contraception during middle and high school were encouraged or discouraged within family and cultural community contexts, along with a separate item asking respondents to indicate agreement with the statement that stigma exists around discussing sex or contraception in their cultural community. Respondents could also describe misconceptions or myths they had encountered.

Health-system knowledge was assessed through questions asking whether respondents knew if their current health insurance covered contraception and whether they were aware of Affordable Care Act contraceptive coverage. Information-seeking was assessed through a check-all-that-apply question asking where respondents would seek abortion information, with options including friends, sexual partners, online sources, the Tang Center, and local clinics. Open-ended questions asked about personal contraceptive use since coming to college, factors that influenced method choice, perceived benefits of birth control, and perceived side effects. These items provided contextual information for interpreting the quantitative responses.

Data Analysis

Closed-ended responses were analyzed descriptively using counts, percentages, and the mean for the 1-to-5 self-rated knowledge and communication items. Because the sample was

small, no inferential statistical tests were conducted. Percentages are reported primarily to make patterns easier to compare, but each percentage should be interpreted alongside the underlying count out of 13. Open-ended responses were reviewed for recurring concepts rather than subjected to formal qualitative coding with multiple coders. The analysis identified recurring themes related to reproductive autonomy, pregnancy prevention, menstrual or hormonal benefits, accessibility, fear of side effects, mood or hormonal changes, and misinformation.

Results

Participant Characteristics

Thirteen respondents completed the survey. Five (38.5%) identified as third-year students, four (30.8%) as fourth-year students, one (7.7%) as a second-year student, one (7.7%) as a visiting scholar, and two (15.4%) as having graduated within the previous two years. Six respondents identified as Chinese only. Other self-described identities included Japanese; Filipina; Filipina and Chinese; Vietnamese Chinese; Chinese and Vietnamese; Filipina and Black; and Asian. Because respondents could use their own wording, ethnic identities are reported as self-described rather than collapsed into mutually exclusive categories.

Table 1
Participant affiliation/year (N = 13)

Affiliation/year	n	%
3rd Year	5	38.5
4th Year	4	30.8
2nd Year	1	7.7
Visiting Scholar	1	7.7
Graduated within past 2 years	2	15.4

Contraceptive Method Awareness

Respondents generally recognized common contraceptive methods. All 13 respondents (100%) recognized both birth-control pills and external condoms. Twelve (92.3%) recognized the arm implant. Nine (69.2%) recognized hormonal IUDs, nine (69.2%) copper IUDs, and nine (69.2%) internal condoms. Eight (61.5%) recognized spermicide. Awareness was lower for the birth-control patch (46.2%), vaginal ring (38.5%), birth-control shot (30.8%), tubal ligation (30.8%), natural family planning (30.8%), diaphragm (23.1%), vaginal gel (15.4%), and minipill (7.7%).

Self-rated knowledge was more moderate than method recognition suggested. On a 1-to-5 scale, the mean self-rated knowledge score was 3.23. Six respondents selected 4, two selected 3, three selected 2, one selected 1, and one selected 5. This pattern suggests that recognizing contraceptive names did not necessarily translate into a strong subjective sense of contraceptive knowledge.

Table 2
Awareness of contraceptive methods (N = 13)

Method	n	%
Birth-control pill	13	100.0
External condom	13	100.0
Arm implant	12	92.3
Hormonal IUD	9	69.2
Copper IUD	9	69.2
Internal condom	9	69.2

Spermicide	8	61.5
Birth-control patch	6	46.2
Vaginal ring	5	38.5
Birth-control shot	4	30.8
Tubal ligation	4	30.8
Natural family planning	4	30.8
Diaphragm	3	23.1
Vaginal gel	2	15.4
Minipill	1	7.7

Family and Community Communication

Responses suggested that sex and contraception were often not openly discussed in respondents' family or cultural environments. On the 1-to-5 communication item, seven respondents selected 1 and two selected 2, meaning nine of 13 respondents (69.2%) placed their experience on the discouraged side of the scale. Three respondents selected the midpoint of 3, and one selected 5. The mean score was 1.92.

Perceived stigma was similarly common. Eight respondents (61.5%) strongly agreed and two (15.4%) agreed that stigma was associated with discussing sex or contraception within their cultural community. Two respondents were neutral and one disagreed. In total, 10 of 13 respondents (76.9%) agreed or strongly agreed that such stigma existed.

Only two respondents provided explicit examples of cultural misconceptions. One described a family belief associating tampon use with sexual activity and noted that sexual health, contraception, and women's health were generally not discussed at home. Another reported encountering the misconception that emergency contraception such as Plan B could affect future fertility. The limited number of written examples prevents broader conclusions about the prevalence of specific myths, but the examples show how reproductive-health beliefs can extend beyond contraceptive methods themselves.

Insurance and Affordable Care Act Knowledge

Knowledge about insurance coverage was weaker than method recognition. Seven respondents (53.8%) said they were not sure whether their current health insurance covered contraception, four (30.8%) said yes, and two (15.4%) said no. Therefore, nine respondents (69.2%) either did not know whether contraception was covered or believed that it was not.

Ten respondents (76.9%) answered that they were not aware of Affordable Care Act contraceptive coverage, while three (23.1%) said they were aware. The survey question simplified a policy area that includes plan-specific rules and exemptions, so these responses should be interpreted as a measure of general awareness rather than as a test of detailed insurance literacy. Nonetheless, the contrast between near-universal recognition of pills and condoms and low awareness of coverage suggests that contraceptive knowledge may be stronger at the level of method names than at the level of navigating access.

Sources of Reproductive-Health Information

Every respondent selected online sources, described in the survey as examples such as Google, Reddit, or Twitter, as a place they would seek abortion information. Eight respondents (61.5%) selected a friend, six (46.2%) selected a local clinic, four (30.8%) selected the Tang Center, and four (30.8%) selected a sexual partner. Respondents could select multiple sources.

The universal selection of online sources is notable because digital information can provide privacy and immediate access, particularly when family conversations are uncomfortable. At the same time, online environments vary widely in accuracy. This makes

digital health literacy an important component of reproductive-health education: the goal is not simply to tell students not to search online, but to help them distinguish reliable clinical information from anecdote, advertising, misinformation, and social-media amplification.

Table 3
Selected communication, access, and information-seeking findings (N = 13)

Finding	n	%
Agreed/strongly agreed stigma exists	10	76.9
Communication rated on discouraged side (1 or 2)	9	69.2
Not aware of ACA contraceptive coverage	10	76.9
Unsure/no current insurance coverage	9	69.2
Would seek abortion information online	13	100.0
Would seek abortion information from a friend	8	61.5
Would seek abortion information from a local clinic	6	46.2
Would seek abortion information from Tang Center	4	30.8
Would seek abortion information from a sexual partner	4	30.8

Contraceptive Use and Accessibility

Nine respondents described having used at least one contraceptive method since coming to college, while three explicitly answered no and one wrote “N/A.” Condoms were the most commonly described method. Several respondents connected condom use directly to accessibility, describing condoms as available, free, or easy to obtain through campus organizations. Two respondents described use of Plan B or emergency contraception. Two described birth-control pill use, with one noting that cost influenced the choice because the pill was free. These responses reinforce that contraceptive decisions are not determined only by medical preference; immediate availability and perceived cost also shape behavior.

Perceived Benefits of Contraception

Open-ended responses consistently framed contraception as beneficial. Respondents emphasized preventing unintended pregnancy, reproductive autonomy, the ability to decide if or when to have children, and greater control over life circumstances. One respondent described contraception as important for allowing people to direct their lives in ways that fit their social, economic, and cultural circumstances. Others described hormonal benefits such as reducing menstrual bleeding, cramps, or other symptoms.

Some responses also mentioned prevention of sexually transmitted infections. This reflects an area where future education should be precise: barrier methods such as condoms can reduce STI transmission, while most hormonal and long-acting contraceptive methods prevent pregnancy but do not protect against STIs. The presence of this idea in the dataset illustrates why broad positive attitudes toward “birth control” should be paired with method-specific education.

Side Effects, Fear, and Misinformation

Concern about side effects was one of the clearest themes in the open-ended responses. Respondents mentioned headaches, nausea, mood changes, depression, bleeding, weight changes, acne or hormonal changes, and generalized concern about long-term effects. Several described being influenced by stories from friends. One respondent reported being discouraged by a friend's prolonged bleeding after starting contraception, while another described initially fearing hormonal contraception but eventually finding a pill with tolerable effects after trying more than one option.

These responses combine legitimate concern, incomplete knowledge, and anecdotal learning. They also show why reproductive-health education cannot treat fear as simply irrational. Side effects vary across methods and individuals, and experiences shared by peers can strongly influence expectations. The educational challenge is to provide enough trustworthy information for people to distinguish known side-effect profiles and clinical warning signs from unsupported claims such as the belief that emergency contraception causes infertility.

Discussion

This exploratory study found a consistent tension between familiarity and uncertainty. Respondents knew the names of many contraceptive methods, particularly pills, condoms, implants, and IUDs, but they were substantially less certain about insurance coverage, Affordable Care Act protections, and side effects. Most also described sex and contraception as stigmatized or discouraged topics within family and cultural contexts. Taken together, the findings suggest that contraceptive literacy should not be reduced to recognition of method names.

A more useful understanding of contraceptive literacy includes at least four dimensions: method knowledge, access knowledge, communication confidence, and decision-making agency. Method knowledge includes what a contraceptive is and how it works. Access knowledge includes where to obtain it, whether it is confidential, and how cost or insurance applies. Communication confidence includes the ability to ask questions of providers, partners, peers, and trusted adults. Decision-making agency includes the ability to weigh benefits and side effects without coercion and choose whether or not to use a method. Respondents in this study appeared strongest in method recognition and less consistently supported in the other dimensions.

Silence and the Social Production of Reproductive Knowledge

The communication findings align with prior Asian American sexual-health research. Lee et al. (2013) found that parents were the least common source of sex education among Chinese, Filipina, Korean, and Vietnamese college women.[13] Frost et al. (2016) found that stigma could limit open discussion and lead young Asian American women to seek information confidentially.[14] The present sample similarly reported high perceived stigma and low encouragement of discussion.

Importantly, the findings should not be interpreted as evidence that "Asian culture" is inherently sexually repressive. Such a conclusion would flatten the diversity visible even within

[13] Lee, Christine, Denise Yen Tran, Deanna Thoi, Melissa Chang, Lisa Wu, and Sang Leng Trieu. 2013. "Sex Education Among Asian American College Females: Who Is Teaching Them and What Is Being Taught." Journal of Immigrant and Minority Health 15 (2): 350–56. https://doi.org/10.1007/s10903-012-9668-5.

[14] Frost, Madeline, Alexa Cares, Katie Gelman, and Rita Beam. 2016. "Accessing Sexual and Reproductive Health Care and Information: Perspectives and Recommendations from Young Asian American Women." Sexual & Reproductive Healthcare 10 (December): 9–13. https://doi.org/10.1016/j.srhc.2016.09.007.

this 13-person sample and reproduce the same aggregation problem criticized in AANHPI health research. Cultural norms operate alongside gender expectations, religion, migration history, socioeconomic conditions, family relationships, education, and generational change. The survey did not measure those factors in enough detail to determine which were most influential.

Instead, the data support a narrower claim: many respondents experienced their family or cultural environment as a place where sexual-health discussion was difficult. That experience matters regardless of its exact cause. When a topic is difficult to discuss, people may still learn about it, but they are likely to construct knowledge from other sources. In this study, online information was universal as a hypothetical source for abortion information, and friends were also common. This is consistent with Ly and Swain's (2026) finding that Asian American college women often relied on online research when family communication about sexual and reproductive health was limited.[15]

Online Information as Privacy, Access, and Risk

The fact that all 13 respondents selected online sources should not be read only as a problem. Digital information can function as a privacy tool. A student who fears judgment from parents, peers, or community members may be able to search for information without disclosing a sexual-health concern. Online sources can also direct users toward clinical services, clarify terminology, and allow people to compare options before speaking with a provider.

However, privacy and convenience do not guarantee accuracy. The same online ecosystem includes evidence-based health websites, personal anecdotes, influencer content, advertising, forums, and misinformation. The participant who reported hearing that Plan B could affect fertility illustrates how reproductive-health myths can coexist with widespread access to information. Campus health education should therefore teach source evaluation rather than assume that students will stop using the internet. A practical intervention might show students how to verify claims using University Health Services, government health resources, professional medical organizations, and evidence-based contraceptive decision aids.

The Knowledge-Access Gap

One of the clearest gaps in the dataset involved insurance. Ten respondents did not know about Affordable Care Act contraceptive coverage, and seven were unsure whether their own insurance covered contraception. This is particularly meaningful because cost and access influenced several respondents' personal method choices. Condoms were described as attractive because they were easy to obtain, and one respondent explicitly described choosing the pill because it was free.

Health-system knowledge may therefore be an overlooked component of sexual-health education. Telling students that an IUD, implant, ring, patch, or pill exists is of limited value if they do not know whether they can obtain it confidentially or affordably. Current UC Berkeley resources demonstrate that campus-level access mechanisms do exist: UHS offers contraceptive services, allows requests for certain methods through MyUCBerkeleyHealth, and reports that multiple prescription contraceptive methods are covered by Berkeley SHIP.[16] Yet only four respondents selected the Tang Center as a place they would seek abortion information. The study

[15] Ly, Emilee, and Kristen Alley Swain. 2026. "Finding Their Voice: How Cultural Background Shapes Sexual and Reproductive Health Communication among College Women." Journal of American College Health 74 (7): 2118–32. https://doi.org/10.1080/07448481.2026.2640444.

[16] "Contraception." 2016. University Health Services. March 4, 2016. https://uhs.berkeley.edu/medical/primary-care/gynecology-services/contraception.

did not ask why, so it cannot determine whether the gap reflects lack of awareness, preference for other sources, perceived confidentiality, convenience, or something else. Still, the result supports making campus reproductive-health pathways more visible.

Side Effects and Contraceptive Agency

Side-effect concerns were not peripheral in this dataset; they shaped both attitudes and decisions. Participants described fear of hormonal changes, mood effects, bleeding, weight changes, and uncertainty about long-term consequences. Some respondents avoided hormonal contraception because of what they had heard from friends, while another described experimenting until finding a pill with tolerable effects. These narratives resemble broader research showing that side effects and perceived health risks are major reasons people do not use preferred contraceptive methods (Wollum et al., 2025; Whitfield et al., 2025).[17]

A reproductive-justice approach should take these concerns seriously.[18] Dismissing fear may reproduce a provider-centered model in which successful contraception is defined simply as continued use of a highly effective method. Rao et al. (2023) instead emphasize contraceptive agency: people need the ability to make their own decisions and feel supported rather than pressured.[19] For campus education, this means presenting benefits, common side effects, method switching, and discontinuation as normal parts of informed decision-making. Students should know that deciding not to use a hormonal method can be a valid choice, just as choosing one can be.

Implications for UC Berkeley and AAPI Health Education

The findings point toward several practical strategies. First, campus sexual-health education should include insurance and navigation information, not only contraceptive definitions. Students should leave knowing how to request contraception, where to ask confidential questions, how Berkeley SHIP coverage works, and where to verify coverage under another insurance plan.

Second, education should directly address side effects and common myths. A useful workshop or digital guide could separate “what can happen,” “what is uncommon but important,” and “what is a myth.” This approach would respect students' concerns while improving accuracy. Emergency contraception and future fertility would be an especially relevant topic given the misconception reported in this study.

Third, outreach should recognize that students may prefer privacy. Requiring students to attend highly visible events or disclose personal questions may not fit everyone. Anonymous question boxes, confidential one-on-one health coaching, QR-code resource guides, and culturally responsive digital content may reduce the social cost of seeking information.

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[17] Wollum, Alexandra, Katherine Key, Carmela Zuniga, Charon Asetoyer, Maricela Cervantes, Sung Yeon Choimorrow, Raquel Z. Rivera, Janette Robinson Flint, and Sarah E. Baum. 2025. “Preferred Use of Contraceptive Methods and Reasons for Non-Use: A Cross-Sectional Survey of a Sample of Black, Indigenous, and People of Colour in the United States.” Sexual and Reproductive Health Matters 33 (1). https://doi.org/10.1080/26410397.2025.2494418.

[18] Whitfield, Brooke, Zoe H. Pleasure, Renee M. Odom-Konja, Cambray Smith, Subasri Narasimhan, Tracey A. Wilkinson, and Laura D. Lindberg. 2025. “Young People’s Perceptions of Why Sexually Active Peers May Not Use Prescribed Contraception.” Journal of Pediatric and Adolescent Gynecology 38 (5): 562–71. https://doi.org/10.1016/j.jpag.2025.04.004.

[19] Rao, Lavanya, Corinne H Rocca, Isabel Muñoz, Brittany D Chambers, Sangita Devaskar, Ifeyinwa V Asiodu, Lisa Stern, Maya Blum, Alison B Comfort, and Cynthia C Harper. 2023. “‘She Should Support Me, She’s My Doctor:’ Patient Perceptions of Agency in Contraceptive Decision-Making in the Clinical Encounter in Northern California,” Perspectives on Sexual and Reproductive Health 55 (2): 94–103. https://doi.org/10.1363/psrh.12226.

Limitations

The survey's cultural measures were limited. Asking whether discussions were encouraged or discouraged within “family and cultural community” combines two potentially different contexts, and the survey did not collect detailed information about immigration generation, language, religion, family structure, socioeconomic status, sexual orientation, gender identity, or prior sex education. As a result, the study cannot determine how specific aspects of cultural background influenced knowledge. Some survey questions also used simplified wording. In particular, the question stating that the Affordable Care Act covers birth control in California did not capture the full complexity of federal contraceptive-coverage rules, exceptions, prescription requirements, provider networks, or insurance-specific policies. The results therefore measure general awareness rather than policy expertise.

Conclusion

This exploratory survey complicates a simple narrative of contraceptive “knowledge.” Respondents generally recognized common contraceptive methods and expressed strong support for the benefits of contraception, especially pregnancy prevention and reproductive autonomy. At the same time, many reported stigma and discouraged communication around sex, uncertainty about insurance coverage, low awareness of Affordable Care Act contraceptive coverage, and concern about side effects. Every respondent selected online sources as a place they would seek abortion information.

These patterns suggest that recognizing contraception is not the same as feeling equipped to navigate reproductive health. Knowledge becomes useful when people can connect method information to trustworthy sources, confidential services, insurance pathways, side-effect counseling, and their own goals. For Asian American young adults who may experience sexual health as difficult to discuss within family or community contexts, privacy and culturally responsive communication are not optional additions to education; they are part of access itself.

Future research should use larger and more diverse samples, disaggregate Asian American ethnic groups, measure family and cultural influences separately, and examine how generation, language, gender, sexual orientation, religion, and socioeconomic status interact with reproductive-health knowledge. Community-based participatory approaches could also involve students in designing survey questions and interventions. Such work would move beyond asking whether Asian American students know about birth control toward a deeper question: whether they have the information, support, and social space needed to make reproductive decisions on their own terms.

Reproductive belonging means more than being included in health statistics. It means being able to ask questions without shame, access care without unnecessary barriers, evaluate risks without coercion, and make informed decisions about one's body. Building that form of belonging requires reproductive-health education that is accurate, practical, culturally responsive, confidential, and centered on autonomy.

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