1991

Santa Clara County Health Department Southeast Asian family planning needs assessment

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planning needs assessment**

Robison, Connie Chan, M.P.H.

San Jose State University, 1991

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SANTA CLARA COUNTY HEALTH DEPARTMENT
SOUTHEAST ASIAN FAMILY PLANNING NEEDS ASSESSMENT

A Thesis

Presented to

The Faculty of the Department of Health Sciences

San Jose State University

In Partial Fulfillment

of the Requirement for the Degree

Master of Public Health

By

Connie Chan Robison

December, 1991

APPROVED FOR THE DEPARTMENT OF HEALTH SCIENCES

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APPROVED FOR THE UNIVERSITY

ABSTRACT

SANTA CLARA COUNTY HEALTH DEPARTMENT SOUTHEAST ASIAN FAMILY PLANNING NEEDS ASSESSMENT

by Connie Chan Robison

The purpose of this study was to assess the family planning knowledge and needs of Southeast Asian refugees in Santa Clara County. Psychosocial factors and acculturation indicators were studied to explore their relationship to use of family planning services.

A total of 110 subjects responded to an original questionnaire designed by the researcher and County staff. The survey was administered by bilingual staff from the County Refugee Health Services Program.

Results showed that contraceptive practice increased with greater acculturation. Acculturation included both objective indicators and self-perceived levels of adjustment. In addition, greater degrees of acculturation were associated with increased joint decision-making rather than decisions made by self or spouse only.

These findings and others have important implications for further research and practice. They imply a need for greater understanding of how acculturation and decision-making influence family planning among Southeast Asian refugees.

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CHAPTER 1

PURPOSE AND PROBLEM STATEMENT

Purpose

The purpose of this study was to assess family planning knowledge and needs of Southeast Asian refugees in Santa Clara County. The researcher explored the psychosocial parameters related to family planning needs such as decision-making and contraceptive practice. In addition, Southeast Asian utilization of family planning services was explored to further describe knowledge and needs.

Problem Statement

Introduction

The last fifteen years has seen a tremendous influx of Southeast Asian refugees into the United States. Between 1975 and 1989, more than 918,600 Southeast Asian refugees were admitted into the country (State of California, Department of Finance, 1991). As of October, 1989, approximately 472,300 Southeast Asian refugees lived in California. So many Southeast Asians have made California their new home that sixteen out of every 1000 persons in California are Southeast Asians.

The urban counties of California have the greatest number of refugees.

Los Angeles County has the largest single population (112,700), followed by Orange County (61,800), Santa Clara (44,300), Fresno (35,400), San Diego (33,300), San Joaquin (32,500), and San Francisco (30,000) (State of California, Department of Finance, 1991). (Appendix A).

Santa Clara County, more than most California counties, must learn to deal effectively with the growing population. Almost 10% of the 472,000 Southeast Asian refugees in California reside in Santa Clara County. This influx into Santa Clara County has had a significant impact on the County's health care system.

Those Southeast Asian refugees who were placed in California are designated as primary entrants. Accordingly, secondary entrants are those Southeast Asians who were originally placed outside of California but have since moved to California.

A large percentage of the Southeast Asians now living in California are secondary entrants. For instance, between 1980 and 1983, secondary entrants constituted 35% of the total Southeast Asian migration into California. In fiscal year 1987-88, secondary migration accounted for 56% of all Southeast Asian migration into California. Meanwhile, the number of primary entrants placed in California per year has been consistent since fiscal year 1983-84, averaging approximately 16,000 individuals a year.

Since October of 1987, 27% of all primary entrants (including non-

Southeast Asians) have emigrated from Vietnam, 20% from Laos, 3% from Cambodia and the remaining from non-Southeast Asia locations. Females represented 49% of all primary refugee arrivals. The median age of all primary refugee arrivals (Southeast Asian and non-Southeast Asian) into California in fiscal year 1988-89 was 24. Family reunification (parents, grandparents, etc.) has increased the average age of the newly arrived. Southeast Asian refugees tend to be young and of childbearing age with almost 50% who are age 18 or younger (State of California, Department of Finance, 1991).

Even if no additional primary entrants were placed in California, Southeast Asian migration would continue to impact California far into the foreseeable future. Understanding and meeting the needs of this ethnically diverse refugee group is an important part of California's health care challenge.

Southeast Asian Health Needs

Upon their arrival in the United States, Southeast Asian refugees, like other refugee groups, are given a health assessment. The primary purpose of the health assessment is to screen for common contagious diseases such as tuberculosis, hepatitis, and parasitic diseases. The health assessment also provides an overview of health status.

The California Refugee Health Program coordinates with local health

departments to conduct health assessments of all refugees and to track the results. During fiscal year 1989-90, a total of 26,485 health assessments were conducted. Of this total, 15,728 Southeast Asians were screened. Of the total assessed, 11,292 Southeast Asians (72%) were diagnosed as having one or more health conditions which required treatment. (State of California, Department of Health Services, 1990).

The five most common health problems identified by the 1989-90 assessments were tuberculosis, Hepatitis B, parasites, anemia, and dental disease. Tuberculosis, in particular, is prevalent in the Southeast Asian refugee population. In fiscal year 1989-90, 47% of all the Southeast Asian refugees who received a tuberculin skin test ($n = 11,000$) had significant results. Of this 47%, 60% were recommended for treatment. Of those who were tested, 49% had parasites, 48% had some form of dental disease, 14% were positive for Hepatitis B, 7% were anemic, and roughly 45% exhibited other health conditions.

A 1989 review of Hepatitis B cases in pregnant refugee women showed that of the 4,952 Southeast Asian pregnant women identified, 4,623 were screened. Of those screened, 805 women (17%) tested positive for Hepatitis B (State of California, Department of Health Services, 1990).

Health Needs Through Resettlement

The health assessments chiefly detect physical health problems with

which this population enters the country. Substance abuse and mental health conditions are more latent in nature and not always apparent to health officials.

In their 1990 Trends Report, the Santa Clara County Strategic Vision Steering Committee found that Vietnamese refugees, along with Latino men and African-Americans, experience above-average rates of alcohol abuse. These three groups were over-represented in the population of alcohol-related arrests and drug treatment clients.

One of the most tragic consequences of such substance abuse is the ever increasing number of babies born with drugs or alcohol in their system. A local survey of selected hospitals in Santa Clara County (Santa Clara County Strategic Vision Steering Committee, 1990) found that from 1986 to 1988, there was an overall increase in the percentage of babies born with drugs or alcohol in their system from 3.8% to the national rate of 7% of all births.

The Southeast Asian population in Santa Clara County faces tremendous mental health problems as well. Research has shown that Asians and Latinos in Santa Clara County experience more mental disorders than the general population (Santa Clara County Strategic Vision Steering Committee, 1990). In particular, studies have shown that refugees experience high levels of depression and anxiety.

Health Care Services

A number of health care services are available to assist the refugees with the health problems identified above. For example, in 1986, Medi-Cal, a state funded program designed to provide health care for the low-income or medically indigent population, provided care to approximately one million people each month in California (County Supervisors Association of California, 1989).

In addition to Medi-Cal, a number of social welfare agencies provide information and referral services. In Santa Clara County, organizations such as Asian Americans for Community Involvement (AACI) and the Cambodian New Life Association provide Southeast Asian refugees with information and referrals to mental health services. In all, there exist some thirty agencies within Santa Clara County that provide general or problem-specific assistance and referrals (Santa Clara County Health Department, 1988). The most widely used are the Santa Clara County Health programs such as the Women, Infants and Children's Supplemental Food Program (WIC), the Women's and Men's Health Clinics, and the Refugee Health Services Program.

Allocating resources to meet the needs of the Southeast Asian community is only the first step. Effective use of the resources requires cultural specific approaches to providing health care.

The ability of refugees to utilize available services has often been

hampered by misunderstandings born of a lack of knowledge regarding cultural beliefs and health practices. Southeast Asian families often lack the experience with which to obtain needed health care. They often do not speak English and do not realize they can get assistance for their health needs.

Financial assistance from sources such as the Women, Infant and Children's Supplemental Food Program (WIC) offsets the cost of care for those knowledgeable enough to obtain the assistance. Nonetheless, research indicates that situational and attitudinal factors must be addressed in order to fully meet the health needs of the refugee community (Strand & Jones, 1983).

Family Planning Needs

Given that over 50% of the Southeast Asian refugees are of childbearing age (15-45), a refugee family's first contact with the health care system frequently occurs in the areas of obstetrics and gynecology (State of California, Department of Finance, 1991). A study of resident births by ethnic groups of mothers in Santa Clara County showed that of the total 26,253 births, 1556 or 6% were born to Southeast Asian mothers. Southeast Asian births constitute the third largest group of births (Santa Clara County Health Department, 1988).

Southeast Asian culture has traditionally prized large families. The high fecundity rate was a direct result of Confucian beliefs and economic necessity in their homelands. However, having a large family places an additional economic burden on refugees struggling to survive in their new country.

Because of the very real conflict between traditional values and economic realities, providing appropriate family planning services is a vital concern for county health programs.

Southeast Asian families view pregnancy and childbirth as a family concern, not a medical one. Traditionally, a woman's care during pregnancy was in the hands of her extended family, not a medical practitioner. Consequently, family planning concepts of limiting family size and seeking medical attention during pregnancy are often alien ideas to Southeast Asians.

Once resettlement in this country has occurred, many Southeast Asian families feel the immediate need to start rebuilding the family structure by having children. Many Southeast Asian women struggle to have children despite having a myriad of health problems such as tuberculosis and nutritional deficiencies. Pregnancy only aggravates these conditions which negatively influence birth outcomes and maternal health.

The health of older women who feel the need to bear additional children is further complicated by their age. The 1988 study of births by ethnic groups in Santa Clara County found that 14% of the 1556 births to Southeast Asians were born to mothers age 35 and older (Santa Clara County Health Department, 1988). Appropriate family planning services are critical to the health and acculturation process of Southeast Asian families. Health care providers feel that decisions regarding when to start a family and how many

children to have should be based on maternal health and family health history. The refugee family should be given choices and sufficient information with which to make an informed decision. Southeast Asian families may choose to have fewer children if they understand that the chances of delivering a healthy infant are much greater through interventions such as prenatal care, fertility awareness and the use of contraceptives.

A number of family planning programs exist to address some of the Southeast Asians' family planning needs. Community based organizations such as Family Health Foundation of Alviso and Planned Parenthood of Santa Clara County provide pregnancy testing and family planning services. Outpatient services, surgical obstetrics and gynecology are provided by agencies such as San Jose Health Center, Santa Clara Valley Medical Center, and other hospitals. The Santa Clara County Health Department plays a central and vital role in providing health care to the refugee community. County programs such as the Women's and Men's Health Clinics offer birth control counseling, testing and treatment for sexually transmitted diseases, and women's health screenings. The Refugee Health Services Program (RHSP) of the County Health Department provides family planning education and other preventive health services for all refugees.

Each of these programs offers a variety of services and is intended to be accessible to those with limited resources. While many of the aforementioned

programs have enjoyed success in reaching their intended population, others have not. Even relatively successful programs such as Planned Parenthood and the County's Refugee Health Services Program encounter compliance problems.

Compliance is one of the areas where cultural differences between Western medicine and traditional Southeast Asian health values often affect health care delivery. Southeast Asian clients typically do not understand the concept of long-term medications and will discontinue taking the medication when symptoms are alleviated (Longo, 1990). This is particularly problematic with tuberculosis treatment where asymptomatic clients are likely to discontinue medication.

Another cultural difference is the expected relationship between the health care provider and the Southeast Asian client. Southeast Asians interact with providers and other authorities with respect. In their homelands, learning was essentially passive. Southeast Asians are taught not to confront and give personal opinions during encounters with elders and persons in positions of authority. Thus, the Western family planning provider needs to explain that questions are permissible and important. Instructions concerning treatment plans must be clear and opportunity provided for questions. Kubota and Matsuda (1982) illustrate an example of misunderstanding in medication compliance. After his wife became ill upon taking the birth control pill, the

husband of a young couple took the pills instead, in order to comply with the provider's emphasis on the importance of taking their birth control pill daily.

Communication problems are one of the most important barriers to the provision of family planning services. Another problem centers on the concept of need. From a provider's standpoint, a health need may exist because statistically an ethnic group receives proportionately less of a particular service than the population at large. Southeast Asian refugees have been identified as being underserved in the area of family planning (Iwataki, 1982). However, no one has assessed whether or not Southeast Asian refugees themselves perceive a need for family planning services. Similarly, no one has yet conducted a thorough assessment of basic family planning knowledge among Southeast Asian refugees.

Foundation of this Study

The Santa Clara County Southeast Asian Family Planning Needs Assessment Project was conducted to assess Southeast Asian refugees' knowledge and perceived needs for family planning services. It also sought to explore some of the psychosocial dynamics surrounding the use of family planning services and concepts.

The Santa Clara County Refugee Health Services Program works in conjunction with other County health programs and community agencies to provide family planning services for the Southeast Asian community. The

Refugee Health Services Program believes that there remains a gap between family planning knowledge and use of family planning services. This belief has been substantiated in other studies of family planning among Southeast Asians (Minkler, et. al., 1988). The program would like to know what barriers exist to prevent access to and provision of services. A direct assessment of client knowledge, needs and utilization of family planning services among the Southeast Asian community in Santa Clara County was necessary for future program development. These ideas were the basis of the Santa Clara County Southeast Asian Family Planning Needs Assessment Project.

Research Objectives

This study employed exploratory descriptive research methods to assess the family planning knowledge and needs of Southeast Asian men and women in Santa Clara County. The research was designed to achieve the following research objectives:

1. To assess the family planning knowledge and needs of Southeast Asian refugees in Santa Clara County.
2. To explore the psychosocial factors relevant to family planning needs of the study population.
3. To explore Southeast Asian utilization patterns of family planning services.

4. To generate data which can be used in the planning and evaluation of Santa Clara County health services for the Southeast Asian community.

Research Questions

This needs assessment was designed to answer the following questions regarding Southeast Asian family planning knowledge and needs:

1. What are the general perceptions of Southeast Asian refugees regarding family planning?
2. How are key family planning decisions made?
3. Is contraception practiced and if so, what methods are most commonly used?
4. Are there differences in the use of family planning services between the various Southeast Asian ethnic groups?
5. What barriers exist to Southeast Asians' use of family planning services?

CHAPTER 2

LITERATURE REVIEW

Southeast Asian Philosophies

Four basic philosophical tenets play a significant role in the health beliefs and practices of Southeast Asian refugees. These philosophical tenets are Buddhism, Confucianism, Taoism, and Phi (Kubota & Matsuda, 1982). These philosophies have in common four common values strongly reflected in Southeast Asian cultures: (1) male authority and dominance; (2) importance of saving face; (3) strong family ties; and (4) respect for parents, elders, teachers and other authority figures. These values influence all aspects of life for Southeast Asian people including their health care.

Buddhism stresses the importance of eliminating the self and personal desires to achieve ultimate salvation. It rejects desires and passions in order to reach a state of enlightenment, or nirvana. One must accumulate merits by doing good deeds and acts of generosity and kindness (Muecke, 1983; Kubota & Matsuda, 1982).

Confucianism has heavily influenced the moral values of Southeast Asians. The guiding principles are cultivation of an individual's moral character and adherence to principles of social behavior. These principles guide family relationships and engender a sense of duty and obligation. The

Confucian system places all people in ascending order of relationships, beginning with the family relationship. Male dominance prevails in most situations. Male children are more desirable.

While Confucianism deals with human relationships and morality, Taoism is concerned with the human achievement of harmony with nature. Taoism is a philosophy and religion that originated in China in the Sixth Century B.C. (Indochinese Cultural and Service Center, 1982). The basic beliefs are the concepts of Tao, the way of nature, and of Yin and Yang, the principles of balance.

The fourth philosophical tenet is that of Phi, the belief in spirits (Indochinese Cultural and Service Center, 1982). The spirits can be dead relatives, animals, or nature. The presence of "good" or "bad" phi depends on the actions of the individual. To avoid "bad" phi which can cause illness or death, the individual must show respect to elders, avoid conflict and, in general, practice the moral beliefs of Confucianism.

Each of these four philosophies plays a vital role in the everyday lives of Southeast Asians in their homelands and when they resettle in the United States. The underlying principles and beliefs are used to explain health and illness and strongly influence the individual's reactions to these life events.

Southeast Asian Health Beliefs

The Southeast Asian concept of health stems from ancient Chinese medicine and culture. Central to the Chinese definition of health are the concepts of Yin and Yang. Taoism views all things in the universe as a balance between two opposite elements, the Yin and the Yang. One element complements the other and balance between the two is essential for the harmonious operation of all things.

In addition to Yin and Yang, all things in nature, including human beings, are understood as composed of five elements: water, metal, wood, fire, and earth. According to Taoist philosophy, good health results from achieving a balance between Yin and Yang and the appropriate interaction of the five elements. An imbalance in the content or the flow of these forces or elements produces disease. Balance can be restored through use of herbs or acupuncture.

Western Medicine and Chinese Medicine

Western medicine, developed since the 1850s in the U.S. and Europe, is based on a reductionistic model, grounded in biomedical sciences. Prior to the advent of modern medicine, Western physicians served as paternalistic counselors who had almost "priestly" functions. Medical practices such as blood-letting did little to mitigate sickness. After the turn of the century, there was a movement to re-evaluate the practice of medicine and the effectiveness

of institutions which trained these practitioners. This inquiry ultimately resulted in the current medical model which utilizes principles of physics, chemistry, and biology (Seldin, 1984). The resulting scientific discipline was developed almost completely independent of social, psychological and behavioral concerns.

Illness, in the medical model, is conceived of as "a deranged biomedical function" (Seldin, 1984, p. 61). The practice of medicine, or illness care, applies knowledge and the instruments of biomedical science to alleviate pain, prevent disability and save lives. Medical training is firmly embedded in the biological sciences and the scientific method. The practitioner of Western medicine treats illness but not necessarily the disease or its direct cause. Unlike Chinese medicine, Western medicine often uses invasive procedures such as surgery. Southeast Asians are very apprehensive about procedures which draw blood, which they see as the draining of one's soul and life force (Longo, 1990). They often feel that Western medicine is fast-acting, of short duration, and designed for big, strong Westerners. In contrast, Chinese medicine, perceived as slow-acting, gentle, and of long duration, is thought to be specially suited to the Asian body (Longo, 1990).

Chinese medicine's approach to health, to treat the "whole" person, has its adherents in the West who endorse the systems view of health and disease. From a systems view, diseases are not regarded as discrete entities in one

location, but as patterns of disruptions exhibited at various levels of the system (Brody & Sobel, 1984). Unlike the dominant biomedical model, the Systems Model considers the environment, behavior and socioeconomic patterns as independent systems which impact on health and health care.

Southeast Asian Health Practices

Both traditional and Western methods of health care are practiced by Southeast Asians in the United States. Individuals often seek help first from traditional medicine and secondly from modern medicine, or sometimes from both simultaneously (Muecke, 1983).

Today, three different types of medicine are practiced in Indochina: Western medicine, Indochinese modern medicine, and traditional Chinese and folk medicine. Western medicine, first introduced to Southeast Asia in the 19th Century by the French, is largely practiced in urban centers and utilized by the more affluent. Health care professionals are in short supply in Indochina. Until 1975, more than 70% of the 2,000 physicians in South Vietnam were in the military. The remaining 30% of civilian physicians practiced for the most part only in large cities (Chow, 1980; Croisier, 1968). The shortage of health care providers resulted in the practice of Western medicine by medical assistants, village health workers, and "injectionists." These health workers functioned with limited training and no physician supervision.

Indochinese modern medicine is the second form of medicine practiced by Southeast Asians in their homelands. Indochinese modern medicine is a variant of Western medicine. Its foundation is more pragmatic than scientific. Western medicine is thought of by many Southeast Asians as "shots that cure" and modern Indochinese medicine has incorporated that concept (Muecke, 1983; Chow, 1980). When seeking modern medical care, Southeast Asian clients expect to receive intramuscular injections. For instance, it is common practice in Vietnam to go to the pharmacist for an injection of Vitamin C for a cold. If a woman thought she had venereal disease, she could also get an injection of antibiotics. If no pill or injection is given, the Southeast Asian client is likely to feel cheated and decide that inadequate care was given. Placebos are used at times to decrease anxiety.

Traditional Chinese and folk medicine form the foundation for the third type of medicine practiced in Indochina: traditional medicine. Chinese medicine is practiced in Indochina by Chinese physicians and their disciples. It involves the use of acupuncture and/or herbal medicine to restore the balance of Yin and Yang. The Southeast Asian refugee will usually seek Chinese medicine as the first recourse in any health problem (Muecke, 1983).

Folk medicine, the other central component of traditional Indochinese medicine, combines folklore with Chinese and medieval French beliefs. Disease is understood to be caused by natural phenomenon (bad wind),

supernatural forces (spirits, gods, demons), metaphysical forces (hot or cold theory), or a combination of all three. Folk medicine is practiced throughout Indochina and is especially advocated by elderly family members.

These three types of medicine are central to the health behavior and health care of Southeast Asians even after resettlement in the United States. Western health care providers must necessarily understand and work with these beliefs in their efforts to promote health and influence behavior.

Acculturation and Health Behavior

Studies on refugees and immigrants show that radical cultural and social changes increase the potential for development of physical and mental disorders (Hoang & Erickson, 1982). For Southeast Asians, prolonged stays in the overcrowded refugee camps, memories of devastation in their homelands, and apprehensions about life in an unfamiliar country take a tremendous toll on health.

The most recent wave of Southeast Asian refugees, those who emigrated after 1975, represent a different socioeconomic group than those who arrived prior to this time. The recent group is more likely to be from rural areas and have a lower socio-economic status. They are likely to have had little formal education and have no knowledge of English. Prior exposure to Western culture, much less modern medicine, is usually limited or nonexistent.

Kubota and Matsuda (1982) delineate the cultural differences confronting Southeast Asian immigrants into the following four categories: way of life, way of thinking, value orientation and social structure, and family interactions. Life, as experienced by refugees in their country, was disrupted by the loss of home and family. Once resettled, language barriers and the inability to gain employment commensurate with their former employment provide further obstacles. Challenges to the traditional way of thinking and value orientations are stimulated by the loss of sociocultural identity and a re-prioritizing of values. Finally, traditional family structure and interaction, where the extended family was often the sole source of help and support, are challenged by the dissolution of the extended family upon resettlement.

The Southeast Asian's ability to cope with these difficulties influences health behavior in general. While health problems such as tuberculosis, hepatitis, anemia, and dental and gum disease continue to persist, increasing attention is being focused on health concerns related to acculturation. These relatively newer concerns include smoking, mental health, and sexually transmitted diseases such as HIV infection and AIDS.

Smoking has become a persistent problem among Southeast Asians, young and old (Department of Health Services, 1990). For the Southeast Asian adolescent, smoking is viewed as a way to "fit in" with American classmates and friends. With the advent of increased marketing efforts directed at teens

and the international market, Southeast Asians are drawn to what may constitute a false sense of identity with American culture (W. Bonta, personal communication, October 23, 1991). For the older Southeast Asian, smoking serves as a status symbol as well as representing a level of acculturation. The older generation of Southeast Asians regards smoking as a method of regaining a "way of life."

The loss of a way of life and attempts to adapt to different cultural values and practices have contributed to the growing numbers of Southeast Asians experiencing mental health problems. Some health care providers feel that depression is the greatest threat to refugee health.

There are many factors that influence the growing prevalence of mental health problems among Southeast Asian refugees. The root cause was the emigration itself which resulted in pervasive and overwhelming loss and change in a relatively short time. These changes can serve to disorient refugees for long periods of time. A sense of isolation from both their past and present environments compounds the problem. In addition, reduced social status and role reversal where women also work outside the home also contribute to anxiety and depression (Muecke, 1983; Cantanzaro & Moser, 1982).

Differences in the degree of acculturation among family members further contribute to mental health problems. Children tend to adapt quickly,

adults age 30-40 acculturate in three to five years, but those over 50 may not adapt at all (Kubota & Matsuda, 1982). This difference in acculturation rates can create generational and cultural gaps between the young and old. Many adults feel that the younger generation has lost the traditional family values and cultural heritage in their struggle to adapt. Beliefs such as filial piety and proper conduct are seen to have increasingly less significance in an adopted culture of individualism and material gain (Kubota & Matsuda, 1982). As a result, parents have less control over their children and greater anxiety about life in their new country.

A third and growing concern related to acculturation is HIV/AIDS and other sexually transmitted diseases among Southeast Asian adolescents. Yoshimura and Chao (1989) discuss the issue of cultural influences on AIDS and Asian youths. In contrast to the acceptance of rebellion and emotional turmoil as normal growth processes of an American adolescent, the Asian youth is brought up on the values of conformity to the family and proper behavior. There is little room for what the researchers term an "adolescent identity crisis." Parents expect to maintain this control over their children well into adulthood, particularly in areas such as dating and sexual behavior.

For Asian youths, assimilation brings more influence from American peer groups. In this context, conflicts arise between parents and the adolescent. This situation creates an even greater barrier to discussing

sexuality, a subject already considered to be a private matter. Asian youths, therefore, often have limited or inaccurate information about sex and STDs, including HIV infection and AIDS. These youths face the dangers of sexually transmitted diseases and unwanted pregnancies.

Cultural Values and Implications For Family Planning

Sex and sexuality are considered to be personal and private matters in Southeast Asian culture. Sex is understood within the larger context of family and community. For the Southeast Asian family, sex is for the sole purpose of procreation, creating a new generation of family members who will care for their parents in old age. Western family planning concepts of birth control to prevent and space pregnancies may be alien to the Southeast Asian client. Family planning as practiced in the American culture assumes that pregnancies can, and even should, be controlled. In contrast to Southeast Asian culture, American culture adopts the belief that sex is for personal fulfillment, making pregnancy an often secondary event. Family planning is used to prevent this event from occurring at an inopportune time or from happening at all. In this context, the goals of the two cultures appear to lie at opposing ends.

Family planning is often considered a woman's responsibility. This is not to say that decisions concerning having children are made without the participation of the husband or other male authority figure. Minkler, et. al.,

(1988) found that 78% of their Southeast Asian respondents felt that the decision to use family planning should be jointly made by both spouses. For example, in Southeast Asia men used condoms only with prostitutes to avoid contracting sexually transmitted diseases. Therefore, the decision to use condoms may be unacceptable among Southeast Asian men in the United States. Thus, while women are expected to shoulder the burden of family planning, men expect to decide when their wives become pregnant.

The differences in Western and Indochinese beliefs has an enormous impact on the provision of family planning services for the Southeast Asian refugee. Since reproductive health issues are not openly discussed, basic understanding of reproductive physiology may be lacking among the client population. Consequently, it may be difficult for many Southeast Asians to understand family planning methods or to participate in birth control discussions.

To most Southeast Asians, a large of number of children still translates into happiness and good fortune. Minkler, et. al., (1988) found that when asked the question, "In your homeland, what is the best number of children to have?" Hmong participants indicated the highest number (9.0). Vietnamese participants indicated the lowest number (3.2). Other Southeast Asian ethnic groups reported a number in between those given by Vietnamese and Hmong participants.

While Americans view pregnancy and childbirth as medical issues, they are treated strictly as family matters among Southeast Asians. A woman's care through the stages of pregnancy, delivery and postpartum lies in the hands of her extended family, not a physician. Therefore, the ideas of limiting family size and seeking medical attention during pregnancy appear unjustifiable to the very traditional Southeast Asian client.

In view of these cultural differences, Southeast Asians' traditional beliefs regarding family issues dramatically impact the family's health and acculturation process. As political refugees escaping persecution, many Southeast Asian families experience hardships resulting from poverty and separation and/or loss of family members (Huyck & Fields, 1981). Two phenomena develop as a result of this refugee experience. Rumbault and Weeks (1986) describe these phenomena as "rebuilding" and "catching up."

Pregnancy rates are generally high in refugee camps. Believing that their stay in the camps will be lengthy, many women hope to "rebuild" their family by bearing more children to replace those lost. Other women may have been forced to postpone childbearing during encampment. When they are resettled in the United States, these women begin the "catching up" process. According to Confucian and Buddhist beliefs, the survival of the family and of the culture requires the individual to rebuild through reproduction. This process occurs once migration has been assured.

Despite the Southeast Asians' early apprehensions, their acceptance of family planning ideas appears to be evolving as they acculturate and become more familiar with Western health care. The traditional extended family usually no longer exists once resettlement occurs. Accordingly, this changes the responsibility for pregnancy and childbirth care from the family to the medical practitioner. Economic constraints and higher survival rates of children also operate to make smaller families desirable.

Attitudes and acceptance of family planning information are slowly changing. However, continued efforts must be made to ensure the health of the mother and baby. Recent Southeast Asian refugees remain at greater risk of pregnancy complications. Hopkins and Clarke (1983) conducted a study of refugee fertility rates and pregnancy risk factors in Oregon. They found that the fertility rate for official Oregon Southeast Asian refugees was 126.7 or 1.8 times the United States fertility rate of 68.5. During the peak childbearing years of the twenties, the refugee birth rate was four times greater than the United States birth rate. This rate increased to 13.9 times the U.S. rate for women age 40-44. The investigators concluded that additional family planning and maternal and child health outreach programs were required to address the needs of long term Southeast Asian residents.

The study by Minkler, et. al., (1988) demonstrated that structural barriers and cultural factors directly contribute to gaps in the use of health

services. Language was the barrier most commonly cited by respondents (73%). Other barriers were related to physical access, including transportation and cost difficulties. The researchers also found a notable gap between knowledge and practice of family planning methods.

Help-Seeking Behavior

The reflection of Asian norms and traditional concepts of health and illness also applies to the help-seeking behavior of Southeast Asian refugees. Southeast Asian refugees' health-seeking behavior is crisis-oriented in the United States as it was in their homelands (Moon & Tashima, 1982). In Indochina, health care was sought only during emergencies or for serious conditions. For many rural people, physicians and hospitals were not readily available. Medical problems were usually handled by the individual or with the help of practitioners of folk medicine. Therefore, visiting a doctor in the United States for non-emergency family planning or prenatal care is seen as unnecessary.

Moon and Tashima (1982) conducted a study of help-seeking behavior and attitudes of Southeast Asian refugees. For physical problems, the majority of the respondents (93%) indicated that they would go to an external agent (someone not specifically a member of the respondent's family). Sources of help for mental health problems were more varied and tended to be ethnic-

specific. Still, the family was the foremost source of help.

The researchers also sought to find significant changes between the traditional help-seeking behavior in their native countries and that practiced in the United States. In this case, external agents were again the most prominent source of help sought for physical problems. However, in their homelands external agents were seen as less significant than in the United States. A significant portion of Cambodians and Vietnamese said they would go to "no one" (20% and 28%, respectively) for help with mental or physical problems.

Moon and Tashima also found radical differences between traditional and current refugee coping strategies, particularly in response to the disruption of the family unit as a primary source of support. In the United States, the family's role has been significantly weakened and replaced by other support agents. In family planning, these agents include family planning counselors and health practitioners. This transferral of confidence and intimacy may not yet have occurred for many Southeast Asian refugees. These findings have significant implications for the provision of reproductive health services.

Health Belief Model

Health promotion efforts must be aimed at lifestyles and cultural practices specific to communities (Vega, et. al., 1988). The literature on the health beliefs and cultural practices of Southeast Asian refugees identifies the

barriers confronting family planning education. Recommendations about spacing pregnancies and seeking the physician for contraceptives may be little understood in a culture that believes a large family means prosperity and that medical attention is warranted only in life-threatening situations.

The Health Belief Model is a psychosocial model which accounts for the differences in an individual's health behaviors by their attitudes and beliefs (Rosenstock, 1974). The model consists of four dimensions including an individual's perception of susceptibility to and severity of a condition or illness, perceived benefits from recommended health actions to alleviate the condition, and the barriers that limit the individual from taking the proposed action. These perceptions are guided by the individual's environment and sociocultural background (Janz & Becker, 1984; Rosenstock, 1974).

Two of the four dimensions of the Health Belief Model were used in the current study: perceived susceptibility to a problem and benefits construed from a recommended health behavior. While the long-term nature of family planning may conflict with the Southeast Asian's crisis orientation toward seeking health care, the individual can perceive potential benefits from family planning education. Economics and lack of traditional family support may influence a family's decision to seek the benefits of birth control. Once the benefits are construed, the individual weighs them against the negative aspects of taking action (language barriers, lack of transportation). A decision is

subsequently triggered by some stimulus, either internal (personal health) or external (economic necessity, media communication) to seek family planning information.

While the Health Belief Model provides a useful framework for assessing the use of family planning information among Southeast Asian refugees, the model is predicated on the belief that "health" is a highly valued concern and "stimuli" are widely prevalent. The model becomes less effective when these premises are not met. Family planning programs need to understand the attitude and belief dimensions of the model and their relationship to other influences on health behaviors.

The Santa Clara County

Family Planning Needs Assessment Project

The Santa Clara County Health Department is committed to providing family planning services under the culturally sensitive framework discussed above. One important aspect of the planning, implementation and evaluation of the services is periodic review and assessment of the knowledge and behaviors of the Southeast Asian client population.

This study, the Santa Clara County Family Planning Needs Assessment Project was conducted to assess the knowledge, needs and utilization of family planning services among Southeast Asian refugees. It was hoped that the data

would provide insight and information to providers wishing to expand their outreach or improve their communication with Southeast Asian clients. It was also hoped that the results would provide data with which the level and content of current family planning services could be evaluated by policy makers and program directors. Finally, it was hoped that this study would provide information which will be used to enhance the physical and mental health of Southeast Asian refugees in Santa Clara County.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Purpose and Objectives

The purpose of this study was to assess family planning knowledge and needs of Southeast Asian refugees in Santa Clara County. The study also explored psychosocial factors related to family planning needs and utilization of family planning services.

The research process was designed to achieve the following objectives:

1. To assess family planning knowledge and needs of Southeast Asian refugees in Santa Clara County.
2. To explore psychosocial factors relevant to family planning needs of the study population.
3. To explore Southeast Asian utilization patterns of family planning services.
4. To generate data which can be used in the planning and evaluation of County health services for the Southeast Asian population.

This research evolved from concerns of Santa Clara County health providers regarding the delivery of appropriate and effective family planning services to the Southeast Asian community. Involvement of these providers

was essential at each phase of the research process. An Advisory Group consisting of community health workers, program administrators and providers was assembled early in the process to assist in the planning and design of the study (Appendix B). This group also provided periodic consultation throughout the assessment and analysis phases. The actual data collection was conducted by the bilingual staff from the Refugee Health Services Program.

Research Approvals

The researcher obtained approvals from the Santa Clara County Health Department, the Human Subjects Review Board at San Jose State University, and the California Institute for Medical Research at the Santa Clara Valley Medical Center (Appendix C).

Design

The study used an exploratory, needs assessment research design. An original survey was developed to elicit information on family planning knowledge and needs. This survey was administered through interpreters who were able to interview respondents in their native languages. The data collection process was designed to provide a non-threatening environment in which participants felt free to answer questions and to provide information.

Sampling

A convenience sample was designed using selected sites in Santa Clara County. Sampling was planned for the Santa Clara County Refugee Health Services Program (RHSP), English as Second Language Classes (ESL), the Santa Clara Valley Medical Center (VMC), Women, Infant and Children's Supplemental Food Program offices (WIC), and other Santa Clara County health clinics. These sites were selected for their accessibility to the study population and their associations with the County Health Department. The Southeast Asians' familiarity with these programs was considered an asset in soliciting their participation.

A sampling goal of 150 was established. The sampling protocol limited participation to Southeast Asian adults, age 18 years and older, regardless of marital status. Voluntary participation was sought from clients at the sampling sites. All clients who arrived for appointments with the agencies were invited to participate. In addition, any adult family members or associates who accompanied them to the appointment were also solicited.

Because of the potentially sensitive nature of the subject matter, the survey was included as a general introduction to County health services. Since the purpose of some of the agencies was not directly health related, the Advisory Group felt that combining an outreach approach with the survey would eliminate uneasiness about the content.

Research Instrument

The research instrument was an original survey designed with the assistance of the Advisory Group. The intent of the survey was to gather information on the family planning knowledge and needs of Southeast Asian refugees who were in contact with health and welfare agencies in Santa Clara County. No other survey had been done in the County to identify clients' perceptions of current services and their effectiveness. The County had a vested interest in generating data which could assist them in planning future programs. A needs assessment survey was envisioned as the most direct and cost-effective way of generating data. Accordingly, a simple, multiple-choice, short-answer survey instrument was developed.

The needs assessment survey consisted of three sections: 1) socio-demographics, 2) psychosocial factors, and 3) barriers to utilization (Appendix D).

The first section, covering socio-demographics, elicited background information from respondents including age, sex, ethnicity, language capabilities, marital status, education, and length of time in the United States.

The second section dealt with psychosocial factors related to family planning needs. It explored the roles played by the respondent, spouse and/or the extended family when making family planning decisions. These decisions include what type of birth control to use, or how many children to

have. The second section also probed the current use of family planning services and sources of family planning information.

The questionnaire's final section, barriers to utilization, briefly explored issues such as language, transportation, and acculturation as possible barriers to family planning services.

The entire survey was translated into Vietnamese, Cambodian and Laotian languages by staff from Refugee Health Services. The translated surveys were designed to be either self-administered or administered through an interviewer, depending on the capabilities and desires of respondents.

Pretesting the Instrument

The survey was pretested with approximately 35 individuals from English as Second Language classes and Refugee Health Services clinics. Pretesting was done to insure understanding of survey questions, review strategies for soliciting participants, review interviewing techniques, and to test for structural soundness in the survey.

During pretesting, the surveys were administered in both groups and individually. Interviewers found that respondents lacked sufficient familiarity with family planning concepts to adequately complete the survey without assistance from the interviewer. Group interviews inhibited individual respondents from asking questions or seeking clarifications. Based on the

pretesting results, the Advisory Group proposed that interviewers personally administer the survey through face to face encounters. In addition to lessening confusion and increasing understanding, the Advisory Group determined that the personal interviews would allow for a more humanistic and interactive approach to the survey process.

Interviewers

Since the researcher was not proficient in Southeast Asian languages, bilingual and bicultural interpreters from the Refugee Health Services Program served as interviewers. They were approached by program directors and coordinators to assist in the project as part of their regular work assignments. Southeast Asian public health assistants, outreach workers, and clerical staff assisted in the data collection process. These individuals served as translators or interpreters for other departments within the County health system as well as for the Refugee Health Services Program. Their familiarity with County programs, bilingual abilities, and cultural sensitivity qualified them as the most effective interviewers for this research.

The interviewers attended an inservice training to review data collection procedures and interviewing techniques. A flow chart outlining steps of the data collection process was presented (Appendix E). The outline was reviewed and comments were solicited on the appropriateness of procedures.

Data Collection

As discussed previously, all Southeast Asian adults age 18 and older who were clients of the selected sampling sites were asked to participate in the study over a five month period. At County sites, the interviewers had prior knowledge of appointment schedules and were usually assigned to a particular clinic for the week. The interviewer was often the first person to speak with the client. At this initial intake session, the interviewer introduced the survey, explained informed consent, and asked the client for her/his participation. If the client agreed to participate, the interviewer proceeded to ask the questions on the survey. If the client declined, the interviewer directed the client on for her/his scheduled appointment.

Each participant was presented with a statement of informed consent before the interview took place (Appendix F). Because the researcher was granted a waiver of written informed consent by the San Jose State University Institutional Review Board, participants did not have to sign the consent form in order to participate. However, participants were given a copy of the form upon request.

At non-County sites (Valley Medical Center, English as Second Language classes), data collection required additional resources. The outreach staff were primarily responsible for soliciting participants at non-County sites since they had more scheduling flexibility. Their responsibilities enabled them

to travel to various locations and the survey was added on as part of their workload.

Prior approval from these sites to conduct the survey allowed the interviewer to contact the agency and check their schedules to see when classes or appointments were being held. At the appropriate time, the interviewer conducted the survey using the same protocol as they would with County sites. Depending on time and resources, other staff were sent to non-County sites to engage participants.

The complexity of the sampling and data collection process required ongoing evaluation. The Advisory Group established periodic meetings during the survey period (March - July, 1991) to review procedures, discuss problems in the field and to provide progress updates. Agendas for these meetings are shown in Appendix G. The meetings provided opportunities to express frustrations, explain problems encountered in the field, and to create dialogue between the researcher and the interviewers.

Data Analysis

Responses from completed questionnaires were entered into a computer file. Data were analyzed using the SPSS-X Statistical Package with the assistance of programmers from the Office of Student Research, University of California, Berkeley.

Definition of Terms

Southeast Asian Refugees: People of Indochinese descent who have immigrated to the United States since 1975 in search of asylum following the collapse of the U.S. backed regimes in South Vietnam, Cambodia and Laos. They include peoples of Laos (Mien and Hmong), Cambodia, and Vietnam. The term is used synonymously with "Indochinese" in this study.

Family Planning: Voluntary, purposive control or spacing of pregnancies.

Family Planning Education: Includes information on birth control methods, fetal development, the birth process and sexually transmitted diseases.

Cultural Values: Traditionally held beliefs regarding family structure, health and health practices, philosophy, religion, and the role of the individual within society. These values include customs and traditions related to the cultural perceptions of the population.

Acculturation: Process of adjusting to the culture and lifestyle of a particular environment. In this study, it applies to Southeast Asian refugees who have resettled in the United States.

Objective Acculturation: Objective, quantifiable indicators of acculturation which include time in residence in the United States, age, education, and prior family planning education.

Subjective Acculturation: Self-perceived acculturation indicators which measure the level of difficulty in adjusting to variables such as adapting to a

new environment, and overcoming language and transportation problems.

Utilization: Participation in family planning services and internalization of family planning concepts as viewed in the United States. Utilization also includes perceived needs for family planning services and where family planning services were obtained.

Assumptions

The researcher made several assumptions in the design and planning of this study. First, the researcher's inability to communicate in the Southeast Asian languages required the use of translators to administer the survey. It was assumed that the translators would frame the questions correctly and would be able to elicit information according to general guidelines.

Second, the researcher assumed that respondents would answer questions candidly and accurately. Respondents were assured of anonymity and were assumed not to be fearful of adverse consequences as a result of their participation. It was felt that respondents would be comfortable and more willing to talk if interviewed by persons who spoke the respondent's language and were themselves of Southeast Asian descent.

Third, the written instrument and method of data collection were assumed to be the most appropriate and effective way to assess knowledge, needs, and use of family planning. Questions were formatted with the

assumption that perceptions of the range of choices on the survey would be linguistically similar across ethnic groups (i.e., very difficult vs. somewhat difficult).

Fourth, the researcher assumed that a variety of sampling sites would be sufficient to attract participants of all Southeast Asian ethnic groups. Although the sample would not represent all Southeast Asian ethnicities, basic cultural beliefs were assumed to be generalizable. The use of male and female interviewers was assumed to be helpful in soliciting adequate sampling of both sexes. Finally, an inservice was conducted to review data collection procedures and insure consistency in the administration of surveys. The researcher assumed that the research would progress according to established protocols.

CHAPTER 4

RESULTS

This study explored the psychosocial factors and utilization patterns associated with family planning services among Southeast Asian refugees in Santa Clara County. The specific psychosocial factors explored in this research include indicators of acculturation and the process of family planning decision-making. The specific utilization indicators include prior exposure to family planning services and perceived need for services. The relationship of both subjective and objective acculturation variables to family planning decision-making, practice and use of family planning services was also explored.

Description of the Total Sample

Characteristics of the total sample are displayed in Table 1. There were a total of 110 respondents to the study. Of the 110 respondents, 75 were women (79%) and 20 were men (21%). There were 15 cases in which the interviewer failed to record the gender of the respondent. Among all 110 respondents, 18% indicated that they were single, 76% were married, 4% were widowed, and 2% said they were divorced. The majority (68%) were Vietnamese followed by 24% Cambodian, 7% Laotian, and 1% Mien.

TABLE 1

Description of the Total Study Sample

Gender	<u>n</u>	(%)
Women	75	(76)
Men	20	(21)
Other/not recorded	15	(3)
Ethnicity		
Vietnamese	74	(68)
Cambodian	26	(24)
Laotian	8	(7)
Mien	1	(1)
Marital Status		
Single	19	(18)
Married	79	(76)
Widowed	4	(4)
Divorced	2	(2)
Education		
No formal education	5	(5)
Elementary	40	(39)
High School	56	(54)
College	1	(1)
Post-Graduate	1	(1)
Length of Time in the U.S.		
0-11 months	57	(62)
1-3 years	14	(15)
≥ 4 years	21	(23)

A review of general education levels of all respondents showed that 44% had elementary level education or less; 56% indicated that they had at least high school education or beyond.

The survey assessed the length of time the respondent had lived in the United States. More than half of all respondents (62%) had been in the country less than one year, 15% had 1-3 years of residency, and 23% had 4 or more years of residency.

Specific questions asked about respondents' aptitude in English as well as their own language (Table 2). On a range of "not well" to "very well," over 85% of all those who responded felt they could neither speak, read, nor write English well. With respect to their own language, results showed greater variability (Table 3). Forty-one percent of respondents said that they could read and write their own language very well compared to 27% who indicated they could not.

Perceived health status was probed as a possible indicator of general health seeking behavior and utilization patterns (Table 4). When asked about their health, the respondents almost overwhelmingly felt themselves to be in either good health (58%) or fair health (37%). Only 5% perceived themselves to be in poor health. No one reported that their health was great.

TABLE 2

Aptitude in English Language

Speak English	<u>n</u>	(%)
Very well	2	(2)
Well	3	(3)
Not well	105	(95)
Read English		
Very well	2	(2)
Well	2	(2)
Not well	106	(96)
Write English		
Very well	2	(2)
Well	12	(11)
Not well	96	(87)

TABLE 3

Ability to Read and Write Own Language

Ability	<u>n</u>	(%)
Very well	45	(41)
Well	35	(32)
Not well	30	(27)
Total	110	(100)

TABLE 4

How Would You Rate Your Health Status?

Health Status	<u>n</u>	(%)
Great		
Good	62	(58)
Fair	40	(37)
Poor	5	(5)
Total	107	(100)

Description of Core Sample

Unanticipated problems in data collection resulted in incomplete questionnaires for almost 47% of the overall sample. Therefore, a subgroup with more complete responses was selected for the primary analysis. This core sample of married women ($n=58$) represents the largest group from the total study sample ($N=110$). Characteristics of the core sample are displayed in Table 5.

Of the Southeast Asian ethnic groups represented, 62% of the core sample were Vietnamese, 24% were Cambodian, and 12% were Laotian or Other Southeast Asian.

Almost half of the respondents (49%) were in the 30-39 age group, 26% were 40 years or older and 24% were under 30 years of age. Vietnamese respondents tended to be older. Cambodian and Other Southeast Asian respondents were primarily under 40 years of age.

Overall, the core sample of married women represented a group of strikingly recent refugees. Approximately two-thirds of the core sample ($n=38$, 66%) had lived in the United States for less than one year. One-third of this sub-sample ($n=21$, 36%) had resided in the United States for less than three months. Only nine women (16%) had five or more years of residence.

While there were more Vietnamese respondents in general, the more recent refugees (0-11 months residence) were predominately Vietnamese ($n=33$,

TABLE 5

Description of Core Sample

Time	Ethnicity						Total <u>n</u> (%)
	Vietnamese		Cambodian		Laotian/ Other		
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	
< 3 months	19	(91)	1	(5)	1	(5)	21 (33)
3 - 11 mos.	14	(82)	1	(6)	2	(12)	17 (30)
1 - 4 years	2	(20)	4	(40)	4	(40)	10 (18)
≥ 5 years	1	(11)	8	(89)			9 (16)
<hr/>							
Age							
Under 30 years	6	(43)	4	(29)	4	(29)	14 (24)
30 -39 years	17	(61)	8	(29)	3	(11)	28 (52)
≥ 40 years	13	(81)	2	(13)			15 (26)
<hr/>							
Education							
Elementary	8	(28)	13	(45)	7	(25)	28 (52)
High School	26	(100)					26 (48)
<hr/>							
Read/Write Own Language							
Very well	16	(76)	1	(5)	3	(14)	20 (35)
Well	18	(86)	1	(5)	2	(10)	21 (37)
Not well	2	(13)	12	(75)	2	(13)	16 (28)

87%). Cambodians ($n=12$, 63%) and Laotian/Others ($n=4$, 40%) had lived in the U.S. one or more years.

Of the 93% of the core sample who responded to the question, 52% of the women had an elementary level education and 48% had a high school education. No one in the core sample had pursued education beyond the high school level. Again, there were marked ethnic differences in education levels. All of the Vietnamese respondents reported completing high school while the Cambodian and Other ethnic groups had only an elementary level education.

When asked how well they could read and write their own language, almost three-fourths of the respondents felt that they could read and write their own language "well" or "very well" ($n=42$, 72%). Again, there were pronounced differences between ethnic groups. Of respondents who could read and write their own language "well" or "very well," 81% were Vietnamese while only 5% of the Cambodians and 12% of the other groups reported the same ability.

There appears to be a relationship between length of time in the U.S. and level of education. A similar relationship appears between length of time in the U.S. and how well respondents know their own language (Tables 6, 7). In general, more recent refugees tended to be more educated and more skilled in their own language. Table 6 shows the relationship between length of time in the U.S. and education. Almost all of the 23 respondents reporting high

TABLE 6

Length of Time in the U.S. and Education

Time	Education			
	Elementary <u>n</u> (%)	High School <u>n</u> (%)	Total <u>n</u> (%)	
0 - 11 months	14 (38)	23 (62)	37 (67)	
1 - 4 years	8 (80)	2 (20)	10 (18)	
≥ 5 years	7 (88)	1 (13)	8 (15)	
Total	29 (53)	26 (47)	55 (100)	

TABLE 7

Length of Time in the U.S. andAbility to Read and Write Own Language

Time	Ability			
	Well/very well <u>n</u> (%)	Not Well <u>n</u> (%)	Total <u>n</u> (%)	
0 -11 months	34 (87)	5 (13)	39 (67)	
1 - 4 years	5 (12)	5 (50)	10 (17)	
≥ 5 years	3 (7)	6 (67)	9 (16)	
Total	42 (72)	16 (28)	58 (100)	

school education had been in the United States less than one year. In contrast, half of the smaller proportion with only elementary education had been in the U.S. one year or more; seven respondents had been here over 5 years. Table 7 shows a similar pattern. Of respondents who had lived in the U.S. less than one year, 34 women (87%) could read and write their own language "well" or "very well." Among those with 1-4 years of residency, only 12% reported this level of ability. Only three women with five or more years of residency (7%) reported that they could read and write their own language well.

Birth Control Practice and Family Planning

Decision-Making

A number of questions were asked regarding respondents' birth control practices. At the time of the survey, 22% of the core sample of married women wanted to become pregnant (Table 8).

While a sizeable percentage of women (22%) said they "never" practiced birth control, half of the respondents (50%) indicated that they "sometimes" or "always" practiced birth control (Table 9). When asked what type of birth control they used, 17 women (33%) reported condoms as their birth control method (Table 10). Of those who did not want pregnancy to occur, 51% indicated that they were engaging in unprotected sex (Table 11).

A series of questions about how family planning decisions are made

TABLE 8

Do You and/or Your Spouse Want to Become Pregnant?

Intentions	<u>n</u>	(%)
Yes	13	(22)
No	45	(78)
Total	58	(100)

TABLE 9

Frequency of Birth Control Use

Birth Control Use	<u>n</u>	(%)
Always	8	(14)
Sometimes	21	(36)
Rarely	9	(16)
Never	13	(22)
¹ NA	7	(12)
Total	58	(100)

¹ NA denotes no answer.

TABLE 10

Birth Control Method

Method	<u>n</u>	(%)
Birth Control pill	3	(6)
IUD	7	(14)
Rhythm Method	4	(8)
Condoms	17	(33)
Condom and foam	7	(14)
Tubal ligation	1	(2)
None	12	(23)
Total	51	(100)

TABLE 11

Are You Currently Having Unprotected Sex¹

Occurrence	<u>n</u>	(%)
Unprotected sex	23	(51)
² Other	22	(49)
Total	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant at this time.

² Other denotes protected sex or no answer.

showed nearly equal numbers of women stating "self" and "self and spouse" as the primary decision-makers (Table 12). Although not part of this core sample, it is interesting to note a marked difference in responses of married men with nearly all of the men stating that a joint effort was made (n=14, 93%).

Family Planning Needs

When asked what types of family planning information they wanted, 85% of the women wanted birth control information. Information on women's health and sexually transmitted disease was requested by 53% and 33% of the respondents respectively (Table 13).

Utilization Patterns

Participants were asked a series of "subjective" acculturation questions to explore their relationship to family planning utilization (Table 14). On a scale of "very serious" to "not serious," 76% of the respondents felt they had very serious problems with the English language; 50% had very serious difficulty in getting transportation. Respondents also reported difficulty in adapting to the American way of life and finding public resources. When asked where general medical care was sought, most respondents stated that either they had no place to go (41%) or that the County clinics served as their source of medical care (38%) (Table 15).

TABLE 12

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Who Makes Family Planning Decisions?

Decision-Maker	<u>n</u>	(%)
Self	24	(41)
Spouse	7	(12)
Self and Spouse	27	(47)
Total	58	(100)

TABLE 13

What Type of Family Planning Information Are You
Interested In?¹

Information	<u>n</u>	(%)
Birth Control	49	(84)
STDs	19	(33)
Women's Health	31	(53)
Men's Health	5	(9)

¹ Totals are not provided since respondents were able to select more than one information type.

Self-Perceived Difficulty and Subjective Acculturation
Indicators

Indicators						
Difficulty	American Way of life		English Language			
	<u>n</u>	(%)	<u>n</u>	(%)		
Very serious	39	(70)	44	(76)		
Somewhat serious	15	(27)	13	(22)		
Not serious	2	(4)	1	(2)		
<hr/>						
	Adapting to new environment		Community Agencies			
	<u>n</u>	(%)	<u>n</u>	(%)		
Very serious	31	(53)	25	(43)		
Somewhat serious	21	(36)	28	(48)		
Not serious	6	(10)	5	(9)		
<hr/>						
	Transportation		Medical Help		Finding Resources	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	29	(50)	27	(47)	24	(41)
Somewhat serious	27	(47)	27	(47)	32	(55)
Not serious	2	(3)	4	(7)	2	(3)

Where Do You Go for General Medical Care?

Source	<u>n</u>	(%)
None	24	(41)
County clinics	22	(38)
Private physician	10	(17)
¹ Other	2	(3)

Total	58	(100)
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¹ Other denotes community clinics.

Respondents' choices of sites for family planning information showed a similar pattern although there was greater variability among sites. Over half of the married women (53%) reported that they do not go anywhere for family planning information. The remaining 47% were almost equally distributed among community clinics, private physicians, and other sources (Table 16).

Objective Acculturation and Birth Control Practice

Objective acculturation variables include length of time in the U.S., age, level of education, ability to read and write own language, and past exposure to family planning services. Each of these variables was analyzed in relation to birth control practice.

Length of time in the U.S.

Time intervals were collapsed into four groups: less than three months, 3-11 months, 1-4 years, and five or more years. Of the core sample of married women, 13 (22%) expressed that they wanted pregnancy to occur, while 45 women (78%) did not want to be pregnant at the time of the survey. Slightly more respondents who had resided in the U.S. for less than one year wanted to be pregnant compared with those having one or more years of residency (Table 17). However, this finding was not statistically significant.

Of the 45 respondents not wanting pregnancy, 23 (51%) were having

TABLE 16

Where Do You Go for Family Planning Information?

Source	<u>n</u>	(%)
None	31	(53)
County clinics	10	(17)
Private physician	8	(14)
¹ Other	9	(16)
Total	58	(100)

¹ Other denotes community clinics.

TABLE 17

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Length of Time in the U.S. and Pregnancy Intentions

Time	Intentions					
	Pregnant		Not Pregnant		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
< 3 months	4	(19)	17	(38)	21	(36)
3 - 11 months	5	(28)	13	(29)	18	(31)
≥ 5 years	3	(33)	6	(13)	9	(16)
Total	13	(22)	45	(78)	58	(100)

TABLE 18

Length of Time in the U.S. and Occurrence of Unprotected Sex Among Respondents not Intending Pregnancy¹

Time	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
< 3 months	10	(59)	7	(41)	17	(38)
3 - 11 months	5	(38)	8	(62)	13	(29)
1 - 4 years	5	(38)	4	(62)	9	(20)
≥ 5 years	3	(50)	3	(50)	6	(13)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

unprotected sex and 22 (49%) were either having protected sex or did not answer the question (Table 18). Unprotected sex appeared to occur most often among the most recent refugees with 10 women (59%) who had less than three months of residency engaging in this practice.

Questions pertaining to the frequency of birth control practice showed that for the most recent refugees (less than three months residency), birth control is rarely or never practiced (Table 19). Birth control increased slightly from 31% to 52% for those who had 3-11 months residence. Frequency of use declined as years of residence increased.

Regardless of time in residence, a majority (46%) of respondents chose condoms or condoms with foam as their choice of birth control (Table 20). For those with less than three months of residency, 10 respondents (50%) used condoms alone and five respondents (25%) used the IUD.

Age

Age was examined for its relationship to birth control practice. Regardless of age, most respondents (78%) did not want pregnancy to occur (Table 21). Among this group, 10 of the 19 respondents age 30-39 (52%) were having unprotected sex. There was little variability between the three age groups (Table 22). Age and frequency of birth control use also showed insignificant differences. Fifty percent of the core sample under 30 years of age stated that they "always" or "sometimes" used birth control, and 50% stated

TABLE 19

Length of Time in the U.S. and Frequency
of Birth Control Use

Time	Frequency							
	Always/ Sometimes		Rarely/ Never		¹ NA		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
< 3 months	8	(31)	7	(33)	6	(29)	21	(36)
3 -11 mos.	10	(56)	7	(39)	1	(5)	18	(31)
1 - 4 yrs.	6	(60)	4	(40)			10	(17)
≥ 5 years	5	(56)	4	(44)			9	(16)
Total	29	(50)	22	(38)	7	(12)	58	(100)

¹ NA denotes no answer

Length of Time in the U.S. and Birth Control Method

Time	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
< 3 months			5	(25)	1	(5)
3 - 11 mos.	1	(6)	2	(13)	2	(13)
1 - 4 years	1	(13)				
≥ 5 years	1	(13)			1	(13)
Total	3	(6)	7	(14)	4	(8)
	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
< 3 months	10	(50)				
3 - 11 mos.	6	(38)				
1 - 4 years	1	(13)	4	(50)	1	(13)
≥ 5 years			3	(38)		
Total	17	(33)	7	(14)	1	(2)
	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
< 3 months	4	(20)	20	(39)		
3 - 11 mos.	4	(25)	15	(29)		
1 - 4 years	1	(13)	8	(16)		
≥ 5 years	3	(38)	8	(16)		
Total	12	(23)	51	(100)		

TABLE 21

Age and Pregnancy Intentions

Age	Intentions					
	Pregnancy		No Pregnancy		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Under 30	2	(14)	12	(86)	14	(24)
30 -39	9	(32)	19	(68)	28	(48)
≥ 40 yrs	2	(13)	14	(88)	16	(28)
Total	13	(22)	45	(78)	58	(100)

TABLE 22

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Age and Occurrence of Unprotected Sex Among
Respondents not Intending Pregnancy¹

Age	Occurrence				Total	
	Unprotected Sex		² Other			
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Under 30	7	(58)	5	(42)	12	(27)
30 - 39	10	(52)	9	(48)	19	(42)
≥ 40 years	6	(43)	8	(57)	14	(31)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they do not wish to become pregnant at this time.

² Other denotes protected sex or no response.

that they "rarely" or "never" used birth control. Among older respondents (40 years or older), 56% "always" or "sometimes" used birth control and 25% "rarely" or "never" used birth control. However, it is important to note that there were seven cases in which the response was missing (Table 23).

Condoms and condom and foam were selected by 60% of respondents age 30-39 as their method of birth control. Only three respondents under 30 years of age (25%) chose condoms and none in this age group chose condom and foam. For women under 30 years of age, most (33%) used no birth control, followed by 25% who chose the birth control pill or condoms (Table 24).

Education

Analysis of education level and birth control practice showed some potentially important relationships. Overall, only 7% of the respondents with an elementary level education wanted to become pregnant compared to 42% of those with a high school education (Table 25). This suggests that increased education may be related to greater use of protection during sex (Table 26). Of the 27 respondents with elementary level education who did not want to become pregnant, 15 women (56%) were engaging in unprotected sex compared to 6 respondents (40%) among those with high school education.

Overall, frequency of birth control use appeared higher for respondents with more education. Among the 29 respondents with an elementary level

Age and Frequency of Birth Control Use

Age	Frequency						Total	
	Always/ Sometimes <u>n</u>	(%)	Rarely/ Never <u>n</u>	(%)	¹ NA <u>n</u>	(%)	<u>n</u>	(%)
Under 30	7	(50)	7	(50)			14	(24)
30 - 39	13	(46)	11	(39)	4	(14)	28	(48)
≥ 40 years	9	(56)	4	(25)	3	(19)	16	(28)
<hr/>								
Total	29	(50)	22	(38)	7	(12)	58	(100)

¹ NA denotes no answer.

TABLE 24

Age and Birth Control Method

Age	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Under 30	3	(25)			2	(17)
30 - 39			3	(12)	1	(4)
≥ 40 years			4	(27)	1	(7)
Total	3	(6)	7	(14)	4	(8)
	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Under 30	3	(25)				
30 - 39	11	(44)	4	(16)	1	(4)
≥ 40 years	3	(20)	3	(20)		
Total	17	(33)	7	(14)	1	(2)
	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
Under 30	4	(33)	12	(24)		
30 - 39	4	(16)	24	(47)		
≥ 40 years	4	(27)	15	(29)		
Total	12	(23)	51	(100)		

TABLE 25

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Education and Pregnancy Intentions

Education	Intentions					
	Pregnancy		No Pregnancy		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Elementary	2	(7)	27	(93)	29	(53)
High School	11	(42)	15	(58)	26	(47)
Total	13	(24)	42	(76)	55	(100)

TABLE 26

Education and Occurrence of Unprotected SexAmong Respondents not Intending Pregnancy¹

Education	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Elementary	15	(56)	12	(44)	27	(64)
High School	6	(40)	9	(60)	15	(36)
Total	21	(50)	21	(50)	42	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

education, 10 (35%) said they "always" or "sometimes" practiced birth control (Table 27). In comparison, 16 of the 26 respondents with high school education (62%) stated a similar frequency of use.

For respondents with elementary level education, 30% used no birth control; six women (26%) chose condom and foam as their birth control method (Table 28). There were four respondents (17%) who used the IUD and two women (9%) who used birth control pills. For those with high school education, 13 women (50%) chose condoms alone, five respondents (19%) used no birth control, five respondents (15%) used the rhythm method, and three respondents (12%) chose the IUD.

Ability to Read and Write Own Language

Interesting results were derived from an analysis of the question, "How well do you read and write your own language?" with birth control practice. Again, most respondents did not want to become pregnant (Table 29). For the 13 respondents who wanted pregnancy to occur, 12 could read and write their own language "well" or "very well." Among those not wanting pregnancy to occur, 18 of the married women who could read and write their own language "well" or "very well," were having unprotected sex compared to five women (33%) who could not read and write well engaging in the same practice (Table 30). This pattern suggests a tendency towards unprotected sex among those most knowledgeable in their own language.

Education and Frequency of Birth Control Use

Education	Frequency							
	Always/ Sometimes		Rarely/ Never		¹ NA		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Elementary	10	(34)	16	(55)	3	(10)	29	(53)
High School	16	(62)	6	(23)	4	(15)	26	(47)
<hr/>								
Total	26	(47)	22	(40)	7	(13)	55	(100)

¹ NA denotes no answer.

TABLE 28

Education and Birth Control Method

Education	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Elementary	2	(9)	4	(17)		
High School			3	(12)	4	(15)
Total	3	(6)	7	(14)	4	(8)
Education	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Elementary	2	(9)	6	(26)	1	(4)
High School	13	(50)	1	(4)		
Total	17	(33)	7	(14)	1	(2)
Education	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
Elementary	7	(30)	22	(46)		
High School	5	(19)	26	(54)		
Total	12	(23)	48	(100)		

TABLE 29

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Ability to Read/Write Own Language and Pregnancy Intentions

Ability	Intentions					
	Pregnancy		No Pregnancy		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very well	9	(43)	12	(57)	21	(36)
Well	3	(14)	18	(86)	21	(36)
Not well	1	(6)	15	(94)	16	(28)
Total	13	(22)	45	(78)	58	(100)

TABLE 30

Ability to Read/Write Own Language and Occurrence of
Unprotected Sex Among Respondents not Intending Pregnancy¹

Ability	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very well	4	(33)	8	(61)	12	(27)
Well	14	(78)	4	(22)	18	(40)
Not well	5	(33)	10	(67)	15	(33)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

The same variable analyzed against frequency of birth control practice showed that 21 respondents who could read and write their own language "well" or "very well" (60%) stated they "always" or "sometimes" used birth control (Table 31). There were seven cases where the response data was not recorded. For respondents who could not read and write well, eight respondents (50%) "always" or "sometimes" used birth control.

When asked what type of birth control was used, more respondents who could read and write their own language "well" or "very well" (45%) chose condoms alone over other methods (Table 32). The IUD was the chosen method for seven respondents (18%) in this same category. Most of the respondents with limited education in their own language chose condoms and foam or did not use birth control at all.

Prior Family Planning Education

Overall, most of the core sample of married women had never attended a family planning education class ($n=46$, 79%). Table 33 illustrates the relationship between prior exposure to family planning and the desire to become pregnant. Results show that the only case of a respondent wanting to be pregnant appeared among those with prior family planning education. However, a slightly larger percentage of women who had attended a family planning class indicated that they did not want to become pregnant (92%) than those who did not have previous exposure to family planning (74%).

TABLE 31

Ability to Read/Write Own Language and
Frequency of Birth Control Use

Ability	Frequency						Total	
	Always/ Sometimes <u>n</u>	(%)	Rarely/ Never <u>n</u>	(%)	¹ NA <u>n</u>	(%)		
Very well	10	(34)	16	(55)	3	(10)	29	(53)
Well	16	(62)	6	(23)	4	(15)	26	(47)
Not well	8	(50)	8	(50)			16	(28)
Total	29	(50)	22	(38)	7	(12)	58	(100)

¹ NA denotes no answer.

TABLE 32

Ability to Read/Write Own Language and Birth Control Method

Ability	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very well			2	(11)	4	(22)
Well	1	(5)	5	(25)		
Not well	2	(14)				
Total	3	(6)	7	(14)	4	(8)
	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very well	8	(44)	1	(6)	1	(6)
Well	9	(45)	6	(43)		
Not well						
Total	17	(33)	7	(14)	1	(2)
	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
Very well	2	(11)	18	(35)		
Well	5	(25)	20	(39)		
Not well	5	(36)	13	(26)		
Total	12	(23)	51	(100)		

TABLE 33

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Prior Family Planning Education and Pregnancy Intentions

Education	Intentions					
	Pregnancy		No Pregnancy		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Yes	1	(8)	11	(92)	12	(21)
No	12	(26)	34	(74)	46	(79)
Total	13	(22)	45	(78)	58	(100)

Table 34 suggests a relationship between family planning education and rates of unprotected sex. Fewer women who had attended a family planning class were engaging in unprotected sex ($\underline{n}=7$, 9%) compared to women who had not attended a class ($\underline{n}=22$, 48%).

Women who had attended a family planning class practiced birth control more often. Results show that a greater percentage of women who had previous family planning exposure "always" or "sometimes" practiced birth control ($\underline{n}=9$, 75%), as compared to the percentage of women having had no prior education ($\underline{n}=20$, 43%) (Table 35).

Among respondents with prior family planning education, four women (40%) chose condoms as their birth control method; three women (30%) chose condoms and foam and two women (20%) selected birth control pills. All of the women in this category used some form of birth control (Table 36). While many of the respondents with prior exposure to family planning used condoms ($\underline{n}=17$, 33%), there were almost equal numbers of women who used no birth control at all ($\underline{n}=12$, 23%).

In summary, all of the variables except age were shown to have some association with birth control practice. Although these relationships were not statistically significant due to the small sample size, acculturation may be related to increased frequency of birth control use.

Prior Family Planning Education and Occurrence of
Unprotected Sex Among Respondents not Intending Pregnancy¹

Education	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Yes	1	(9)	10	(91)	11	(24)
No	22	(48)	12	(52)	34	(76)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

TABLE 35

Prior Family Planning Education and
Frequency of Birth Control Use

Education	Frequency						
	Always/ Sometimes		Rarely/ Never		¹ NA		Total
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u> (%)
Yes	9	(75)	1	(8)	2	(17)	12 (21)
No	20	(43)	21	(46)	5	(11)	46 (79)
<hr/>							
Total	29	(50)	22	(38)	7	(12)	58 (100)

¹ NA denotes no answer.

Prior Family Planning Education and Birth Control Method

Education	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Yes	2	(20)			1	(10)
No	1	(2)	7	(17)	3	(7)
Total	3	(6)	7	(14)	4	(8)
	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Yes	4	(40)	3	(30)		
No	13	(31)	4	(10)	1	(2)
Total	17	(33)	7	(14)	1	(2)
	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
Yes			10	(20)		
No	12	(29)	41	(80)		
Total	12	(23)	51	(100)		

Objective Acculturation and Family Planning

Decision-Making

The process by which family planning decisions are made may influence perceptions of need and use of family planning services. Respondents were asked a series of questions regarding how family planning decisions are made in their homes. These results were cross-tabulated with the objective acculturation variables described above.

Length of Time in the U.S.

Overall, approximately equal numbers of respondents from the core sample of married women felt that family planning decisions were made by themselves ("self") or by themselves and their spouse together ("self and spouse"). Few suggested that their spouse made all the decisions. An examination of time in the U.S. and its relationship with who makes family planning decisions showed slightly more sharing of decision-making roles among more recent refugees (Table 37). Of those living in the U.S. less than three months, 15 women (71%) indicated joint decision-making compared to nine women (50%) with 3-10 months of residence and two respondents (20%) with 1-4 years of residency who stated that self and spouse made decisions. Decision-making by self alone was slightly greater for women who had lived in the U.S. for five or more years ($n=7$, 78%).

A similar pattern emerged in response to the question "Who decides on

TABLE 37

Length of Time in the U.S. and Who Makes
Family Planning Decisions

Time	Decision-Maker						Total	
	Self <u>n</u>	(%)	Spouse <u>n</u>	(%)	Self & Spouse <u>n</u>	(%)		
< 3 mos.	6	(29)			15	(71)	21	(36)
3 - 11	7	(39)	2	(11)	9	(50)	18	(31)
1 - 4 yrs.	6	(40)	4	(40)	2	(20)	10	(17)
≥ 5 yrs.	7	(78)	1	(11)	1	(11)	9	(16)
Total	24	(41)	7	(12)	27	(47)	58	(100)

TABLE 38

Length of Time in the U.S. and Who Decides on
the Number of Children

Time	Decision-Maker						Total	
	Self <u>n</u>	(%)	Spouse <u>n</u>	(%)	Self & Spouse <u>n</u>	(%)		
< 3 mos.	6	(29)			15	(71)	21	(37)
3 - 11	8	(47)	1	(6)	8	(47)	17	(30)
1 - 4 yrs.	4	(40)	3	(30)	3	(30)	10	(18)
≥ 5 yrs.	7	(78)	1	(11)	1	(11)	9	(16)
Total	25	(44)	5	(9)	27	(47)	57	(100)

how many children to have?." Among the most recent refugees (less than 3 months residence), 15 respondents (71%) said self and spouse made this decision. For those with 3-10 months of residence, eight women (47%) involved both self and spouse. As time increased to up to four years, only three women (30%) stated that both self and spouse made the decision (Table 38).

Results showed greater variability for the question of "Who decides when to start having children?." Overall, 30 women (59%) felt that self and spouse were involved in making this decision compared to 17 respondents (33%) who stated "self" as the decision-maker. Again, it appears that more recent refugees relied on both self and spouse to make family planning decisions (Table 39). Among those with less than three months of residency, 13 women (77%) relied on both self and spouse compared to one woman who had lived in the U.S. five or more years (11%) indicating joint involvement.

Age

Age appears to have little association with the process by which family planning decisions were made (Table 40). Forty-three percent of the women under 30 years of age said self and self and spouse made family planning decisions. This same pattern was repeated for women age 30-39 with slightly more older women relying on both self and spouse for decision-making ($n=9$, 56%).

TABLE 39

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Length of Time in the U.S. and Who Decides When to Start Having Children

Time	Decision-Maker							
	Self <u>n</u>	(%)	Spouse <u>n</u>	(%)	Self & Spouse <u>n</u>	(%)	Total <u>n</u>	(%)
< 3 mos.	16	(6)	3	(18)	13	(77)	17	(33)
3 - 11	3	(20)			12	(80)	15	(29)
1 - 4 yrs.	6	(60)			4	(40)	10	(20)
≥ 5 yrs.	7	(78)	1	(11)	1	(11)	9	(18)
Total	17	(33)	4	(8)	30	(59)	51	(100)

TABLE 40

Age and Who Makes Family Planning Decisions

Age	Decision-Maker							
	Self <u>n</u>	(%)	Spouse <u>n</u>	(%)	Self & Spouse <u>n</u>	(%)	Total <u>n</u>	(%)
Under 30	6	(43)	2	(14)	6	(43)	14	(24)
30 - 39	12	(43)	4	(14)	12	(43)	28	(48)
≥ 40 years	6	(38)	1	(6)	9	(56)	16	(28)
Total	24	(41)	7	(12)	27	(47)	58	(100)

Education

Analysis of education level and decision-making roles showed greater tendencies toward "self" as the primary decision-maker for respondents with less education and "self and spouse" for those with higher level education.

As mentioned previously, all of the married women respondents had at least an elementary or a high school level education. None of the core sample respondents pursued education beyond high school. In answer to the question, "Who makes family planning decisions?," 16 respondents with elementary level education (55%) indicated "self" as the decision-maker compared to seven respondents with high school education (27%) who made the same response (Table 41). The pattern is reversed for the "self and spouse" group. Of those with elementary education, six women (21%) stated "self and spouse" as joint decision-makers, while this same response was made by 19 women (73%) with high school education. These results attained statistical significance at $p < .001$. The same pattern emerged for succeeding questions concerning decision-making roles at a significance level of $p < .001$.

Ability to Read and Write Own Language

Although less striking, analysis of respondents' ability to read and write their own language and decision-making found similar relationships as those associated with the education variable. In general, most of the women could read and write their own language "well" or "very well" ($n=42$, 72%), so that

TABLE 41

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Education and Who Makes Family Planning Decisions

Education	Self		Spouse		Decision-Maker Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Elementary	16	(55)	7	(24)	6	(21)	29	(53)
High School	7	(27)			19	(73)	26	(47)
Total	23	(41)	7	(13)	25	(46)	55	(100)

TABLE 42

Ability to Read/Write Own Language andWho Makes Family Planning Decisions

Ability	Self		Spouse		Decision-Maker Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very well	5	(24)	1	(5)	15	(11)	21	(36)
Well	10	(48)	1	(5)	10	(48)	21	(36)
Not well	9	(56)	5	(31)	2	(13)	16	(28)
Total	24	(41)	7	(12)	27	(47)	58	(100)

results were skewed in this direction. When asked, "Who makes family planning decisions?," 15 women (36%) of those most knowledgeable about their own language made their own decisions compared to nine women (56%) who could not read and write their own language well (Table 42). In contrast, 25 respondents who could read and write at least "well" (59%) said self and spouse were involved. A joint effort was made by only two respondents not able to read and write their own language well (13%). These results were consistent for other decision-making questions.

Prior Family Planning Education

The presence or absence of prior family planning education bore little relationship to how family planning decisions are made. Table 43 shows that among those who had prior family planning education, 25% relied on self as the decision-maker; 33% relied on their spouse; and 42% chose to involve both self and spouse in making family planning decisions. For the question of "Who decides to use birth control?," slightly fewer women indicated that spouse alone made this decision ($n=2$, 17%) (Table 44). Overall, prior family planning education was not significantly related to decision-making roles.

Objective Acculturation and Family Planning Needs

Questions were asked about respondents' need for and interest in family planning information. Interest in birth control information was cited by most

TABLE 43

Prior Family Planning Education and
Who Makes Family Planning Decisions

Education	Decision-Maker				Total <u>n</u> (%)	
	Self <u>n</u> (%)	Spouse <u>n</u> (%)	Self and Spouse <u>n</u> (%)			
Yes	16 (55)	7 (24)	6 (21)		29 (53)	
No	7 (27)		19 (73)		26 (47)	
Total	23 (41)	7 (13)	25 (46)		55 (100)	

TABLE 44

Prior Family Planning Education and
Who Decides to Use Birth Control

Education	Decision-Maker				Total <u>n</u> (%)	
	Self <u>n</u> (%)	Spouse <u>n</u> (%)	Self and Spouse <u>n</u> (%)			
Yes	5 (42)	2 (17)	5 (42)		12 (21)	
No	21 (47)	3 (7)	21 (47)		45 (79)	
Total	26 (46)	5 (9)	26 (46)		57 (100)	

of the women (85%). Of this group, 20 women (95%) had less than three months residence time. Overall, length of time in the U.S. did not have any direct association with type of family planning information needed (Table 45).

Similarly, age cross-tabulated with family planning needs failed to show any apparent differences except that the age group, 30-39, expressed interest in most family planning issues except men's health information (Table 46).

Education levels showed no direct relationship to family planning issues with the exception of information on sexually transmitted diseases (STDs). Although fewer respondents in general wanted STD information, most of the interest came from those with elementary education (55%) as opposed to two respondents with high school education (7%) who wanted STD information (Table 47).

An analysis of respondents' ability to read and write their own language and family planning needs again failed to find any significant differences (Table 48). Birth control information was needed by 37 women who could read and write their own language "well" or "very well." A large percentage of respondents not able to read and write their own language well wanted birth control and STD information (75%).

Table 49 shows the relationship between respondents' prior family planning education and family planning needs. No significant differences emerged. Eleven women (92%) who had prior family planning education and

Length of Time in the U.S. and Family Planning Needs¹

Time	Needs			
	Birth Control <u>n</u>	(%)	STDs <u>n</u>	(%)
< 3 months	20	(95)	2	(10)
3 - 11 months	16	(89)	3	(17)
1 - 4 years	7	(70)	6	(60)
≥ 5 years	6	(67)	8	(89)
Total	49	(84)	19	(33)

	Women's Health <u>n</u>	(%)	Men's Health <u>n</u>	(%)	Total <u>n</u>	(%)
< 3 months	13	(62)	3	(14)	21	(36)
3 - 11 months	10	(56)	1	(6)	18	(37)
1 - 4 years	4	(40)			10	(17)
≥ 5 years	4	(44)	1	(11)	9	(16)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 46

Age and Family Planning Needs¹

Age	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Under 30	12	(86)	6	(43)
30 - 39 years	25	(89)	11	(39)
≥ 40 years	12	(75)	2	(13)
Total	49	(84)	19	(33)

Age	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Under 30	3	(21)	2	(14)	14	(24)
30 - 39 years	18	(64)	1	(4)	28	(48)
≥ 40 years	10	(63)	2	(13)	16	(28)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 47

Education and Family Planning Needs¹

Education	Needs			
	Birth Control <u>n</u>	(%)	STDs <u>n</u>	(%)
Elementary	24	(83)	16	(55)
High School	23	(89)	2	(8)
Total	47	(86)	18	(33)

	Women's Health <u>n</u>	(%)	Men's Health <u>n</u>	(%)	Total <u>n</u>	(%)
Elementary	15	(52)			29	(53)
High School	16	(62)	5	(19)	26	(47)
Total	31	(56)	5	(9)	55	(100)

¹ Respondents were able to select more than one information type.

TABLE 48

Ability to Read/Write Own Language and
Family Planning Needs¹

Ability	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very well	17	(81)	4	(19)
Well	20	(95)	3	(14)
Not well	12	(75)	12	(75)
Total	49	(85)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very well	14	(67)	5	(24)	21	(36)
Well	8	(38)			21	(36)
Not well	9	(56)			16	(28)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 49

Prior Family Planning Education and Family Planning Needs¹

Education	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Yes	111	(92)	4	(33)
No	38	(83)	15	(33)
Total	49	(85)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Yes	5	(42)	2	(17)	12	(21)
No	26	(57)	3	(7)	46	(79)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

38 women (80%) who had no previous education wanted birth control information. The need for other family planning information did not vary significantly between the two groups.

In summary, objective acculturation variables did not appear to be associated with family planning needs.

Subjective Acculturation and Birth Control Practice

Subjective acculturation variables include perceived levels of difficulty with the following issues: understanding the American way of life, English language, adapting to a new environment, dealing with community agencies, getting transportation, getting medical help, and finding resources.

Analysis of perceptions of the American way of life and birth control practice revealed insignificant differences among variables such as frequency of birth control practice and method of birth control used.

Difficulty with the English language bore no relationship with birth control practice indicators with the exception of birth control method. Table 50 illustrates the relationship between level of difficulty and method of birth control used. All of the core sample of married women had either "somewhat serious" or "very serious" difficulty with the English language. Among respondents with "somewhat serious" difficulties, condom and foam was the most commonly used form of birth control ($n=6$, 50%). No one in this group

TABLE 50

Difficulty with English Language and Birth Control Method

Difficulty	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	2	(5)	7	(18)	3	(7)
Somewhat serious	1	(8)			1	(8)
Total	3	(6)	7	(14)	4	(8)
	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	17	(43)	1	(3)		
Somewhat serious			6	(50)	1	(8)
Total	17	(33)	7	(14)	1	(2)
	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
Very serious	9	(23)	39	(76)		
Somewhat serious	3	(25)	12	(24)		
Total	12	(23)	51	(100)		

chose condoms alone. Among those expressing "very serious" difficulty with the English language, 17 women (43%) chose condoms alone and only one woman (3%) selected condom and foam. In addition, all of the women who used the IUD had "very serious" problems with the English language ($n=7$, 18%).

Analysis of difficulty in adapting to a new environment with birth control practice suggest some relationship between levels of difficulty and practice of unprotected sex and frequency of birth control use.

Overall, most respondents had "somewhat serious" or "very serious" problems adapting to a new environment ($n=52$, 90%) (Table 51). Only six women (10%) felt they were not seriously affected by this issue. Among those who did not want to become pregnant, 16 women who felt they had "very serious" difficulties (64%) were engaging in unprotected sex. Only five women who had "somewhat serious" difficulties (31%) were engaging in unprotected sex. Results indicate a trend towards greater practice of unprotected sex for those experiencing greater difficulty in adapting to a new environment.

This adaptation issue also showed some differences when cross-tabulated with frequency of birth control use. Table 52 shows a trend toward less frequency of use with increasing level of difficulty. In this analysis, 15 respondents who had "somewhat serious" difficulty with a new environment (71%) practiced birth control "always" or "sometimes." The number of

TABLE 51

Difficulty in Adapting to a New Environment and Occurrence
of Unprotected Sex Among Respondents not Intending
Pregnancy¹

Difficulty	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	16	(64)	9	(36)	25	(56)
Somewhat serious	5	(31)	11	(69)	16	(36)
Not serious	2	(50)	2	(50)	4	(8)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

TABLE 52

Difficulty in Adapting to a New Environment and
Frequency of Birth Control Use

Difficulty	Frequency				¹ NA		Total	
	Always/ Sometimes		Rarely/ Never					
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	11	(35)	14	(45)	6	(19)	31	(53)
Somewhat serious	15	(71)	5	(24)	1	(5)	21	(36)
Not serious	3	(50)	3	(56)			6	(10)
Total	29	(50)	22	(38)	7	(12)	58	(100)

¹ NA denotes no answer.

respondents at this frequency drops to 11 women (35%) when level of difficulty increases to "very serious." At the same time, the percentage of women who "rarely" or "never" practice birth control increased from 24% to 45% with an increase in difficulty.

Difficulty in dealing with community agencies varied only with the practice indicator of unprotected sex. Among the 45 women not wanting pregnancy, eight women experiencing "somewhat serious" difficulty (38%) were engaging in unprotected sex compared to 14 women having "very serious" difficulty (66%) engaging in this practice (Table 53). Results show a tendency towards unprotected sex with increasing difficulty in dealing with community agencies.

Analysis of transportation difficulties failed to show any relationship with birth control practice. As with the acculturation variable of community agencies, the issue of getting medical help appears to have some relationship with the practice of unprotected sex (Table 54). Among those not wanting pregnancy, the percentage of women who engage in unprotected sex increases from 33% to 64% as level of difficulty increases from "somewhat serious" to "very serious" respectively. Data suggest that more respondents who felt unable to get medical help were engaging in unprotected sex than others with less difficulty.

The final variable, finding resources, also exhibited some relationship

TABLE 53

Difficulty in Dealing With Community Agencies and Occurrence
of Unprotected Sex Among Respondents not Intending
Pregnancy¹

Difficulty	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	14	(66)	7	(34)	21	(47)
Somewhat serious	8	(38)	13	(62)	21	(47)
Not serious	1	(33)	2	(67)	3	(6)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

TABLE 54

Difficulty in Getting Medical Help and Occurrence of
Unprotected Sex Among Respondents not Intending Pregnancy¹

Difficulty	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	14	(64)	8	(36)	22	(49)
Somewhat serious	7	(33)	14	(67)	21	(47)
Not serious	2	(50)			2	(4)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

with birth control practice indicators. Table 55 displays the relationship between level of difficulty in finding resources with the indicator, unprotected sex. Results show a similar pattern of increased practice of unprotected sex with increasing level of difficulty. This analysis revealed a percentage increase of 38% to 68% among respondents who were having unprotected sex when level of difficulty increased from "somewhat" to "very" serious difficulty in finding resources.

Table 56 shows an increase in the percentage of women using condoms from 19% to 50% as level of difficulty increases from "somewhat serious" to "very serious." More women who have "very serious" difficulty finding resources chose to use the IUD ($n=5$, 21%) than women who experience "somewhat serious" difficulties ($n=2$, 71%).

In summary, most of the subjective acculturation variables were related to unprotected sex. Two of the variables, English language and finding resources were shown to have some relationship with birth control methods. The issue of adapting to a new environment was also related to frequency of birth control use. No striking relationships were found for two variables, adjusting to the American way of life and transportation.

TABLE 55

Difficulty in Finding Resources and Occurrence of
Unprotected Sex Among Respondents not Intending Pregnancy¹

Difficulty	Occurrence					
	Unprotected Sex		² Other		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	13	(68)	6	(32)	19	(42)
Somewhat serious	10	(38)	16	(62)	26	(58)
Total	23	(51)	22	(49)	45	(100)

¹ Includes only those respondents who said that they did not want to become pregnant.

² Other denotes protected sex or no response.

TABLE 56

Difficulty in Finding Resources and Birth Control Method

Difficulty	Method					
	Birth Control Pill		IUD		Rhythm Method	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	1	(4)	5	(21)		
Somewhat serious	2	(7)	2	(7)	3	(11)
Not serious					1	(100)
Total	3	(6)	7	(14)	4	(8)
	Condoms		Condom & Foam		Tubal Ligation	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	12	(50)				
Somewhat serious	5	(19)	7	(26)	1	(4)
Not serious						
Total	17	(33)	7	(14)	1	(2)
	None		Total			
	<u>n</u>	(%)	<u>n</u>	(%)		
Very serious	5	(21)	23	(45)		
Somewhat serious	7	(26)	27	(53)		
Not serious			1	(2)		
Total	12	(23)	51	(100)		

Subjective Acculturation and Family Planning

Decision-Making

The relationship of how family planning decisions are made and subjective acculturation variables was analyzed. Analysis of difficulty in adjusting to the American way of life and family planning decision-making revealed several interesting relationships. Data show more reliance on self and spouse in making family planning decisions as adjustment difficulty increases. Results displayed in Table 57 show a marked increase of "self and spouse" decision-making from 27% to 59% as level of difficulty rose from "somewhat serious" to "very serious." Conversely, the reliance on "self" alone decreased as difficulty decreased from 53% to 31% respectively.

A similar pattern of increased "self and spouse" decision-making is seen with the question of "Who decides on the number of children to have?" As shown in Table 58, four women (27%) who expressed "somewhat serious" problems adjusting to the American way of life relied on self and spouse to decide how many children to have. As difficulty increased to the "very serious" level, there was a proportional increase in the number of "self and spouse" decision-makers ($n=23$, 61%).

The last key finding associated with the American way of life involves the question of "Who decides to use birth control?" Table 59 shows that among women who had "somewhat serious" difficulty with this issue, 29%

TABLE 57

Difficulty in Adjusting to the American Way of Life
and Who Makes Family Planning Decisions

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	12	(31)	4	(10)	23	(59)	39	(70)
Somewhat serious	8	(53)	3	(20)	4	(27)	15	(27)
Not serious	2	(100)					2	(3)
Total	22	(39)	7	(13)	27	(48)	56	(100)

TABLE 58

Difficulty in Adjusting to the American Way of Life
and Who Decides on the Number of Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	13	(34)	2	(5)	23	(61)	38	(69)
Somewhat serious	8	(53)	3	(20)	4	(27)	15	(27)
Not serious	2	(100)					2	(4)
Total	23	(42)	5	(9)	27	(49)	55	(100)

TABLE 59

Difficulty in Adjusting to the American Way of Life
and Who Decides to Use Birth Control

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	15	(39)	2	(5)	22	(56)	39	(71)
Somewhat serious	7	(50)	3	(21)	4	(29)	14	(26)
Not serious	2	(100)					2	(4)
Total	24	(44)	5	(9)	26	(47)	55	(100)

stated that this decision was made by self and spouse; 50% relied on self alone. As the level of difficulty increases from "somewhat serious" to "very serious," there is a resultant decrease in "self" decision-making ($\underline{n}=15$, 39%) and an increase in "self and spouse" decision-making ($\underline{n}=22$, 56%).

Associations between problems with the English language and decision-making mirrored previous discussions concerning the American way of life. In general, more respondents reported "very serious" language problems ($\underline{n}=44$, 76%) than they did difficulty adjusting to the American way of life. In answer to the question, "Who makes family planning decisions?," reliance on self and spouse decision-making increased from 8% to 59% for those "somewhat seriously" and "very seriously" affected (Table 60).

As shown in Tables 61-63, similar patterns emerge for the questions, "Who decides on the number of children?," "Who decides when to start having children?," and "Who decides to use birth control?" Data suggest that increasing level of difficulty is associated with greater reliance on "self and spouse" decision-making. Each of these relationships approached statistical significance.

The issue of adapting to a new environment exhibited some association with the question of "Who decides when to start having children?." In general, more respondents relied on "self and spouse" ($\underline{n}=30$, 59%) than "self" alone ($\underline{n}=17$, 33%). Among those stating "self and spouse" decision-making, there

TABLE 60

Difficulty with the English Language and
Who Makes Family Planning Decisions

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	14	(32)	4	(9)	26	(59)	44	(76)
Somewhat serious	9	(69)	3	(23)	1	(8)	13	(22)
Not serious	1	(100)					1	(2)
<hr/>								
Total	24	(41)	7	(12)	27	(47)	58	(100)

TABLE 61

Difficulty with the English Language and
Who Decides on the Number of Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	15	(35)	2	(5)	26	(61)	43	(75)
Somewhat serious	9	(69)	3	(23)	1	(8)	13	(23)
Not serious	1	(100)					1	(2)
Total	25	(44)	5	(9)	27	(47)	57	(100)

TABLE 62

Difficulty with the English Language and
Who Decides When to Start Having Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	6	(16)	4	(11)	27	(73)	37	(72)
Somewhat serious	10	(77)			3	(23)	13	(26)
Not serious	1	(100)					1	(2)
Total	17	(33)	4	(8)	30	(59)	51	(100)

TABLE 63

Difficulty with the English Language and
Who Decides to Use Birth Control

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	17	(40)	2	(5)	24	(56)	43	(75)
Somewhat serious	8	(62)	3	(23)	2	(15)	13	(23)
Not serious	1	(100)					1	(2)
Total	26	(46)	5	(9)	26	(46)	57	(100)

was a slight decrease in the percentage of women as difficulty increased; 67% to 58% respectively. There was also a decline in the percentage of women in the "self" decision-making group from 33% to 25%. This pattern reversal may have been attributed to the increase in the number of respondents who reported no serious problems (Table 64).

The remaining four acculturation variables, dealing with community agencies, getting transportation, getting medical help, and finding resources, each showed an association with one question, "Who decides when to start having children?" Tables 65-68 illustrate each of these relationships. Results indicate a general tendency towards more "self and spouse" decision-making with increase in the perceived level of difficulty among acculturation issues.

In summary, the issue of who decides when to start having children appears to have common relationships among all the subjective acculturation variables. Difficulty with adjusting to the American way of life and with the English language bore statistically significant relationships with a number of family planning decisions including how many children to have, who decides to use birth control, who makes family planning decisions as well as when to start having children. Each of these indicate a general inclination toward greater "self and spouse" involvement as level of difficulty increases.

TABLE 64

Difficulty with Adapting to a New Environment and
Who Decides When to Start Having Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	6	(25)	4	(17)	14	(58)	24	(47)
Somewhat serious	7	(33)			14	(67)	21	(41)
Not serious	4	(67)			2	(33)	6	(12)
<hr/>								
Total	17	(33)	4	(8)	30	(59)	51	(100)

TABLE 65

Difficulty in Dealing with Community Agencies
and Who Decides When to Start Having Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	3	(17)	4	(22)	11	(61)	18	(35)
Somewhat serious	11	(39)			17	(61)	28	(55)
Not serious	3	(60)			2	(40)	5	(10)
Total	17	(33)	4	(8)	30	(59)	51	(100)

TABLE 66

Difficulty Getting Transportation and Who
Decides When to Start Having Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	6	(25)	4	(17)	14	(58)	24	(47)
Somewhat serious	10	(40)			15	(60)	25	(49)
Not serious	1	(50)			1	(50)	2	(4)
Total	17	(33)	4	(8)	30	(59)	51	(100)

TABLE 67

Difficulty Getting Medical Help and Who
Decides When to Start Having Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	4	(20)	4	(20)	12	(60)	20	(39)
Somewhat serious	12	(44)			15	(56)	27	(53)
Not serious	1	(25)			3	(75)	4	(8)
Total	17	(33)	4	(8)	30	(59)	51	(100)

TABLE 68

Difficulty Finding Resources and Who Decides
When to Start Having Children

Difficulty	Decision-Maker							
	Self		Spouse		Self and Spouse		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	3	(16)	3	(16)	13	(68)	19	(37)
Somewhat serious	13	(43)	1	(3)	16	(53)	30	(59)
Not serious	1	(50)			1	(50)	2	(4)
Total	17	(33)	4	(8)	30	(59)	51	(100)

Subjective Acculturation and Family Planning Needs

Data shows few significant differences between family planning needs and level of difficulty among subjective acculturation issues. More women were interested in birth control information than all other family planning information. For all acculturation variables, most of the need for birth control information came from respondents who were "very seriously" affected by the particular issue. Among those experiencing "somewhat serious" problems, information on STDs was most needed. Tables 69-75 illustrate the family planning needs for each acculturation variable.

Ethnicity

Ethnicity may have played a key role in determining many of the relationships found in birth control practice and family planning decision-making. Overall, the core sample of married women were found to be predominately Vietnamese ($n=36$, 62%). Fourteen were Cambodian (24%) and seven (14%) were Laotian or Other. The Vietnamese appear to be a somewhat homogeneous group, despite the small sample size. Data describing ethnic group characteristics is shown in Table 5.

In general, the Vietnamese sub-sample showed the following characteristics: more recent immigration (67% with less than one year residence), higher education (all with high school education), and older, with

Difficulty in Adjusting to the American Way of Life
and Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	36	(92)	5	(13)
Somewhat serious	10	(67)	11	(73)
Not serious	1	(50)	2	(100)
Total	47	(84)	18	(32)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	22	(56)	4	(10)	39	(70)
Somewhat serious	7	(47)	1	(7)	15	(27)
Not serious	1	(50)			2	(4)
Total	30	(54)	5	(9)	56	(100)

¹ Respondents were able to select more than one information type.

TABLE 70

Difficulty with the English Language and
Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	41	(93)	7	(16)
Somewhat serious	7	(54)	11	(85)
Not serious	1	(100)	1	(100)
Total	49	(84)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	23	(52)	4	(9)	44	(76)
Somewhat serious	8	(62)	1	(8)	13	(22)
Not serious					1	(2)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 71

Difficulty in Adapting to a New Environment and
Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	29	(94)	5	(16)
Somewhat serious	17	(81)	9	(43)
Not serious	3	(50)	5	(83)
Total	49	(84)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	15	(48)			31	(53)
Somewhat serious	13	(62)	4	(19)	21	(36)
Not serious	3	(50)	1	(17)	6	(10)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 72

Difficulty in Dealing with Community Agencies
and Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	23	(92)	2	(8)
Somewhat serious	22	(79)	13	(46)
Not serious	4	(80)	4	(80)
Total	49	(84)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	11	(44)			25	(43)
Somewhat serious	19	(68)	4	(14)	28	(48)
Not serious	1	(20)	1	(20)	5	(9)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 73

Difficulty Getting Transportation and Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	27	(93)	6	(21)
Somewhat serious	21	(78)	11	(41)
Not serious	1	(50)	2	(100)
Total	49	(84)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	11	(38)			29	(50)
Somewhat serious	19	(70)	4	(15)	27	(47)
Not serious	1	(50)	1	(50)	2	(3)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 74

Difficulty Getting Medical Help and Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	26	(96)	3	(11)
Somewhat serious	21	(78)	14	(52)
Not serious	2	(50)	2	(50)
Total	49	(84)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	13	(48)			27	(47)
Somewhat serious	16	(59)	4	(15)	27	(47)
Not serious	2	(50)	1	(25)	4	(7)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

TABLE 75

Difficulty Finding Resources and Family Planning Needs¹

Difficulty	Needs			
	Birth Control		STDs	
	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	23	(96)	2	(8)
Somewhat serious	25	(78)	15	(47)
Not serious	1	(50)	2	(100)
Total	49	(84)	19	(33)

	Women's Health		Men's Health		Total	
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	11	(46)	1	(4)	24	(41)
Somewhat serious	19	(59)	3	(9)	32	(55)
Not serious	1	(50)	1	(50)	2	(3)
Total	31	(53)	5	(9)	58	(100)

¹ Respondents were able to select more than one information type.

over half above 30 years of age ($n=30$, 68%).

This sub-sample showed significant differences in birth control practice. Analysis of ethnicity and frequency of birth control practice found that Vietnamese are more likely to practice birth control. Table 76 shows that among the 29 women who "always" or "sometimes" practiced birth control, 19 (66%) were Vietnamese while only six (21%) were Cambodian and four (13%) were Laotian or Other. Of those who "never" practice birth control, three (25%) were Vietnamese and seven (58%) were Cambodian. These results, controlled for time in residence, substantiate the findings suggesting that higher acculturation is related to increased contraceptive practice.

The Vietnamese sub-sample also displayed marked differences in how family planning decisions are made. Table 77 illustrates the relationship between ethnicity and who makes family planning decisions. Results show that the Vietnamese display mostly "self and spouse" decision-making ($n=25$, 93%) while Cambodians rely more on "self" only decision-making ($n=11$, 44%). None of the Cambodian women reported "self and spouse" decision-making. The same pattern emerges with the question of "Who decides how many children to have?" (Table 78). These findings suggest that the relationship between previous results describing increased "self and spouse" decision-making and increased time in residence and education may be actually a function of ethnicity more than anything else.

TABLE 76

Ethnicity and Frequency of Birth Control Use

Frequency	Ethnicity						Total <u>n</u> (%)	
	Vietnamese		Cambodian		Laotian/ Other			
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)		
Always	3	(38)	4	(50)	1	(13)	8	(16)
Sometimes	16	(76)	2	(10)	3	(14)	21	(42)
Rarely	7	(78)	1	(11)	1	(11)	9	(18)
Never	3	(25)	7	(58)	2	(17)	12	(24)
Total	29	(62)	14	(24)	7	(13)	50	(100)

TABLE 77

Ethnicity and Who Makes Family Planning Decisions

Decision-Maker	Ethnicity						Total	
	Vietnamese		Cambodian		Laotian/ Other			
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Self	11	(48)	11	(48)	1	(14)	23	(40)
Spouse			3	(43)	4	(57)	7	(13)
Self/Spouse	25	(93)			2	(7)	27	(47)
Total	36	(63)	14	(25)	7	(12)	57	(100)

TABLE 78

Ethnicity and Who Decides on the Number of Children

Decision-Maker	Ethnicity						Total	
	Vietnamese		Cambodian		Laotian/ Other			
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Self	12	(50)	11	(46)	1	(4)	24	(43)
Spouse			3	(60)	2	(40)	5	(9)
Self/Spouse	24	(89)			3	(11)	27	(48)
Total	36	(64)	14	(25)	6	(11)	56	(100)

To explore the notion that time plays a role in perceived level of difficulty in adjustment, analysis was done on ethnicity and the subjective acculturation variables. For difficulty in adjusting to the American way of life, 32 of the 38 women (84%) who had "very serious" difficulty in adjusting were Vietnamese compared to only six (16%) who were Cambodian or Other. Concurrently, all of the Cambodian respondents stated they had no serious problems with adjusting to the American way of life ($n=2$, 100%) (Table 79). The same pattern emerges with succeeding issues. Earlier results found that Vietnamese respondents were of more recent immigration. This finding combined with the sample's increased sense of difficulty supports the association between shorter residence time with more difficulty in acculturation.

In summary, ethnicity appears to play a major role in the associations found between acculturation (both objective and subjective) and birth control practice and decision-making.

Overall Summary

The core sample of married women represent primarily Vietnamese women age 30-39 who had less than one year of residence in the United States. A review of education levels revealed higher education among the more recent refugees. There was a high percentage of the core sample who did not want

TABLE 79

Ethnicity and Difficulty Adjusting to the American
Way of Life

Decision-Maker	Ethnicity						Total	
	Vietnamese		Cambodian		Laotian/ Other			
	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)	<u>n</u>	(%)
Very serious	32	(84)	3	(8)	3	(84)	38	(69)
Somewhat serious	3	(20)	8	(53)	4	(27)	15	(27)
Not serious			2	(100)			2	(4)
Total	35	(64)	13	(24)	7	(13)	55	(100)

to become pregnant but were, nevertheless, engaging in unprotected sex.

Analysis of subjective acculturation suggests some association between birth control practice and family planning decision-making. A relatively high percentage of respondents reported that they make family planning decisions on their own. As the level of acculturation increases, data suggest that more self and spouse decision-making occurs. Greater difficulty in acculturation, such as adjusting to the American way of life, appears related to greater joint involvement in family planning decision-making.

Neither objective nor subjective acculturation variables showed significant association with family planning needs; however, respondents expressed considerable interest in birth control information.

A review of ethnic differences showed that Vietnamese respondents tended to be older, had lived in the United States for a shorter period of time, and had at least a high school education. The Cambodian and Other Southeast Asian ethnic groups were, in general, younger, had lived in the United States for a longer period of time, and reported having only an elementary level education. Vietnamese respondents appeared to practice birth control more often and employed greater self and spouse decision-making.

CHAPTER 5

DISCUSSION

This study was designed to assess the family planning knowledge and information needs of Southeast Asian refugees in Santa Clara County. The research explored contraceptive practice and various psychosocial factors related to family planning. In addition, Southeast Asian utilization of family planning services was explored.

The study was prompted by the concerns of Santa Clara County health providers regarding the delivery of family planning services to the Southeast Asian community. The research process was intentionally designed to involve these providers in order to make the resulting information useful and relevant to their needs. County staff were involved at each phase of the research including selection of the research questions, sampling protocol, design of the research instrument, and actual data collection.

Data collection was conducted in County clinic sites by bilingual staff from the Refugee Health Services Program under often hectic conditions. Staffing within the clinics generally is comprised of clinic nurses, one physician, and various community health workers and support staff. Some health educators and bilingual staff were "shared" by other departments. Therefore, staff members (serving as interviewers) were often called to one or

two different clinics in the same day depending on clinic schedules.

Depending on the nature of the visit and clinic staffing, clients normally could expect to be at the clinic for 30 minutes to an hour. In order to interview clients for this study, the appointment time was usually extended for an average of 20 minutes.

Amidst the busy schedules and limited staff resources, data collection was initiated and research objectives were met albeit with only the core sample of married women. Key findings related to each of the original objectives are described below.

Objective 1: Assess Family Planning Knowledge and Needs

The assessment of family planning knowledge and needs showed consistent relationships between knowledge and actual birth control practice. Most of the core sample had not attended a family planning class. This was reasonable in light of the sample's recent immigration characteristics. Among women with previous family planning education, more were practicing birth control and with greater frequency. These results were substantiated by findings that showed fewer women who had attended a family planning class were engaging in unprotected sex.

While family planning education had a positive influence on birth control practice, it did not necessarily change the type of birth control used.

Condoms were used by most women regardless of previous family planning education. This choice is understandable given the respondents' lack of knowledge about other methods and the ease with which condoms can be obtained. Similar arguments can be made for this choice among those with prior family planning education. In addition, education about the condom's ability to prevent sexually transmitted diseases provides further justification for its use over other methods.

Overall, for the sub-sample of married women, birth control information was needed by most respondents regardless of previous family planning education. Information on women's health and sexually transmitted diseases was also needed but by fewer respondents. The lack of variability between those who had previous family planning knowledge and those who had no prior family planning education may be due in part to respondents' need for changes in birth control method. In addition, the content of previous family planning education may have been insufficient.

It is important to note that in the process of inquiring about respondents' family size, the question "How many children do you plan to have?" was left unanswered by 37 respondents from the total study sample (34%). This was initially attributed to interviewer negligence. However, interviewers were questioned in retrospect about these missing frequencies and the consensus was that they had left the questions blank because respondents

had no answer. This suggests that regardless of what respondents knew about family planning, it did not include deciding in advance how many children to have.

Objective 2: Explore the Psychosocial Factors

Relevant to Family Planning Needs

Acculturation indicators of residence time, education, ability to read and write in their own language, as well as the previously mentioned prior family planning education, all showed interesting relationships with birth control practice.

There was a surprisingly high percentage of recent refugees in the sample who had less than three months residency. In addition, this group was comprised of mostly Vietnamese refugees who were older and had more education. Knowing this prior to data collection might have changed the way the survey was conducted.

As expected, birth control practice increased as years of residency increased. It appears that more education and exposure to Western health care may be associated with perceived need for smaller families and sense of family planning.

Overall, frequency of birth control use was greater among women with higher levels of education. However, surprising results were obtained from

the analysis of ability to read and write one's own language and birth control practice. There was a greater desire to become pregnant, substantiated by a greater number having unprotected sex, among women more educated in their own language.

Family planning decision-making also appears to be related to acculturation. Increased education, ability to read and write own language, and prior exposure to family planning services were all associated with greater "self and spouse" decision-making. Length of residence time also bore this relationship once ethnicity was factored in.

A greater reliance on self and spouse decision-making necessarily involves increased knowledge of family planning issues, more communication between individuals, and greater sharing of information. Acculturation through time and education enhances these abilities and may, thereby, influence the decision-making process.

The presence or absence of prior family planning education had little influence on how family planning decisions were made. Respondents were divided between making decisions themselves or with their spouse.

Adjusting to the American way of life and language problems represented major concerns for the core sample of married women. These issues require significant mental as well as physical adjustment and represent more personal issues for the refugee. These issues impact a greater number of

decision-making issues, such as use of birth control and number of children to have. Consequently, it is understandable and almost expected that these decisions would involve more "self and spouse" decisions as respondents experience greater levels of difficulty.

Objective 3: Explore Southeast Asian Utilization Patterns

Most of the respondents stated that they had no formal source for medical care or family planning information. For those with a source, County clinics were selected by approximately one-third of the sub-sample as their source of health care and family planning services. These results substantiate claims that County services are often the first and/or only source of health care for many refugees. This reaffirms the need for health care providers, particularly in the County setting, to be aware of cultural differences in health behavior and practice.

Respondents' choice for sources of family planning services is influenced by their ability to access these services. Of all the subjective acculturation variables, English language was very problematic for 76% of the core sample. This was followed closely by difficulty in adjusting to the American way of life. These same issues were found to be associated with a number of family planning decisions. Perhaps in order to cope with these problems and make reasonable decisions, the married women may involve

their spouses in the decision-making process. This pattern was consistent with traditional Southeast Asian cultural norms that involve the family, the male authority figure in particular, in making important decisions.

Objective 4: Generate Data to be Used in Planning
and Evaluation of County Health Services

This objective was accomplished through incorporation of a research process designed in conjunction with key providers from the Santa Clara County Health Department. An Advisory Group of 12 staff members, including eight bilingual interpreters collecting the data, provided constant input into the kinds of questions and respondents that would be most helpful.

The Advisory Group feels that the data generated from this study provide a perspective on some of the dynamics of family planning decision-making among the intended population that will enable the County health department staff to define their outreach and service efforts.

Limitations

Although the study met its objectives, both the process and the results have important implications. Involvement of several people collecting data in multiple locations expanded the locus of decision-making and introduced some important limitations to the data collection process. These include an

abbreviated version of the survey, missing data, institution of a "two-step" data collection procedure, and changes in sampling.

An original questionnaire designed by the researcher and key County staff was used in the data collection process and administered by bilingual interpreters from the Refugee Health Services program. The survey was originally designed as a four page, one-sided document with a record form attached. The survey was a multiple-choice, short answer questionnaire designed to be simple and quick to complete. At some point between the inservice training and the second Advisory Group meeting, the original survey was condensed to a one page, two-sided questionnaire which made it easier to handle and less forbidding to the participant (Appendix H). This was an understandable action but one which caused the loss of some survey content. For example, information regarding education levels resulted in general categories of education (elementary, high school) rather than specific number of years in school. Differences in Southeast Asian interpretation of education levels could have influenced answers to this question. Therefore, while accuracy was maintained, precision was affected.

Condensing a four page survey to a single, two-sided page resulted in unintentional deletion of words, abbreviation of words and changes in spacing and format. While the survey questions were presented to each respondent orally, there still may have been differences in how individual interviewers

interpreted these changes. For example, changes in spacing caused the choices for Question 10, "Where do you go for general medical care?" to be moved about 2-3 spaces below the question so that they appear out of context. Not surprisingly, there were 21 cases with missing data on this particular item.

Question 13 illustrates a second example in which both format changes and deleted words may have caused misinterpretation of the question, oversight of questions, or both. The word "total" was deleted from the abbreviated question, "How many children do you plan to have total?" In addition, placement of the question was such that reading may have been hampered in the hands of an inexperienced interviewer under busy clinic conditions. As a result, responses are missing to this important item and those that were recorded need to be interpreted cautiously.

Problems with a condensed survey were further complicated by use of multiple interviewers. An interviewer who had only surveyed one or two clients may not have had the same familiarity with the instrument as that of a second interviewer who had conducted ten interviews.

The researcher was surprised to find such a high proportion of missing data once the interviews were completed. Most of the missing information can be attributed to misinterpretation and/or oversight of questions resulting from format changes and condensing of information. There were a large number of missing cases from Questions 10 and 16 which asked respondents about their

sources of medical care and family planning information. These questions were intended to explore health behavior and health service utilization and had important implications for program planning.

In hindsight, it is understandable that interviews conducted in a busy clinic environment and by several different interviewers would result in some degree of oversight. Unfortunately, this oversight influenced the strength of relationships but did not change the general trend showing County sources as the predominant source of health care and family planning information.

The introduction and use of a "two-step" interviewing procedure created further limitations to the study. Interviewers were trained to conduct the interviews in one sitting with one interviewer. This was felt to be the best strategy to avoid participant confusion and assure greater consistency across interviews. However, because the interviews were usually conducted during the client's appointment time, the survey was an added component to an already full schedule.

During the second month of the survey process, some members of the Advisory Group who also served as interviewers felt it was necessary to present the survey in parts using more than one interviewer. For example, the demographics section could be best completed during the initial intake session, leaving the remaining sections to be completed during or after the actual appointment. This process, the "two-step" method, was intended to divide

workload between staff and decrease the amount of time taken away from the clinician.

The number of interviews conducted by each method is unknown. The use of more than one interviewer may have been disconcerting to a respondent who was uncomfortable in discussing the subject matter with more than one person, especially if there was a change in interviewer gender.

Question 11, "Have you ever attended a family planning education class?," provided a natural break between the demographic questions at the beginning and the more personal questions to come. This question became the first one asked in "Part Two." While this question is not particularly sensitive, it may have appeared quite out of context when asked 30 minutes later and possibly by a different interviewer. In addition, there may have been changes in respondents' attitudes and reactions to questions following their clinic encounters. Waiting time may also have influenced respondents' moods and, therefore, affected quality and accuracy of the data.

Variation and expertise of interviewers from a "two-step" procedure may also influence data collection. A team of eight interviewers from the Refugee Health Services Program was involved in data collection. All used the same survey and were given extensive training on how to conduct the interview, using samples of birth control information when necessary to explain family planning concepts. For example, Question 18 asks about the

respondent's method of birth control. Interviewers were asked to use props and sample materials whenever possible to illustrate birth control types. This was intended to insure greater accuracy of information. However, when the interview was divided in half and two different interviewers were involved, control over how information was presented was significantly diminished. There is no way to accurately gauge the impact of these protocol changes.

Fortunately, the changes were revealed and discussed before a large number of interviews were conducted. Interviewers agreed to use the "two-step" interview procedure only as a last recourse. Although it is unknown how many interviews were conducted using the two-step method, greater numbers were prevented by discussing the issue and reaching a workable compromise.

Finally, sampling changes also created limitations for data collection and analysis. Sample size and subsequent ethnic representation of the sample were limited by time and staff resources.

A variety of sampling sites were set up as a way to reach as many Southeast Asian ethnic groups as possible. Sites consisted primarily of County clinics, English as second language classes and other locations most accessible by County staff. These sites were felt to be common sources of social and health related services for the Southeast Asian refugee population and places where a diverse respondent pool would be available.

The sampling protocol specified that interviewers would sample at each site at least once during the data collection period. Unfortunately, due to conflicting schedules and lack of back-up resources, few interviewers were able to tap into the non-County sites. While understandable, this resulted in a sample population derived primarily from County programs such as the Women's Health Program and consisting of mostly Vietnamese and Cambodian respondents. Therefore, generalization of findings to all Southeast Asian ethnic groups in Santa Clara County is limited. A larger sample may have provided more variability in respondents and generated statistically significant results.

Finally, since most of the respondents were from County programs, the researcher acknowledges the possibility of inherent bias in the sample. The apparent willingness of the sample to seek help and their familiarity with the health and social service systems may not be representative of the larger Southeast Asian population. In addition, the cultural practice of deference to those who are viewed with respect, such as the health care provider and clinic interpreter, might have been teased out with a larger sampling pool.

Wider sampling may have revealed greater variability in education, ethnicity, immigration and perceived levels of difficulty with subjective acculturation issues among others. With the large number of respondents from the core sample who did not have prior family planning education, a

larger sampling pool may result in more pronounced association between prior family planning education, birth control practice, and family planning decision-making.

In summary, an abbreviated survey, presence of missing data, the "two-step" and two interviewer data collection, and changed sampling strategy all served as limitations to this study. Each of these occurrences was unfortunate and limits the availability of data and generalizability of results. However, important results came from both process and analysis. Results may not all reach statistical significance but may imply trends that are useful in planning, implementing and evaluating family planning programs for the County.

CHAPTER 6

IMPLICATIONS AND CONCLUSION

This study explored the family planning knowledge and needs of Southeast Asian refugees in Santa Clara County. The findings from this study have important implications for further research and practice.

Implications for Research

The implications for future research center on issues of control of a dynamic field setting. In hindsight, several steps could have been taken to safeguard against the limitations described in Chapter Five.

In response to the condensing of the survey, responsibility lies with the researcher to maintain vigilance over the data collection process. During the training session, it should be stressed to interviewers and County staff that changes to the survey instrument, whether major or minor, should be reviewed by the researcher before they are made. Survey design and field testing should factor in the "encumbrance threshold," or the ability of interviewers or participants to manipulate the instrument with relative ease.

The problem of missing data requires close attention. Missing data may not only be a function of respondent or interviewer oversight but may also indicate deliberate omission of information not relevant to the respondent.

Missing data due to inconsistencies in survey techniques can be prevented by instituting more extensive role-playing during the training process. Rather than simply reviewing the questionnaire and data collection process with interviewers, they could be asked to demonstrate or role-play an actual interview. Although time-consuming, this process would enable everyone to problem-solve and allows interviewers to practice appropriate ways of approaching participants and handling the questionnaire.

While the "two-step" method introduces some intrinsic limitations to the present study, its occurrence is understandable knowing how the present study was conceived and conducted and the nature of clinic activities. The researcher's insistence on using only one interviewer at one sitting may ultimately be counterproductive in community-based research if the interviewer feels pressed by time. A compromise, such as allowing the two-step method but insisting on one interviewer, may decrease interviewer inconsistencies. Grouping of interviewers into teams might also serve to decrease the potential for distortion or inconsistencies.

Sampling limitations which reduce sample size and composition can be prevented through use of more than one sampling strategy. Convenience sampling, as used by the present study, can be combined with deliberate sampling of major Southeast Asian organizations, snow-ball sampling, or even sampling by mail to obtain a larger sample. Because of the potentially

sensitive nature of the issue, compliance and return rates may be questionable. However, combining strategies can be likened to throwing out a fish net; both increase the pool of possibilities.

Since the researcher had no control over scheduling, opportunities to interview at locations other than County Health Department sites was always an unknown factor. To increase outreach and representative sampling, it may have been helpful to establish outside survey sites where the questionnaire could be self-administered and returned either by mail or directly to the data collection site. Preventing unrepresentativeness among ethnic groups could be accomplished through cross-sectional sampling and deliberate sampling which increase the likelihood of ethnic variability. Research into ethnic distribution within the County and subsequent cross-sectional sampling may have resulted in more generalizable data.

Further research is recommended to resolve some of the methodological problems encountered in the current study. For this study, an original survey, designed by the researcher and County staff, was used to explore family knowledge, information needs, and use of family planning services. The survey instrument needs to be further refined and tested in order to capture additional information on acculturation factors and their relationship to use and knowledge of family planning services. Additional testing of linguistic differences in Southeast Asian languages may provide further illumination and

understanding of differences between ethnic groups.

The present survey assesses family planning knowledge and needs through exploration of birth control practices and decision-making roles. The use of pre-tests and post-tests would be helpful in assessing the understanding of family planning information prior to and after education has been initiated. This could also provide insight into compliance and help evaluate educational interventions.

Although the current study was not intended to explore differences among Southeast Asian ethnic groups in detail, a larger sampling pool would enhance current results. Deliberate sampling among Cambodian, Vietnamese, Laotian/Mien and Hmong ethnic groups might bring out information regarding similarities and differences in family planning information needs among these different groups. Further study of men and women across all groups and within each group may reveal gender differences in attitudes about family planning and birth control practice. In addition, comparisons of marital status and perceptions about family planning and use of services could provide important implications for educational strategies.

Self-administered surveys, written in the respondents' native languages, could be used to increase the sample population. Surveys would be distributed at one session and participants would be asked to complete and return the survey at their next meeting. This approach would require less staff

resources and possibly decrease the respondent's anxiety level. However, self-administered surveys require that the respondent has enough knowledge of family planning concepts and self-motivation to independently complete the survey. Such a strategy would also assume accurate translations of the questionnaire into multiple languages, respondents' literacy in their native languages, and compliance with follow-up appointments.

To complement the written needs assessment, use of focus groups or personal interviews would provide additional insight into the dynamics of making family planning decisions. Structured interviews conducted as a follow-up to the written survey would not only substantiate written responses, but also identify feelings and concerns about cultural differences, acculturation factors related to use of family planning services, and access to such services. This information is important and not readily captured by a written survey.

Implications for Practice

The current study has implications for further health education practice. In light of the ethnic differences discovered, educational and clinical approaches must necessarily include an understanding of cultural differences among Southeast Asian ethnic groups. Data from this study imply that although there are similarities in health behavior and cultural practices within the Southeast Asian group as a whole, the practitioner must not assume that

traits are homogeneous across ethnicities. For example, in the present study sample, Cambodians tend to be younger and less educated. A health program or educational strategy using unconventional methods such as theatre drama may be appropriate for the Cambodians, but not necessarily for the Vietnamese, who are older, more educated and have less residence time in the United States. Likewise, a family planning brochure designed for more sophisticated readers with more education may be more appropriate for the Vietnamese than for the Cambodians. Family planning providers need to acknowledge differences within groups to fully effectuate family planning services.

Most of the study respondents were either Vietnamese or Cambodian. Very few were Laotian and even fewer were Mien or Hmong. This finding could indicate a need for increased health education outreach to other Southeast Asian ethnic groups. Under the present study, we cannot pinpoint why the actual sample was so different from what was expected by both the researcher and Advisory Group. However, even with this small sample, the results suggest that current County health programs are out of reach for the Laotian, Mien and Hmong communities. Future program planning should consider a deliberate outreach component designed to fill this gap in services.

The large numbers of more recent refugees who are not practicing birth control indicate a need for the introduction of family planning programs early

on, perhaps during the initial health assessment stage. Results show that birth control is practiced more often as length of time in residence increases. This is important information for family planning educators.

Important implications for practice lie with the findings on the process of family planning decision-making. Research indicates that self and spouse decision-making is associated with ethnicity, increased length of time in the U.S., and increased education. Joint decision-making is also a function of increasing levels of difficulty with subjective acculturation variables (i.e., transportation, English language). For a family planning program, this implies the need to include both client and spouse in family planning education classes in order to bring about informed decisions. Instructions on taking birth control pills should be presented to both spouses to assure understanding and proper compliance.

In addition to practice implications, there lies another realm of recommendations related to efforts to link research with practice. The research process and its results reveal some of the difficulties encountered when scientific methodology is imposed at the community level. Further research must draw upon a realistic model that takes into account potential problems in clinic structure and the reality of limited resources, and then work within these parameters as best as one can.

This study was dependent on the reactions of the community under

trying conditions. Despite flow charts and detailed data collection models, community-based research necessarily has a life of its own. While these additional dynamics may cause some disappointment to the investigators, much was gained in terms of new information and new university-community relationships. Both are extremely valuable in the effort to provide relevant and accessible family planning services to Santa Clara County's Southeast Asian population.

Conclusion

The overall conclusion from this study is that there is a relationship between acculturation and family planning knowledge and utilization. This relationship includes objective indicators of acculturation such as education, time of immigration, and prior exposure to family planning education. Perceived difficulty with subjective indicators, particularly in the areas of adjusting to the American way of life and the ability to learn and understand the English language, also shows a relationship with the decision to use family planning services. These results suggest that as level of perceived difficulty increases, there is a trend towards the use of joint decision-making on key family planning issues.

Overall, family planning needs was not directly related to acculturation or who was making the family planning decisions. Birth control information

most respondents regardless of residence time, education, or prior exposure to family planning education.

In general, the core sample represents primarily Vietnamese respondents who exhibit certain homogeneous characteristics including more recent immigration, older age, greater education, and more self and spouse decision-making. This group also tended to practice birth control more often and with greater frequency.

Methodological problems during the data collection process may have influenced the availability of information as well as the generalizability of data across Southeast Asian ethnic groups. Increased sampling efforts would serve to provide more variability within the sample and generate more significant results.

In spite of the small sample size and limited generalizability of results, the present study has shown that family planning education is important in determining contraceptive practice and impacting a family's decision-making process. Results have generated important practice implications which include additional outreach to Laotian and Hmong populations within Santa Clara County. In addition, results indicate that educational approaches must be cognizant of the ethnic differences within the Southeast Asian refugee population.

The complexity of the research process introduced some inherent

problems with data collection procedures. However, these are, in part, a reflection of the dynamics of community-based research within the diversity of a multicultural environment. The corroborative approach of this study was an important first step in assessing the population's current family planning needs and establishing a cooperative arrangement between the needs of the Santa Clara County Health Department and the resources of the University.

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Appendix A

Estimates of Refugees in California Counties

SOUTHEAST ASIAN REFUGEES PER 1000 POPULATION

By County

Refugees/1000

November 1990

SOUTHEAST ASIAN REFUGEES IN CALIFORNIA

BY COUNTY

DECEMBER 1980

Appendix B

List of Advisory Group Members

ADVISORY GROUP MEMBERS

Loan An
Vietnamese Public Health Assistant

Victor Seng
Cambodian Public Health Assistant

Peter Chittavong
Public Health Assistant

Thuy Tran
Vietnamese Public Health Assistant

Mai Daily
Public Health Assistant

Vinh Vu
Vietnamese Public Health Assistant

Mai Duong
Public Health Assistant

Savann Ho
Cambodian Public Health Assistant

Thai Hoang
Vietnamese Public Health Assistant

Betty Kinoshita, Program Manager
Refugee Health Services Program

Don Luna
Outreach Supervisor

Molly Manithep
Laotian Clerk

Dau Nguyen
Vietnamese Community Worker

Trang Nguyen
Vietnamese Community Worker

Lucy Ni, Senior Nurse
Refugee Health Services Program

John Palmer, MPH
Health Education Specialist

Appendix C

Research Approvals from the Committee for the
Protection of Human Subjects, Santa Clara County Health
Department and Santa Clara Valley Medical Center,
California Institute for Medical Research

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Connie Chan, Health Science
555 Elmira Road #168
Vacaville, CA 95687

From: Charles R. Bolz
Office of Graduate Studies and Research

Date: January 25, 1991

The Human Subjects Institutional Review Board has reviewed and approved your request for exemption from Human Subjects Review for the proposed study entitled:

"Santa Clara County Health Department, Family
Planning Assessment Project"

You may proceed with this study without further review by the Human Subjects Institutional Review Board.

I do caution you that Federal and State statutes and University policy require investigators conducting research under exempt categories to be knowledgeable of and comply with Federal and State regulations for the protection of human subjects in research. This includes providing necessary information to enable people to make an informed decision regarding participation in your study. Further, whenever people participate in your research as human subjects, they should be appropriately protected from risk. This includes the protection of the confidentiality of all data that may be collected from the subjects. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised when people participate in your research as human subjects, each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact Dr. Stanford or me at (408) 924-2480.

cc: Kathleen Roe, Ph.D.

County of Santa Clara

Health Department

2220 Moorpark Avenue
San Jose, California 95128

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SANTA CLARA COUNTY HEALTH DEPARTMENT

INSTITUTIONAL AGREEMENT

The following agreement has been made between Santa Clara County Health Department and Connie Chan, Candidate for Master of Public Health, San Jose State University.:

Santa Clara County Health Department, Refugee Health Services agrees to provide the following services to Connie Chan in conjunction with her thesis research at Valley Medical Center and selected County Clinic sites.

- * Access to voice mail telephone system
- * Bilingual staff for translation and interviewing
- * Consultation services with program managers
- * Clerical, office staff for documentation and data retrieval
- * Access to client records when deemed necessary

We understand that Ms. Chan will be conducting a pilot study and thesis research involving family planning issues among the Southeast Asian Refugee population. The study will consist of a written questionnaire and an interview session with participants. Any questions or concerns regarding this study will be answered by Connie Chan, investigator at (408) 374-3720 or by Dr. Kathleen Roe, Department of Health Sciences, San Jose State University at (408) 924-2976. The Health Department will be given the opportunity to review research findings and use data for purposes of program planning.

This agreement can and will be revoked if research procedures show harm to the participant and/or the institution. Having reviewed and been notified of all research procedures, we hereby enter upon this agreement with the investigator, Connie Chan.

Signatures:

Program Manager

Investigator

Date Signed

Date Signed

March 25, 1991

Ms. Connie Chan
555 Elmira Road
#168
Vacaville, CA 95687

RE: Project entitled "Santa Clara County Health Department Family Planning Assessment Project"

Dear Ms. Chan:

On March 22, 1991, the Research and Human Subjects Review Committee for Santa Clara Valley Medical Center (an IRB holding Department of Health and Human Services Assurance #M1306) approved continuation of the above referenced project.

Approval is granted with the understanding that no changes will be made in the protocol or approved consent form without the knowledge and prior approval of the Committee. Please be advised that all adverse events/complications or problems having to do with subject safety must be reported to the Committee within five (5) working days.

The approval number assigned to this project is 3/22/91-03. It would be helpful if in future correspondence concerning this project, you would refer to this number.

In compliance with federal regulations, all research projects require continuing review at intervals appropriate to the degree of risk but not less than once per year. If the project is to continue beyond the expiration date of March 20, 1992, it must be renewed in accordance with the Committee's renewal instructions. As a courtesy reminder, a renewal application will be mailed to you approximately two months prior to the expiration date. If the project is terminated/completed prior to the expiration date, you should immediately notify the Committee in writing.

Ms. Connie Chan
March 25, 1991
Page 2

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Should you have any questions, please contact the Administrator of the Committee, Carole Guthrie, at 408/998-4554.

Sincerely,

A handwritten signature in cursive script, appearing to read "Elisabeth Mailhot".

Elisabeth Mailhot, M.D., Chair
Research and Human Subjects Review Committee

EM/cg

Appendix D

Survey Instrument

FAMILY PLANNING NEEDS ASSESSMENT SURVEY

Record No. _____

Date _____

Interview Site _____

Interviewer _____

Language Spoken _____

Comments: _____

FAMILY PLANNING NEEDS ASSESSMENT SURVEY

Please complete the following questionnaire by writing or checking the appropriate answer. All information will be kept anonymous. Thank you for your help.

1. How long have you lived in the United States? (state in months)

2. Age (years)_____ Sex: Female_____ Male_____

3. Marital Status: Single_____

Married_____

Widowed_____

Divorced_____

4. What is the highest grade you completed in school>

_____No formal education

_____Elementary school (K-8): (Circle year)

K 1 2 3 4 5 6 7 8

_____High School (9-12) (Circle year)

9 10 11 12

_____College

_____Postgraduate

5. What is your ethnicity?

_____Vietnamese

_____Mien

_____Cambodian

_____Hmong

_____Laotian

_____Other:_____

6. Are you able to speak English?

_____Very well _____Well _____Not well

7. Are you able to write English?

_____Very well _____Well _____Not well

8. Are you able to read English?

_____Very well _____Well _____Not well

9. Are you able to read and write your own language?
 _____Very well _____Well _____Not well
10. Where do you go for medical care for reasons other than Obstetrics and Gynecology?
- _____Emergency room, Where?_____
- _____Community clinics, Where?_____
- _____Private doctor, Type?_____
- _____County health services, Type?_____
- _____Other:_____

Family planning is used to regulate the number of children that a family wants to have based on prior births, age at first delivery, age of mother and other important issues that may influence the health of the mother and baby. Family planning education consists of information on birth control, fetal development, sexually transmitted diseases, nutrition, birth process, etc.

11. Based on the description above, have you ever attended a family planning education class? _____Yes _____No
- If so, where?_____
12. How many children do you have currently?_____
13. How many children do you plan to have total?_____
14. Are you currently having unprotected intercourse?
 _____Yes _____No
15. Do you or your spouse wish to become pregnant at this time?
 _____Yes _____No
16. Where do you go for family planning information?
- _____Private doctor
- _____Community clinics
- _____County health department
- _____Family and friends
- _____I don't
- _____Other:_____

17. Do you currently practice birth control at home?
- ☐ All of the time
 - ☐ Some of the time
 - ☐ Rarely
 - ☐ Never
18. If you do, which method are you and your partner currently using?
(Check all that apply).
- ☐ Withdrawal
 - ☐ Birth control pills
 - ☐ Diaphragm
 - ☐ IUD
 - ☐ Rhythm Method
 - ☐ Condoms
 - ☐ Sponge
 - ☐ Foams, jellies
 - ☐ Other: _____
19. Overall, who makes the decisions about family planning in your home?
- ☐ Self
 - ☐ Spouse
 - ☐ Self and Spouse
 - ☐ Family members, Who? _____
20. Who decides how many children to have?
- ☐ Self
 - ☐ Spouse
 - ☐ Self and Spouse
 - ☐ Family members, Who? _____
21. Who decides when to start having children?
- ☐ Self
 - ☐ Spouse
 - ☐ Self and Spouse
 - ☐ Family members, Who? _____

22. Who decides whether or not to use birth control?

- ☐ Self
☐ Spouse
☐ Self and Spouse
☐ Family members, Who? _____

23. If you use birth control, who decides what type?

- ☐ Self
☐ Spouse
☐ Self and Spouse
☐ Family members, Who? _____

24. What type of family planning information are you interested in? (Check all that apply).

- ☐ Birth control
☐ Sexually transmitted diseases
☐ AIDS (Acquired Immune Deficiency Syndrome)
☐ Fetal development (growth of fetus, birth process)
☐ Women's health (nutrition, menopause)
☐ Men's health (STDs, birth control)
☐ Human sexuality
☐ Other: _____

Below are some problems refugees have encountered seeking medical care of health information once they resettle in the U.S. For each item below, please circle the response that best rates the level of difficulty with which it affects you and your family.

25. Understanding American Way of Life

Very difficult Somewhat difficult Not difficult

26. English language problems

Very difficult Somewhat difficult Not difficult

27. Adapting to new environment

- Very difficult Somewhat difficult Not difficult
28. Dealing with community agencies
- Very difficult Somewhat difficult Not difficult
29. Getting transportation
- Very difficult Somewhat difficult Not difficult
30. Getting medical help
- Very difficult Somewhat difficult Not difficult
31. Finding resources (medical, housing, etc.)
- Very difficult Somewhat difficult Not difficult
32. Do you have a regular physician?
- _____Yes _____No
33. How would you rate your health status?
- _____Great
- _____Good
- _____Fair
- _____Poor

Appendix E

Survey Flow Chart

SANTA CLARA COUNTY HEALTH DEPARTMENT
FAMILY PLANNING NEEDS ASSESSMENT

Survey Flow Chart

Procedures above are used for interviews conducted at non-County sites (WIC, Valley Medical Center, ESL, Etc.)

Appendix F

Statement of Informed Consent

School of Applied Arts and Sciences • Department of Health Science
One Washington Square • San Jose, California 95192-0052 • 408/924-2970

Agreement to Participate in Research
San Jose State University

RESPONSIBLE INVESTIGATOR: Connie Chan, Candidate
Master of Public Health
4005 Cowell Blvd. #407
Davis, CA 95616
(916) 756-4443

TITLE OF PROTOCOL: Santa Clara County Health Department
Family Planning Needs Assessment

I have been asked to participate in a research study that is investigating the knowledge, needs and current use of family planning among Southeast Asian men and women in Santa Clara County. The results of this study should further our understanding of family planning needs and perceptions regarding this issue. The study also has implications for developing more appropriate health care resources and create awareness between providers and clientele in this area.

I UNDERSTAND THAT:

1. I will be asked to fill out a questionnaire requesting general demographic information as well as information on my knowledge and use of family planning services. The questionnaire will require 15-30 minutes to complete.
2. There are no possible risks associated with the study. All Southeast Asian clients and individuals age 18 and over who are patients or clients of the Santa Clara Valley Medical Center, Refugee Health Services Program, Women's Clinic, Women, Infant, and Child Supplemental Food Program and other selected sites will be included in the study.
3. Possible benefits from the study include better understanding of the knowledge and perceptions of family planning leading to the development of more effective family planning programs.
4. The investigator or study sites cannot and do not guarantee or promise that I will receive any benefits from this study.
5. There will be no cost to me for participating in this study nor will I receive any compensation for my participation.
6. The results from this study may be published, but the questionnaire is anonymous and any information that can be identified with me will remain confidential to the extent permitted by law and will be disclosed only with my permission.

7. Any questions about my participation in this study will be answered by CONNIE CHAN, (916) 756-4443. Complaints about the procedures may be presented to Dr. Kathleen Roe, (408) 924-2976. For questions or complaints about research subject's rights, or in the event of research-related injury, contact Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies & Research at 924-2480.
8. My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with SJSU and other institutions used as study sites.
9. I have received a copy of this consent form for my file.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

DATE

SUBJECT'S SIGNATURE

INVESTIGATOR'S SIGNATURE

Appendix G

Agendas for Advisory Group Meetings

Santa Clara County Health Department
Family Planning Needs Assessment

Advisory Group Meeting
March 15, 1991

Agenda

- I. Introduction
- II. Research Purpose and Objectives
- III. Survey Process
 - A. Flow chart
 - B. Review of Survey
 - C. Review of interview process (consistency, flow)
 - D. Study sites
- IV. Timelines
- V. Staff Concerns/Problems
 - A. Access to study sites (Valley Medical Center, WIC, etc.)
 - B. Getting clients to consent
 - C. Other concerns
- VI. Future meetings

Advisory Group Meeting
May 16, 1991

Agenda

- I. Progress Updates
- II. Review of Survey Process
 - A. Questions and Problems (see attached)
 - B. Presence of gaps in ethnic representation
 - Laotian, Mien groups needed
- III. Survey goals
- IV. Timeline
- V. Future meeting date

Advisory Group Meeting
June 29, 1991

Agenda

- I. Progress Updates
- II. Review of initial findings
 - A. Sample size
 - B. Ethnic groups represented
 - C. Birth control practices
 - D. Family planning needs
 - E. Other
- III. Survey Process
 - A. Problems
 - B. Goals
- IV. Interviewer concerns
- V. Timeline
- VI. Closing

Appendix H

Survey Instrument: Condensed Version

(ASK QUESTIONS/RECORD ANSWERS AFTER COMPLETING MEDICAL HISTORY
AND CLIENT SIGNS CONSENT FORM 1)

FAMILY PLANNING SURVEY ANSWER FORM

DIRECTIONS: Ask questions from Needs Assessment Survey; fill in
blank spaces/ circle correct answers.

- ① ____ YEARS ____ MONTHS in the United States?
- ② AGE: ____ (years) SEX: F M
3. SINGLE MARRIED WIDOWED DIVORCED NA
- ④ EDUCATION: NONE ELEM. ____ (years) HIGH ____ (years) COLLEGE POS
5. VIETNAMESE CAMBODIAN LAOTIAN MIEN HMONG OTHER: ____ (spe
6. SPEAK ENGLISH: VERY WELL WELL NOT WELL NA
7. WRITE ENGLISH: VERY WELL WELL NOT WELL NA
8. READ ENGLISH: VERY WELL WELL NOT WELL NA
9. READ/WRITE OWN LANGUAGE: VERY WELL WELL NOT WELL
10. WHERE DO YOU GO FOR GENERAL MEDICAL CARE: specify belc

Emergency Rm. Com. Clinic PMD Co. Clinic Other: ____

NA-09

READ DEFINITION RE: FAMILY PLANNING/FAMILY PLANNING EDUCATION

11. HAVE YOU EVER ATTENDED A FAMILY PLANNING EDUCATION CLASS?

1 NO 2 YES IF YES, WHERE ____

- ⑫ CHILDREN: # YOU HAVE ____ 13. # YOU PLAN TO HAVE ____
14. CURRENTLY HAVING UNPROTECTED SEX: YES NO
15. YOU/YOUR SPOUSE WANT TO BECOME PREGNANT: YES NO
16. WHERE YOU GO FOR FAM. PLAN. INFO.: ER C.C. PMD Co. Other?
17. YOU PRACTICE BIRTH CONTROL: ALWAYS SOME RARELY NEVER
- ⑬ METHOD OF BIRTH CONTROL YOU'RE USING: ____ (specify

19. IN YOUR HOME: WHO

WHO MAKES FAM. PLAN. DECISIONS? SELF SPOUSE FAMILY

Both-4

WHO DECIDES ON # OF CHILDREN? SELF SPOUSE FAMILY

Both-4

WHO DECIDES ON WHEN TO START HAVING CHILDREN? SELF SP. FM

Both-4

WHO DECIDES TO USE BIRTH CONTROL? SELF SPOUSE FAMILY

Both-4

WHO DECIDES TYPE OF B. C. TO USE? SELF SPOUSE FAMI:

20. What type of family planning information are you interested in? (Check all that apply)

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- 1 ☐ Birth control
2 ☐ Sexually transmitted diseases
3 ☐ AIDS (Acquired Immune Deficiency Syndrome)
4 ☐ Fetal development (growth of fetus, birth process)
5 ☐ Women's health (nutrition, menopause)
6 ☐ Men's health (STDS, birth control)
7 ☐ Human sexuality
8 ☐ Other: _____
09 ☐ NA

Below are some problems some refugees have encountered seeking medical care or health information once they resettle in the U.S. For each item below, please circle the response that best rates the seriousness with which it affects you and your family.

a. Difficulty in understanding American way of life.

very ¹serious somewhat ²serious not ³serious

b. English language problems

very ¹serious somewhat ²serious not ³serious

c. Difficulty in adapting to new environment.

very ¹serious somewhat ²serious not ³serious

d. Difficulty in dealing with community agencies.

very ¹serious somewhat ²serious not ³serious

e. Difficulty in getting transportation.

very ¹serious somewhat ²serious not ³serious

f. Difficulty in getting medical help.

very ¹serious somewhat ²serious not ³serious

g. Difficulty in finding resources (medical, housing, etc.)

very ¹serious somewhat ²serious not ³serious

Do you have a regular physician? 1 ☐ Yes 2 ☐ No

How would you rate your health status?

- 1 ☐ Great
2 ☐ Good
3 ☐ Fair
4 ☐ Poor
09 ☐ NA