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EXPLORING THE CULTURAL INFLUENCES ON SEXUAL AND REPRODUCTIVE HEALTH BEHAVIORS: A CROSS-CULTURAL STUDY OF ASIAN AMERICAN AND CAUCASIAN FEMALE COLLEGE STUDENTS

by

Emilee Duyen Ly

A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

Oxford, MS

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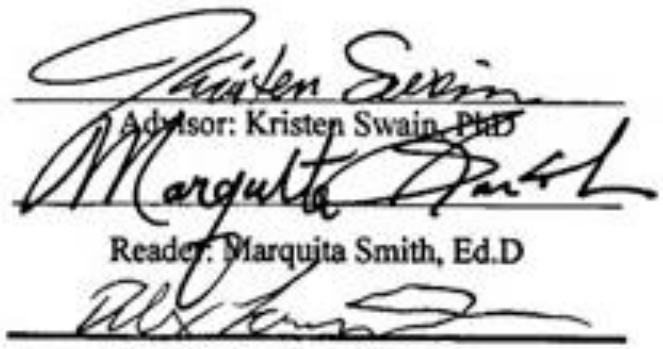

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DEDICATION

This thesis is dedicated to all of the women in my family who have struggled so much with communicating about Sexual and Reproductive Health and to the future generation of women who I hope will live in a world where they can freely communicate about their health.

ACKNOWLEDGEMENTS

There are many people to whom I must express my utmost gratitude regarding the completion of this thesis. First, I would like to begin by thanking my advisor, Assistant Professor Kristen Swain, PhD. Dr. Swain has been crucial in the completion of this thesis. I am especially thankful for her continuous encouragement, guidance, and patience throughout this process. Her help during the brainstorming process and knowledge of research techniques have helped me immensely. I would also like to thank my second reader Associate Professor Marquita Smith, E.D., and my third reader Alex Langhart. Thank you both for your feedback and input.

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Lastly, I would like to express my extreme gratitude to my friends and family who have encouraged me throughout this intimidating process. It is with their constant love and support that I have been able to persevere through the late nights and early mornings. This project truly could not have been completed without everyone's help and support and for that, I am truly grateful.

ABSTRACT

EXPLORING THE CULTURAL INFLUENCES ON SEXUAL AND REPRODUCTIVE HEALTH BEHAVIORS: A CROSS-CULTURAL STUDY OF ASIAN AMERICAN AND CAUCASIAN FEMALE COLLEGE STUDENTS

This capstone honors project aims to investigate the influence of cultural backgrounds on the healthcare behaviors of Asian American and Caucasian college students. The main research question of this focus group study is: "How do cultural backgrounds influence healthcare behaviors, including communication, seeking, and access to sexual and reproductive health, information, and services, among Asian American and Caucasian female college students?"

Drawing upon the World Health Organization's 2003 Social Determinants of Health (SDOH) framework, this study explores how structural determinants, social networks, cultural backgrounds, and healthcare systems factors collectively influence the way female college students communicate, seek, and have access to sexual and reproductive healthcare (SRH) information and services. The SDOH framework informed the development of a focus group protocol that explored the complex interplay of socioeconomic, cultural, and systemic factors that underlie disparities across women's experiences in healthcare settings. The research also explores concepts including cultural models of illness, cultural competence theory, and health disparities.

Using the qualitative constant comparative analysis method, this study draws insights from two moderated focus group discussions involving 20 Asian American and 20 Caucasian female University of Mississippi students between the ages of 18 and 24.

The findings of this honors capstone project highlighted the significant role cultural beliefs, parental influence, and social determinants play in shaping the SRH perceptions and behaviors of both Asian American and Caucasian female college students. Distinct differences were observed between these groups, emphasizing the need for tailored healthcare communication and services to address cultural and individual requirements effectively.

In conclusion, the study promotes both equitable healthcare access and effective patient-physician communications by recognizing the influence of cultural background. It serves as a critical step toward fostering a more inclusive healthcare environment where individuals from diverse cultural backgrounds can access healthcare services and information without barriers. Ultimately, every individual regardless of ethnicity or cultural background, should have equal opportunities to benefit from inclusive healthcare services.

Keywords: cultural backgrounds, healthcare behaviors, college students, Social Determinants of Health, focus group discussions, healthcare access, patient-physician communication, sexual and reproductive health, disparities, cultural influences

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INTRODUCTION

Within the realm of healthcare, understanding the nuances of cultural backgrounds is crucial in addressing persistent disparities, especially regarding sexual and reproductive health. This research aims to investigate the influence of cultural backgrounds on the behaviors and beliefs of female college students in healthcare settings, focusing on Asian American and Caucasian backgrounds within the University of Mississippi's diverse student population. The main research question of this capstone project is: *How do cultural backgrounds influence healthcare behaviors, including communication, seeking, and accessing sexual and reproductive health information and services among Asian American and Caucasian female college students at the University of Mississippi?*

This topic is of the utmost significance, today, due to the growing and diverse student populations where Asian American and Caucasian backgrounds coexist within the same educational environment. Within the last decade, the Asian population in the United States experienced an approximate 81 percent increase, with a record of nearly 18.9 million Asian Americans residing in the United States in 2019 (Budiman, 2021). This demographic shift underscores the pressing need to address the knowledge gap in existing literature concerning the Sexual Reproductive Health behaviors of Asian American individuals.

Previous research, as highlighted by Zhao (2017) indicates that Asian American adolescents have some of the lowest levels of communication with healthcare providers about sexual health topics such as sexual activity, sexually transmitted diseases, and contraception. Furthermore, the perpetuation of the "model minority" myth, defined by Stella (2016), has led both researchers and healthcare workers to believe that Asian Americans do not share the same healthcare needs as other minority groups. This harmful misconception not only further intensifies the barriers Asian Americans face in accessing sexual reproductive healthcare services but also contributes to their exclusion from broader research.

This study builds upon these insights by exploring the cultural dynamics and barriers faced by Asian American female college students in an area –Sexual and Reproductive Health – that remains under-researched to address the social dynamics and vulnerability within these groups to better assess their needs. By assessing their needs, these findings can contribute to the overall development of more tailored and effective clinical practices, ensuring that healthcare services are both culturally sensitive and relevant.

Factors such as a lack of health literacy, language barriers, cultural misconceptions, taboos, negative experiences, and an overall mistrust in healthcare providers impact how students engage with both healthcare information and services about sexual and reproductive health, in ways that ultimately shape health outcomes. The study aims to uncover distinct patterns of healthcare disparities shaped by cultural diversity and contribute to a deeper understanding of the complex dynamics influencing sexual and reproductive health outcomes among female college students. To gain deeper insights into the nuanced interplay of cultural backgrounds and healthcare behaviors, the research

seeks to address four specific research questions rooted in the Social Determinants of Health Framework:

RQ1: How do cultural norms and values surrounding sexuality and reproductive health differ between Asian American and Caucasian female college students?

RQ2: How do familial and societal expectations influence the sexual and reproductive health decisions of Asian American and Caucasian female college students?

RQ3: How does cultural identity impact healthcare-seeking behaviors and access to sexual and reproductive health services among Asian American and Caucasian female college students?

RQ4: What are the specific barriers and facilitators to effective communication with healthcare providers, and how do they differ between the two groups?

The following literature review synthesizes findings from relevant studies, identifies gaps in existing research, and acts as a guide for the current study. The literature review covers the Social Determinants of Health framework, cultural influences on health behaviors, healthcare disparities faced by both Asian Americans and college students, and the importance of patient-physician communications.

The methodology section describes the study's qualitative approach which includes the recruitment process, focus group procedures, and data analysis techniques. Following the methodology section, the results section presents key findings from the focus group discussions by highlighting the emerging themes and patterns related to the influence of cultural backgrounds on healthcare behaviors and experiences among the study's participants.

Lastly, the conclusion section discusses the significance of the emergent themes and other findings in light of existing literature and the study's research questions. The conclusion also identifies areas for future research, summarizes the main findings, reiterates the significance of the research, and offers recommendations for healthcare providers, policymakers, and future researchers to address the identified healthcare disparities and promote more inclusive and accessible sexual and reproductive healthcare services for diverse communities.

Healthcare behaviors and communication with providers are profoundly influenced by cultural backgrounds. These dynamics often result in healthcare disparities among individuals of diverse ethnicities and backgrounds. At the University of Mississippi, there is a growing and diverse student population that includes but is not limited to both Asian American and Caucasian college students. While these students share the same educational environment, their healthcare information-seeking behaviors and communication with healthcare providers differ greatly. This research seeks to illuminate the role of cultural diversity in shaping sexual and reproductive healthcare behaviors and interactions among female college students. Uncovering the complex interplay of socioeconomic, cultural, and systemic factors can contribute to the overall enhancement of healthcare accessibility and inclusivity within the community the research focuses on and beyond.

The study seeks to identify how cultural backgrounds significantly influence the healthcare behaviors, information seeking practices, and communication patterns of Asian American and Caucasian female college students at the University of Mississippi, specifically in the context of sexual and reproductive health. It also examines how factors

– including health literacy, language barriers, cultural misconceptions, taboos, negative experiences, and overall mistrust in healthcare providers – impact how female students engage with healthcare information and how these interactions affect overall health outcomes.

This capstone project will uncover healthcare disparities shaped by cultural diversity and contribute to a deeper understanding of the complex dynamics influencing sexual and reproductive healthcare experiences and outcomes among female college students.

LITERATURE REVIEW

The pursuit of good health, while marked by significant advancement in recent decades remains challenged by persistent health inequalities between socio-economic classes. In 2008, the World Health Organization (WHO) recognized the profound impact of socioeconomic conditions on health and established the Commission on Social Determinants of Health (CSDH).

The Social Determinants of Health (SDOH) framework broadly encompasses non-medical factors that contribute to an individual's health, including their socio-economic environment, living conditions, upbringing, education, and access to resources (Fink-Samnick, 2018). These factors play a pivotal role in determining an individual's long-term health outcomes across physical, mental, and social health dimensions (WHO, 2008). Contrary to conventional beliefs, health outcomes are influenced not only by genetics but also these complex social factors. Various studies have further shed light on the multifaceted nature of health behaviors and outcomes due to the specific categories of SDOH.

To synthesize and evaluate the relationship between SDOH and emergency department outcomes of pediatric patients, Amjad (2023) conducted a systematic review and meta-analysis involving nearly 18 million children and over 100 million emergency department visits. The results showed that race, ethnicity, and socioeconomic status were

the most reported social determinants of health. Nearly 71% of the participants who utilized the emergency department more frequently and for extended periods fell into one or more of those categories. Other factors that contributed to the frequent utilization of the emergency department included low income, public insurance, and proximity to healthcare institutions. Children who came from homes that had another language as their primary language had both a longer length of stay and an increase in hospital admissions (Amjad, 2023). These findings underscore the impact of language barriers, socio-economic status, and culture on health outcomes.

Garrido (2018) found Lack of environmental structural factors can contribute to sexual risk-taking behaviors and overall sexual health outcomes, as evidenced by a prevalence of STIs and unplanned pregnancies. Neighborhoods that lack safe and diverse environments for recreational activities contribute to unhealthy situations and foster sexual risk-taking behaviors in adolescents. The quantitative study found that these chaotic environments lead to an increase in illicit drug use, littering, higher prevalence of STIs, and overall worse health outcomes than the adolescents' peers who lived in more stable environments.

Other SDOH categories found to affect health outcomes include social networks, familial guidance, and overall education. Garrido (2018) found that formal and informal sexual education from both guardians and the public school system is inadequate. Comprehensive sexual education – such as instruction about the types of STIs, how they are transmitted, the process of pregnancy, and contraceptive use – is crucial in helping youth form positive attitudes and safe sexual practices. Adolescents also need to engage

in more personal discussions to fully comprehend and form opinions about conflicting messages regarding sex, sexuality, and relationships.

Through a series of in-depth interviews about topics of birth control, STIs, and HIV with male and female adolescents from ages 15 to 17, Donaldson (2012) found that as the number of effective, in-depth, comprehensive sexual education and discussions increased, so did positive sexual attitudes alongside better sexual health outcomes. Males reported having a higher value of positive behaviors in comparison to females, partly because of the harsher standards and stigmas surrounding female sexual behaviors.

Many teens emphasized the lack of in-depth information given to them about these topics from formal and informal channels. Teens also expressed the importance of comprehensive sexual education from their schools and their parents, especially instruction that provided specific examples of unhealthy, dangerous sexual practices (Donaldson, 2012). These findings serve as a call to action to establish Sexual Education as a standard across all schools and within guardian-adolescent relationships. They also highlight the importance of fostering conversations that focus on scientific information, as well as the personal and emotional aspects of sexual behaviors.

Overall, these studies underscore the far-reaching implications of SDOH on various aspects of health. Understanding and addressing these health determinants are crucial steps in developing effective strategies to combat health inequities across different communities.

Healthcare Disparities Among College Students and Adolescents

Within the scope of the investigation into healthcare disparities among Asian American and Caucasian female college students, the study must first investigate the broader examination of adolescents, particularly those within a college setting. Adolescents represent a critical developmental stage marked by significant physical, emotional, and social changes.

Garrido (2018) found that college adolescents face a transitioning period in which they encounter a myriad of challenges and disparities in accessing healthcare, navigating healthcare systems, and making informed health-related decisions. The SDOH also plays a role in shaping the health outcomes of college students, specifically within the categories of socioeconomic status, cultural background, education, and geographic location. These factors can all intersect in ways that heavily influence the health outcomes of adolescent college students. The transition into college and even graduate schools – as well as the lack of parental guidance – often causes adolescents to face more distinct barriers within the new environment.

For this research, the following portion provides a review of literature that highlights various challenges and disparities that adolescent college students face when seeking and navigating the healthcare system and its resources.

Santos and colleagues (2016) used a cross-sectional study design to gather information and insights about Sexual Reproductive Health (SRH) behaviors, knowledge, and attitudes of college students. They found that college students displayed moderate levels of knowledge regarding SRH topics, with notable gaps in knowledge about

contraception methods, STI prevention, and SRH surveillance. Despite moderate knowledge levels, students generally exhibited positive attitudes toward SRH issues. Attitudes were multidimensional and encompassed responsible sexuality, preventive behaviors, attitudes towards STIs, condoms, and hedonism. Gender, age and their area of study significantly influenced both SRH knowledge and attitudes among college students. Female and younger students studying life and health sciences tended to have a higher knowledge and more favorable attitudes compared to their counterparts (Santos, 2016).

Decker (2002) examined whether a comprehensive sexual health education program could truly change the perceptions of barriers, facilitators, and utilization of SRH services for adolescents. Adolescent participants enrolled in a comprehensive sexual health education program were surveyed before the course to serve as a baseline and then completed follow-up surveys after completing the course.

After the program, the results showed a significant reduction in adolescents' perceived barriers to cost and judgment of staff, along with
a significant increase and understanding of the importance of healthy sexual reproductive health behaviors (Decker, 2022). As patient knowledge and skills increased, so did positive patient health outcomes include increased utilization of services and overall positive health behaviors.

Cultural Backgrounds and Health Behaviors among Asians

An individual's culture encompasses a wide range of elements that can significantly influence health-related decisions and behaviors. These include, but are not limited to, cultural norms, values, beliefs, traditions, religious practices, language

proficiency, perceptions of illness, taboos, and stigmas. These cultural factors intricately shape an individual's attitudes toward health behaviors, healthcare information-seeking practices, and engagement with healthcare providers. They can also influence preferences for treatment modalities, adherence to medical advice, and overall perception of healthcare providers.

From 2000 to 2019, the Asian population in the United States grew by 81 percent, highlighting the importance of understanding complex, multifaceted cultural aspects in improving the health outcomes of minority communities (Budiman, 2021). LaViest (2003) found that Asian Americans are the least likely of all minority ethnicities to have a personal physician, undergo routine pap smears and other crucial physical examinations, or obtain mammograms. This, in part, can be attributed to the fact that Asian culture does not involve preventative care, and the utilization of healthcare services is usually reserved for critical situations and emergencies.

Frost and colleagues (2016) found that Asian American participants often expressed that individual health is normally not discussed unless it is an emergency or critical issue, and that many families do not understand the need for preventative care unless physicians thoroughly explain the dangers associated with not utilizing the preventative care resources.

Through a cross-cultural analysis, Armstrong (2001) found that cultural values and structure – such as the importance of the collective vs. the individual – are influential in shaping health beliefs. In addition, societies that practice holistic medicine tend to be collectivist. Within specific cultures, individuals seeking healing and healthcare services often take into consideration the views of the many individuals who surround

them (Armstrong, 2001). Asian patients with this mindset often prioritize a harmonious relationship with their social network.

In turn, this mindset prompts patients to cautiously offer personal health information or withhold information from their healthcare providers for fear of confidentiality and reprimand. They are also more likely to gauge the reactions and body language of healthcare providers before engaging in an open and honest conversation. These individuals are often too afraid to speak against healthcare providers, ask for further clarification, and accept unclear medical advice (Armstrong, 2001).

Individuals who come from individualistic societies tend to be more direct, unconcerned with maintaining harmony and often become frustrated with vague health solutions (Armstrong, 2001). Okazaki (2002) found that Asian cultural characteristics, such as the primacy of the family and the collective's goals over individual wishes further emphasize the prioritization of sexuality only within the context of marriage, sexual restraint, or modesty. Frost et al (2016) found that the cultural values of Asian adolescents significantly affected their healthcare perceptions, the way they accessed services, and how they engaged in sexual and reproductive health behaviors.

Through in-depth interviews and metanalysis, Okazaki (2001) found that due to the highly collectivist and patriarchal culture, sexuality is viewed as a threat to the interdependent social order and integrity of the family. When compared to their peers, Southeast Asian American girls indicated the least desire to have children or participate in having sexual intercourse out of shame, were extremely fearful of the idea of having children outside of wedlock and stated the oldest age range when asked the best age to start engaging in intercourse. These factors often contribute to sexual guilt which can lead

to Asian Americans withholding information about their sexual behaviors from family members and healthcare providers, having an unequal education regarding these matters, and becoming vulnerable to poor health outcomes. Sex guilt also contributes to the historically poor sexual and reproductive health outcomes of immigrants and their offspring. Individuals often delay prenatal care due to misconceptions, stigma, and the overall fear of going to OBGYNs (Ajjarapu, 2021).

Besera (2023) conducted in-depth semi-structured interviews about 45 minutes long with females of similar cultural backgrounds to further understand the intricacies that contribute to specific Sexual Reproductive Health Behaviors. By utilizing the constant comparative method to analyze the interviews, Besera (2023) found that social and cultural norms influence the utilization of sexual and reproductive health services. When speaking on healthcare experiences, many participants mentioned unmet accommodations, inadequate services, misdiagnoses, and other negative experiences that further deterred them from ever seeking out and utilizing healthcare resources again. This further highlights the many opportunities to help healthcare providers better deliver services and emphasizes the importance of making cultural accommodations to make the patients feel comfortable enough and how important it is to facilitate healthy behaviors for these minority groups (Besera, 2023).

Healthcare Disparities for Asian Americans

Despite the diverse cultural landscape of the United States, certain minority groups, including Asian Americans, continue to encounter significant healthcare disparities that impact their access to and quality of care. Understanding these disparities is essential for developing targeted interventions and fostering inclusive healthcare

practices. Some common healthcare disparities and challenges faced by Asian Americans include cultural misconceptions, language barriers, discrimination, and systemic inequities.

The term “model minority” was coined to describe the ability of Asian Americans to not only overcome hardship but also succeed in American society (Stella, 2016). This harmful stereotype goes further than just academic and economic success but also contributes to the misconception that Asian Americans often have better health behaviors and health outcomes than other minority groups (Yi SS). The model minority stereotype often results in governments overlooking Asian American problems and allowing individuals, even healthcare providers, to believe that Asian Americans do not experience health disparities. This further contributes to a lack of research and exclusion of Asian Americans from research studies that may be necessary for them to get the necessary resources and awareness to help them overcome the health disparities that it seems no one believes they experience (Stella, 2016).

The view that Asian Americans are the model minority is extremely harmful because it assumes that these ethnic communities have minimum sexual and reproductive needs, which contributes further to Asian Americans and Native Pacific Islanders having extremely poor care and education regarding sexual and reproductive health (Heyrana, 2023).

Scott (2023) utilized nationally representative survey data from the AAMC (Association of American Medical Colleges) for a cross-cultural analysis between Sexual Minority Women of Color and their Sexual Minority Caucasian counterparts. The results quantified that while only 19 percent of Caucasian Sexual Minority females experienced

discrimination during their latest medical appointment, 33 percent of Sexual Minority Women of Color experienced discrimination during their latest appointment. Although both groups of sexual minority women experienced discriminatory treatment, women of color were the most consistent in reporting experiences of discrimination based on their identity during medical encounters (Scott, 2023).

SRH Information Seeking, SRH Perception, and Health Literacy

Understanding the complexities of sexual and reproductive health (SRH) behaviors requires a multifaceted exploration of how individuals seek information and perceive SRH and the different levels of health literacy. According to Dong et. al (2024), women specifically face a problem with disseminating information, information overload, and misconceptions, alongside misinformation. These factors make it extremely difficult for individuals to become health literate and further warp the overall perception of sexual reproductive health matters. To worsen matters, the overwhelming amount of information and the responsibility of differentiating between factual and falsified information contribute to information avoidance or putting more emphasis on extremely common misconceptions (Dong et. al, 2024). These factors play pivotal roles in further shaping individual's attitudes, beliefs, and actions concerning SRH practices, perceptions, and utilization of healthcare resources.

Frost and colleagues (2016) conducted focus groups over two years in a cross-cultural qualitative approach to explore the experience of Asian American women and their Caucasian counterparts' experience with accessing Sexual and Reproductive health care and information. The majority of the Asian American participants reported that stigmas and cultural taboos often acted as a significant barrier to discussing these topics

within their familial setting and communities, they emphasized the importance of finding confidential ways to seek help and gather information regarding SRH (Frost, 2016).

Sexual literacy can be viewed as the utilization of critical thinking, overall knowledge, skills, and actions to achieve sexual health across an individual's life course (Herdt, 2021). An individual's level of sexual literacy can be hindered by various elements including but not limited to religion, morality, cultural stigmas, and other sex-negative sources. The development of an individual's sexual literacy is crucial in forming good health habits, but there is little research regarding female sexual literacy as it conflicts with both formal and informal education.

Through 18 semi-structured interviews with women between the ages of 26-68, Flanagan (2004) found that the majority of the participants reported an overall lack of adequate sexual health education, both formal and informal. Participants were not equipped with the depth of knowledge many physicians view as necessary to make effective, informed health decisions regarding their sexual and reproductive health. Overall, Flanagan (2024) found a consistent lack of sexual literacy across all ages.

The researchers identified gender differences and how sexuality was presented to the participants as the main barrier to developing sexual literacy. These findings highlight that despite the importance of sexual literacy, education is still lacking and unequal across the different genders identified. While gender and bias in the presentation of information play a large role in equipping individuals with the skills and knowledge necessary to make good health decisions, there are still various other barriers that play a large role in an individual's overall perception of sexual and reproductive health and how individuals seek information.

Dong (2024) conducted a nationwide survey of Chinese women to analyze and gain insights regarding stigma management communication and exposure effects. The study hoped to understand the process of Sexual Reproductive Health (SRH) misconceptions alongside how individuals seek health information. Using descriptive statistics and Pearson correlation metrics, Dong (2024) identified significant differences in misinformation exposure, information avoidance, information overload, and misperceptions. In addition, women who displayed more SRH stigma and misconceptions were more likely to take part in information avoidance and completely refuse to seek out SRH information. There was also a direct link between being exposed to misinformation and overall misperception of SRH. The study highlighted the importance of addressing stigma and information avoidance within public health campaigns. Practical implications included carefully curated messages for different communities to combat information overload (Dong, 2024).

Lu et al (2022) found that the impact of cultural backgrounds on the sources individuals trust emphasizes the importance of further understanding these cultural influences in ensuring effective health information-seeking behavior (HISB). In addition, individuals may discuss these decisions with trusted sources within their cultural framework, showcasing how interconnected the cultural backgrounds and health decision-making strategies truly are. The results confirmed that structural social capital including networks and group memberships promotes health information-seeking behaviors. Emotional support was negatively associated with all health information-seeking behavior indicators. Individuals with strong emotional support were less likely to search for their health information. Overall, emotional support impeded people from

using the internet and traditional media to obtain health information, and strong, emotional, and familial ties impeded adolescents from initiating HISB on their own (Lu et al, 2022).

Patient-Physician Communications

Another significant contributor to shaping health outcomes is effective patient-physician communication, which stands as a cornerstone in fostering safe and inclusive healthcare environments needed to address the diverse needs of individuals from all backgrounds. The dynamic interplay between patients and healthcare providers has a large impact in shaping both positive health attitudes and behaviors, which ultimately lead to good health outcomes.

Positive interactions such as feeling comfortable enough to engage in open conversations, asking clarifying questions with health care providers, and finding staff and providers who listen and are responsive to individual needs are crucial to whether the individuals continue to utilize the resources provided to them (Besera, 2023). Despite the importance of effective patient-physician communications, many individuals have negative health experiences, which further contribute to them not feeling comfortable utilizing or openly communicating with their healthcare providers

Ajjarapu (2021) conducted a study regarding OBGYN outcomes among immigrant and refugee communities and emphasized the importance of collaborative efforts in increasing understanding of healthcare systems, specifically concerning how health insurance works. The study's findings also emphasized the importance and

effectiveness of cultural humility training with healthcare providers, to equip them with the skills necessary to be more aware and responsive to specific cultural needs.

Cultural humility, an approach to intercultural interactions and healthcare delivery that involves healthcare providers practicing awareness, openness, and a willingness to learn from their patients who come from different cultural backgrounds, is crucial in improving the relationship between patients and physicians. As part of the study, the community worked in partnership with healthcare institutions to train 30 healthcare providers, cultural humility was a part of training. Community engagement and empowerment in addressing the specific needs along with open channels of communication with the physicians had been specifically successful. Patients of the 30 trained healthcare providers voiced appreciation and an increase in positive healthcare attitudes (Ajjarapu, 2021).

Despite the importance of educating young adolescents on the topic of sexual and reproductive health, 20% of parents and 65% of providers never bring up the subject with their younger children/young patients (Sanchez, 2023). Many perceived barriers hinder the ability of physicians to effectively communicate with their patients, especially concerning sexual and reproductive health. The study results show that young adults need greater influence and convincing to open up a channel of communication regarding sexuality with physicians (Sanchez, 2023).

Zhao (2017) investigated the communications between Asian American adolescents and healthcare providers, specifically regarding the topic of Sexual Reproductive Health, Sexually Transmitted Infections, and pregnancy prevention. Through in-depth interviews, Zhao (2017) found that adolescents often lie to their

healthcare providers about their sexual history and refuse hormonal contraceptives, partly because they. fear that their confidentiality could be violated. These findings highlight a significant need for healthcare providers to prioritize confidentiality, for adolescents of all backgrounds, but specifically those of Asian American ethnicities. The findings also revealed that adolescents expressed many concerns about healthcare providers initiating comprehensive, educative conversations regarding sexual activity, contraceptives, STIs, and pregnancy prevention (Zhao, 2017).

These findings are consistent with other studies, where the recommendations based on insights gathered from focus groups and in-depth interviews suggested that providers working with Asian Americans and other minority communities should be aware that Sexual Reproductive Health, specifically, may be an extremely uncomfortable topic of discussion. The findings also support the recommendation that providers should emphasize confidentiality within the healthcare setting in discussing these topics (Frost, 2016).

The studies highlight various ways that patient-physician communications could improve. Addressing communication barriers and promoting cultural humility among healthcare providers are imperative steps in fostering inclusive healthcare environments and mitigating disparities in patient-physician interactions. The studies further highlight the importance of prioritizing patient comfort, confidentiality, and culturally competent care. Healthcare institutions should aim to provide more meaningful dialogue, alongside gaining the trust of their patients to improve patient health outcomes.

METHODOLOGY

Participant Recruitment

To ensure diversity and validity within the participant pool, participants were recruited, the primary researcher sent out recruitment announcements and mass email invitations to 13 registered student organizations at the University of Mississippi. The student organizations were the Vietnamese American Student Association, Japanese Student Association, Taiwanese Student Organization, American Medical Women's Association, Health Professional Advising Offices, American Medical Student Association, Women in Dentistry, 5 Greek organizations on campus, and the Honors College.

In addition, the primary researcher personally visited 6 of the 13 organizations to introduce the research topic and solicit participants. This multi-channel recruitment strategy aimed to capture a representative sample of female college students from different cultural backgrounds at the University of Mississippi.

The selection of these specific registered student organizations to recruit focus group participants was based on their relevance to the research focus. After obtaining Institutional Review Board approval for the study, the PI crafted and distributed the recruitment announcements and emails to the student organizations, about a month before the focus groups were conducted. These communications included a concise

overview of the research project emphasizing the project's goals, significance, incentives, and the opportunity for students to contribute to a broader understanding of the topic.

A total of 40 female students from ages 18 to 24 from the University of Mississippi were recruited to participate in focus groups. The students were evenly divided to form two focus groups of 20 students each, based on whether the students identified as Asian or Caucasian.

Ethical Considerations

Ethical guidelines, including participant confidentiality and their right to withdraw at any point without consequence, were reiterated both during the recruitment process and during the focus groups. The confidentiality of participant responses and the overall importance of their contributed time and effort to the research were strongly emphasized. All focus group questions were crafted with these factors in mind. Participants also were informed about the incentive structure, as well as the purpose and process of receiving the incentive, a $10 gift card.

Focus Group Discussion Question Development

The development of the focus group discussion questions was guided by the overarching objective of investigating the impact of cultural backgrounds on healthcare behaviors within the realm of sexual and reproductive health among Asian American and Caucasian female college students. The questions, separated into different categories, were tailored to explore specific dimensions, including Health Information Seeking Behaviors, Cultural Implications, Social Support Network, Social Determinants of Health, and Patient-Physician Communications.

Each focus group question was crafted to explore specific aspects of cultural influences on healthcare behaviors. For example, questions addressing cultural norms and values surrounding sexuality and reproductive health aimed to uncover the differences and similarities between the Asian American participant's and Caucasian participants' perceptions and beliefs. Questions about familial and societal expectations were crafted to understand how external pressures shaped participants' decisions regarding sexual and reproductive health.

Additionally, questions pertaining to health disparities and Social Determinants of Health were included to gain insights into the participants' comprehension and perceptions of healthcare involving sexual and reproductive health issues. These questions aimed to uncover the participant's perspectives and experience with existing healthcare disparities, in hopes that the discussion could also lead to improvements in the healthcare landscape. Overall, the process of developing the questions for the focus group discussion sought to illuminate insights on both the major and minor research questions.

Focus Group Procedures

After the recruitment process was completed, an even number of individuals from both the Asian American Group and the Caucasian group were randomly selected to participate in the focus group. Those selected were sent a confirmation email stating the date, time, and location in which the focus group would take place. Participants were asked to arrive 10-15 minutes early to look through the confidentiality agreement and procedures.

Two separate focus groups, each comprising 10 participants, were conducted simultaneously in different conference rooms. Upon arrival, participants were randomly assigned to different rooms. After signing the confidentiality agreement and familiarizing themselves with the procedure, the moderator addressed any questions before initiating the discussion.

During the hour-long session, the moderator posed 13 questions and allowed ample time for participants to respond and engage with one another. After the discussion was completed, participants received a gift card and signed the form confirming that they received their incentive. A total of 4 hour-long focus groups with 10 participants in each group were conducted. 2 Asian American focus group discussions ran from 5 pm to 6 pm while 2 Caucasian focus groups ran from 6:30 pm to 7:30 pm.

All focus group discussions were audio-recorded, using digital recording devices, to ensure the accurate capture of the participants' responses. The recordings were stored in a secure location and destroyed after the transcription process. The transcription process did not reveal the names of any participants and participants were numbered. A quality check was conducted to verify the accuracy of the transcriptions to rectify any discrepancies before the destruction of the recording.

Qualitative Transcript Analysis

To accurately analyze the results of the focus group discussion, the constant comparative method was utilized for qualitative analysis of the transcripts. This process involved a careful, verbatim transcription of the audio recordings for annotation and further analysis.

The initial steps of the constant comparative method included going through the various focus group scripts and taking a lot of detailed notes, making sure to pinpoint certain themes and comments that stood out as interesting, important, confusing, or conflicting. The primary researcher noted different points or opinions, ideas, problems, and issues that might further illuminate the barriers or opportunities for future health communication strategies.

After initial notes on the transcripts, the researcher created a code list composed of 14 words and short phrases. The words and phrases were then grouped into different conceptual categories. Around 5 overarching themes were then identified with 9 specific emerging themes, making sure to provide supporting evidence from the transcripts before an executive summary was developed.

The constant comparative method was utilized to analyze the transcripts because it allows for a thorough systematic exploration of a complex phenomenon such as the cultural influences of sexual and reproductive health behaviors. Its iterative nature facilitates the generation of beneficial insights from the qualitative data. One of the strengths of the constant comparative method is its flexibility to adapt to the evolving nature of qualitative data. This is extremely beneficial when exploring culturally sensitive topics where emergent themes may require further exploration and refinement. The techniques are also reliable and further, enhance the trustworthiness of findings while increasing confidence in the interpretations drawn from the collected data.

RESULTS

Health Information Seeking Behaviors

Asian American discussion focused mainly on the importance of reliable, credible sources such as WebMD, Cleveland Clinic, Planned Parenthood, and medical journals. Asian American participants were conflicted about whether or not to trust family members, with a majority of the participants saying that they would rather utilize alternative sources for health information such as the internet and close peers. However, a few participants said they would go to them to discuss health information in critical situations. When asked how participants' families affected the sources they trust for health information, Asian American participants acknowledged their parents' and families' lack of formal education and attributed their knowledge of reliable sources and finding information to their formal education, with little influence from their families.

> Asian American participant: *"I don't think my family, per se, does. I think that my educational background has taught me what sources to trust, but I don't think I get that from my family, per se."*
>
> Asian American participant: *"Yeah, I think a lot of us come from families and parents that didn't go to college, so they wouldn't know where to turn in that sense. So, a lot of the sources that we would seek for, we'd most likely find on our own."*

Caucasian responses reflected a high level of trust in getting information from healthcare professionals, with mentions of personal connections and relationships with healthcare providers.

> Caucasian participant: *"I am very comfortable with my gynecologist…and he is a man, and I will ask him like point blank, and he will ask me very up-front questions about what I'm doing and who I'm doing it with, and things like that, and I would go to him first."*
>
> Caucasian participant: *"I feel like primary care physicians usually, doctors and all that, like, I trust them."*
>
> *Caucasian Participant: "My friend's mom is a gynecologist, so if I have like questions, I will just text her."*

Some Caucasian participants said they have open communication with their family members but consider the education level of their parents. Participants went into detail about how their parents initiated, guided, and encouraged them, playing a large role in shaping their information-seeking behaviors in regard to which sources are credible and which are unreliable. Only 1 participant spoke up about having parents who did not show them how to find credible, reliable sources. Both Asian American participants and Caucasian participants noted the importance of crosschecking sources to verify the credibility of data.

> Caucasian participant: *"Let's say my family went to school. That sounds so nerdy, but I feel like they beat into my head: Look up reliable resources only."*
>
> Caucasian participant: *"I think that my parents were like very comfortable showing me how to get that information, too. So like I, yes with school, but also I think I did have a family that was like open… [they were] like Oh, let's look this up or something on the internet, and I was part of those discussions."*

Cultural Implications

Asian American participants mentioned familial and cultural pressures in regard to guilt about individual sexuality and other Sexual Reproductive Health (SRH) topics. Asian American participants highlighted significant familial and cultural pressures,

including the expectation to honor the sacrifices of their immigrant families by achieving success, something that their parents often viewed pregnancy as a significant threat to.

> Asian American participant: *"There was also like a really high guilt factor to it you know? Like it was always…we worked so hard to get to America, we swam across oceans…but it was like, if you got pregnant before you could go to college and make money, all our sacrifices would be a waste we would hate you."*

With the strict taboos and stigmas surrounding SRH topics, family discussions were often minimal with the focus primarily on abstinence or instruction regarding monthly cycles. Asian American participants also acknowledged the role of immigration status in the level of tradition upheld within the household, along with the overall understanding of SRH.

> Asian American participant: *"Since my parents are born here… I feel like it's not as, like, taboo, you know?"*

Misconceptions and misinformation were extremely common among Asian American participant families with notable preference for Eastern medicinal methods such as herbal medicine, tea, and home remedies over Western medicine. Participants mentioned the immense amount of mistrust their parents and families have in Western medicine due to side effects and the lack of knowledge regarding chemicals. Participants also mentioned common misconceptions such as the repercussions of messing with a female's hormones and many birth control methods being the cause of future infertility.

> Asian American participant: *"My mom also has like a really big misconception…she thinks that birth control is going to affect. fertility in the future, which that's just, obviously we know this is not real, like it's not real, but she thinks that so, you know, 21 years old, never been on birth control for that reason."*

> Asian American participant: *"My sister, who's like five years younger than me, she has that too. And our doctor was like, okay, yes, we should, once she's like older and her hormones are better, like we should go on birth control. So, my mom flew us to India and had an Irani doctor talk to my sister about this. And it's on herb pills now, and I'm like, You guys. And she just needs to exercise and maybe drink water."*
>
> Asian American participant: *"My mom says the same thing. She's like, why, like, alter your hormones?"*

There was also notable amounts of cultural fear and anxiety surrounding large procedures such as surgeries being the worst thing that could possibly happen, and a cultural hesitancy in older generations to seek medical advice because of the fear of receiving bad news. Participants mentioned how within their cultures, their families often did not feel comfortable with male OBGYNs and how seeking medical advice was for critical situations only.

> *Asian American participant: In Asian culture, at least like for my family, like, when something's wrong, it's like, that's when we get to the doctor, because like, that's the last thing they want to hear…I think for Asians, like, surgery is like the last, the last resort.*
>
> *Asian American participant: My mom's currently going through menopause, and so she's been having all these side effects or symptoms, whatever. And I keep telling her, I'm like, go to the doctor, get some medicine. And she's like, no, I don't want to talk about my body with men. And I'm like, they're a doctor, it's fine. Like, they're not there to do something bad to you. But she still won't go."*

Caucasian participants identified religious and Southern influences as the root for many taboos and stigmas surrounding SRH. Caucasian participants mentioned the negative outcomes that occurred due to abstinence-only sexual education often found in Southern or religious-based education institutions.

> Caucasian participant: *I 100 percent know from my small town, like, sex before marriage, any type of sex before marriage was heavily against. I also went to an abstinence-only school, and so, no, talk about birth control, condoms, STDs, it was, nope, just wait. And then we had a couple of girls in my high school get pregnant. Don't know if that's correlated, I think it is. Personal opinion, but...*
>
> Caucasian participant: *I grew up very staunchly Catholic, so while she explains, like, the whole 'this is your period, this is how it works, why it works, the, like, actual, like, sex or reproduction thing, never happened. Like, ever. To this day. She doesn't know that. She could not know that. She'd be completely in the dark. She'd be none the wiser.*

However, Caucasian participants did recognize a change in societal norms overall, making SRH less taboo on a global and national level. The participants mentioned the role of social media, online platforms, and a more accepting society in normalizing previously taboo topics regarding SRH. They mentioned the changing landscape of society and how it normalized talking to peers and individuals about SRH topics.

> Caucasian participant: *I feel like it's just kind of become a lot more normal. Like, obviously it's not like water cooler talk exactly, but I feel like it's not as weird to like talk to your friends about that kind of stuff. Like it's not as taboo. Yeah. And so that's probably really helpful.*
>
> Caucasian participant*: Yeah, I would second that. I think also with like social media and like having conversations about it on like different platforms like that makes it a little less awkward and stigmatized.*

Familial Support Networks

In order to grasp more specific ideas about family support networks in terms of Sexual Reproductive Health (SRH), the participants were asked questions about whether their parents or guardians discussed monthly menstrual cycles and informal sexual education within the household.

A large majority of Asian American participants did not receive a conversation from their parent of guardians about their periods and those who did recall receiving a conversation reported that it was very minimal and focused on what to do instead of why it was happening. An Asian American participant who had a mother in the healthcare field reported attempts of open dialogue about monthly cycles but mentioned how the conversations lacked depth and comprehensiveness. Many Asian American participants mentioned having to turn to alternative sources such as peers, older siblings, and school-provided sources for more information.

> Asian American participant: *"Yes, same, like, when I got mine for the first time, I had never, I didn't know what it was. But, and then when I got it, she just told me what to do. She didn't tell me why it happens, or what it means when it happens. She was just like, wear a pad or a tampon, basically. "*
>
> Asian American participant: *My mom left a brochure on my desk. And then when my older sister got her first period, she gave her a Wikipedia page."*
>
> Asian American participant: *I had the exact same experience. Like I got mine very early, probably earlier than she was expecting. So, I think like if there had been more time, maybe she would've said something, but I was just severely unaware of everything. So, like my entire childhood, if something was wrong with me, I'd probably wait. I always wanted it out to see if I got better before I confided in my parents. I think that was more so in like a, um, I don't want to be a burden, but like, they told me about like literally nothing. They just told me how to deal with it after the fact.*
>
> Asian American participant: *I feel like with Asians, we just skip the talk and go straight to 'don't get pregnant.'*

The responses of the Caucasian participants varied, with some participants stating that they received in depth conversations, to minimal conversations, or none at all. The majority of Caucasian participants did state, however, that they did receive a talk of some sort that went beyond the application of tampons and pads. It is important to note that those who did not receive conversations mentioned justifications such as an extremely

religious background to the fact that they had gotten their cycle much earlier than their mothers were expecting. Some participants mentioned getting their cycle earlier and immediately turning to their mothers for advice and to seek help. Many participants mention their parents and guardians being supportive, going into in-depth questions, and initiating open dialogue where the guardians patiently answered all of their questions, These participants mention feelings of extreme gratitude for those experiences.

> Caucasian participant: *"My mom went into great detail. It's a little emotionally scarring. But I'm very thankful for that… she had like explained to me what it was."*
>
> Caucasian participant: *"No, I've like never, really talked about that with my mom. I guess it's because like her dad is a pastor. So, she grew up like that."*

Regarding family support for information about sexual intercourse, many Asian American participants echoed the statement that they did not receive a talk about sexual intercourse. Asian American participants mentioned that their parents expected them to already know not to get pregnant despite not going into detail about how pregnancy actually occurred.

Topics regarding intercourse were viewed as extremely taboo and rarely spoken about other than cautionary tales about other individuals in the community who had gotten pregnant at a young age and to not make the same mistakes. Asian American participants who did receive any type of conversation about intercourse mentioned that it was limited to contraceptive methods. A significant aspect that arose from this question included the heavy guilt associated with sex due to immigrant parents' sacrifices and cultural backgrounds playing a large role in the taboos and stigmas.

> Asian American participant: *"I feel like for Asian families, I guess. You pass the talk and go straight to the don't get pregnant."*
>
> Asian American participant: *"Well for me I have a cousin that got pregnant as a teen. So, like I was really young when that happened. I mean, I never had a talk but I kind of knew about pregnancy and about sexual health kind of at a younger age just because she got pregnant and it was a whole ordeal in my family, but my parents never talked to us about it. They kind of just expected us to know."*

Caucasian participants responses varied in response to discussions about sexual intercourse within the household. Many Caucasian participants reported getting detailed conversations alongside their siblings about sexual intercourse, contraceptives, and other Sexual Reproductive Health topics. A few participants mentioned their parents' initiating conversations and offering to help them find OBGYN healthcare providers. Another common theme for Caucasian participants included parents and guardians asking if the participants needed a conversation regarding sexual intercourse or if they had questions. Some participants said they took the offer to have an open dialogue with their parents, while others said they were too scared at the time to take their parents' offers but regretted it in the future. Religious backgrounds also played a large role in the discussions of sexual intercourse within the household.

> Caucasian participant: "*I got the whole thing, in my head. It was like I don't even know what grade I was in. At some point during early years of middle school, we had like one program day where we had to learn it, and my mom was like, Okay, you can either hear it from school or from me, so which one do you want to hear first? And so, she just sat me down and I heard all of it. We didn't talk about it again."*
>
> Caucasian participant:*: "I had older brothers, so I kind of knew the majority of it, but I got the very paraphrased Sparks Notes version of the talk in my pediatrician's waiting room, um, because my mom was like, hey, so you're going to be getting your HPV shot today, just in case you're wondering what that is for, there you go, and that was end of discussion, and, yeah."*
>
> Caucasian participant: *"I grew up very staunchly Catholic, so while she explains, like, the whole, um, this is your period, this is how it works, why it works, the, like, actual, like, sex or reproduction thing, never happened. Like, ever. To this*

day. She doesn't know that. She could not know that. She'd be completely in the dark. She'd be none the wiser."

Caucasian participant: *"They offered. They were like, do you want to have a talk? And I figured it out. I didn't have it all figured out back then. Like, looking back, I definitely could have used a few more sentences about the whole thing. But I was sitting there in like sixth grade like, yeah, I got it."*

Social Determinants of Health

Participants were asked specifically about the effectiveness of comprehensive sexual education and how an incomprehensive sexual education affected the perception of Sexual Reproductive Health (SRH).

Both Asian American and Caucasian participants were supportive of a comprehensive sexual education curriculum. Asian American participants focused on addressing the more natural aspects of SRH topics in a way that would reduce shame. Caucasian participant discourse focused on the importance of being informed and not ignorant. Both groups had experience with abstinence-only education in formal school settings in Southern primary schools and religious private schools. All participants agreed on the ineffectiveness of abstinence-only sexual education and the harm that can come from not knowing. While both groups acknowledge the role of technology and the internet access of younger generations playing a role and implying that sexual education should be taught at younger ages, Asian American participants mentioned the possible harmful effects of exposing younger individuals to sexual education.

Asian American participant*:" I think it should be in like public schools because I mean, like, just from, like, our responses, it's like, nobody should be ashamed of, or, like, embarrassed to, like, talk about a natural, like, bodily function, or, like, stuff that everyone does. Like, they shouldn't feel ashamed to talk about that. And I think putting it in school opens up an avenue for, like, people to talk, to talk*

about this to other people with. Like, not necessarily their parents, but, like, a third person, like, they trust, so."

Asian American participant*: "I feel like I don't even, like, vividly remember, like, in any of my classes, like, learning about any of that. I don't think they give, yeah, like, at our school, we both went to the same school. I don't think they give, gave us, like, any of that information or resource."*

Caucasian participant*: "I was like a big, like, youth legislature girl in high school, and I know that Tennessee is abstinence-only education, so like, basically, don't have sex and you'll be fine, is what's taught. When I was a junior, sophomore, junior or something, I wrote like a fake bill. It was like, we're going to change it to comprehensive. It passed, so I'm a supporter. I'm day one, you know."*

Caucasian participant*: "I think comprehensive is good because even if they don't want to talk about it, it's better to be educated than like accidentally get pregnant. Like my high school, even though we had sex ed for four years, a lot of people like in eighth and ninth grade would get pregnant. That's why we had it so much. Not like a lot, but like more than. Yeah, like more than should. So, I think just like them not knowing they didn't know how to be safe, didn't know all that stuff."*

When asked about the role of income in quality of SRH, Asian American discourse leaned more heavily on personal anecdotes and family stories of direct experiences that income had on care whereas Caucasian discourse tended to discuss more broader systematic issues. Asian American participants believed that income directly affects the accessibility and quality of healthcare, emphasizing that healthcare accessibility in the United States is extremely problematic. Asian American participants also reported that they feel like lower-income insurance plans often did not provide adequate coverage for specialized care such as Sexual Reproductive Health resources.

There were acknowledgements of the role race plays in healthcare accessibility, especially for minority communities. Participants mentioned concerns about the experience of minorities at the doctors' office, including issues related to language barriers and cultural understanding which is further explored in the following section.

> Asian American participant: *"I think income affects health point blank, period. Access to health. accessibility to health care in this country is just a shit show. Simply put."*
>
> Asian American participant: *"I think that, you know, even insurance, that is afforded to people that don't have high incomes, they're not good insurances that give people access to specialty care. I think that's like a big thing right now"*
>
> Asian American participant: *"I kind of agree with that. Like when my mom was pregnant with my sister for like the first five months, she just didn't even go to like any doctor's appointments or anything. And it's because like first, like they were like really expensive, like healthcare wasn't there. And then, on top of that, she was just scared."*

Caucasian participants discussed challenges of accessing OBGYN and reproductive services in regard to geographical disparities, mentioning how income specifically affects access to these services in Mississippi and the South in general. The participants mentioned many areas within the state of Mississippi, with limited clinics leading to extremely long wait times and having to arrange appointments ranging from weeks to months in advance. Participants also mentioned age restrictions paired with the cost of such services in some states, preventing the accessibility to health services without parental consent which leads to further delays for care.

Caucasian participants also mentioned the lack of quality of care and appointments available at clinics that are more affordable or provide free services. They also reported the wealth disparities in areas making access to specialized care such as OBGYNs and dermatologists too expensive for the majority of the towns' residents who were low income.

> Caucasian participant*: I live in a county that's like just like the entire county is classified as low income and our like nearest it's like OBGYN or like pregnancy place is like 45 minutes away in like any direction. So, I mean I think that definitely decreases the um, like access to that kind of care.*

> Caucasian participant*: I come from a city north of Dallas that has a lot of wealth disparity. Like you're either very, very wealthy or you are very, very poor and so we have a lot of gynecologists and OBGYNs, but the problem is they're all so expensive that no one on the lower end of the spectrum can access them and we do have some, um, like free clinics and different like women's health clinics, but the lines and the wait times are so long that, um, if you're working or if you have school, you're not able to make it into them.*
>
> Caucasian participant*: I think this is a big one because if you don't have the income or the means to have access to a doctor, which God knows is so hard to do in this country, then 'you can't even go see OBGYN and tell him how you are, let him check on you, and you might have something seriously wrong with you.*

Patient-Physician Dynamics

When asked whether or not participants frequently visit the OBGYN, most Asian American participants reported that they had never been, compared to Caucasian participants who went more regularly. Asian American participants attributed family attitudes and feelings of fear and anxiety as reasons for not visiting the OBGYN. Many Asian American participants mentioned fear of procedures such as pap smears, and there was uncertainty about the ages females needed to get certain procedures. Caucasian participants had a better understanding and awareness of certain screenings and procedures done by OBGYNs. The reasons for visiting OBGYNs for the Caucasian participants included birth control prescriptions, irregular periods, general checkups, and specific health issues.

Asian American participants expressed concerns about confidentiality, especially being under their family's insurance, and indicated a potential reluctance to disclose personal health information and withholding the truth from their health care providers because of it. There was a strong emphasis in Asian American participant discourse regarding the familial relationships, cultural values, and the role of parents in healthcare

decisions and discussions between them and their health care providers. Asian American participants also mentioned how hard it is and how challenging it has been to navigate the healthcare climate as an adult, after seeing how difficult it was for their parents to navigate the healthcare system.

Race and being a minority were mentioned as barriers that hindered patient-physician relationships. Some Asian American participants favored physicians of the same ethnic background. Others said that they feel dismissed by physicians because of their background. When an Asian American participant went into detail about a personal experience of health care workers denying her family member of special, necessary accommodations and being spoken to in a condescending tone, many Asian American participants agreed, saying that they had experienced something similar in the past.

> Asian American participant*: "I had a conversation about this with an attorney yesterday just in terms of like how race just plays a role in accessibility. I think we're kind of moving towards that topic a little bit with this question. And I think like sometimes we forget that, you know, Especially, like, as minorities, sometimes going to the doctor is just a lot more complicated than just the average person. For one, for someone that's never been, like, let's say to the gynecologist, and they're like, not explaining, they're kind of just like, this is what we're about to do, like, you need to spread your legs, like, or whatever, like, I'm just going to insert this. There's, like, no warning, there's not really, like, a let me walk you through, like, this is what, you know, today's appointment is going to be like, this is what I'm going to be doing to test for XYZ. And so, like, with it being, you know, some people's first time, I think it's really intimidating. And it can push people away. Like, you might go once, but that first experience might, like, freak you out and you might not want to go again next year and, you know, things like that. And so, I think accessibility is one thing, but also, like, experience, especially when we're not familiar, is also another that really, like, pushes us away, even if, like, the resources are there."*

Caucasian participants mentioned that having open conversations about SRH with their family members further helped them keep an open, honest dialogue with their HCP.

Some Caucasian participants reported negative experiences with OBGYNs, mainly emphasizing being pressured into certain medical decisions, not being listened to, and being unnecessarily questioned. Caucasian participants reported positive SRH attitudes and behaviors with physicians who took the time to thoroughly walk them through the various options and physicians who listened to their concerns and made active efforts to help them.

When asked about the role of physicians and healthcare workers in the decision-making process, Caucasian participants showed a greater willingness to challenge or seek second opinions they emphasized the benefits and importance of a collaborative relationship with their health care providers. Asian American participants mentioned not feeling comfortable challenging health care providers and mentioned how they normally tend to believe the information given to them by HCP at face value. Asian American participants were also more receptive and appreciative of the information HCP provide regarding SRH topics but did mention there was room for improvement in regard to the depth of the knowledge being provided to them.

After analyzing the transcripts, emergent themes of the overall discussion from both groups can be found in Figure 1 below.

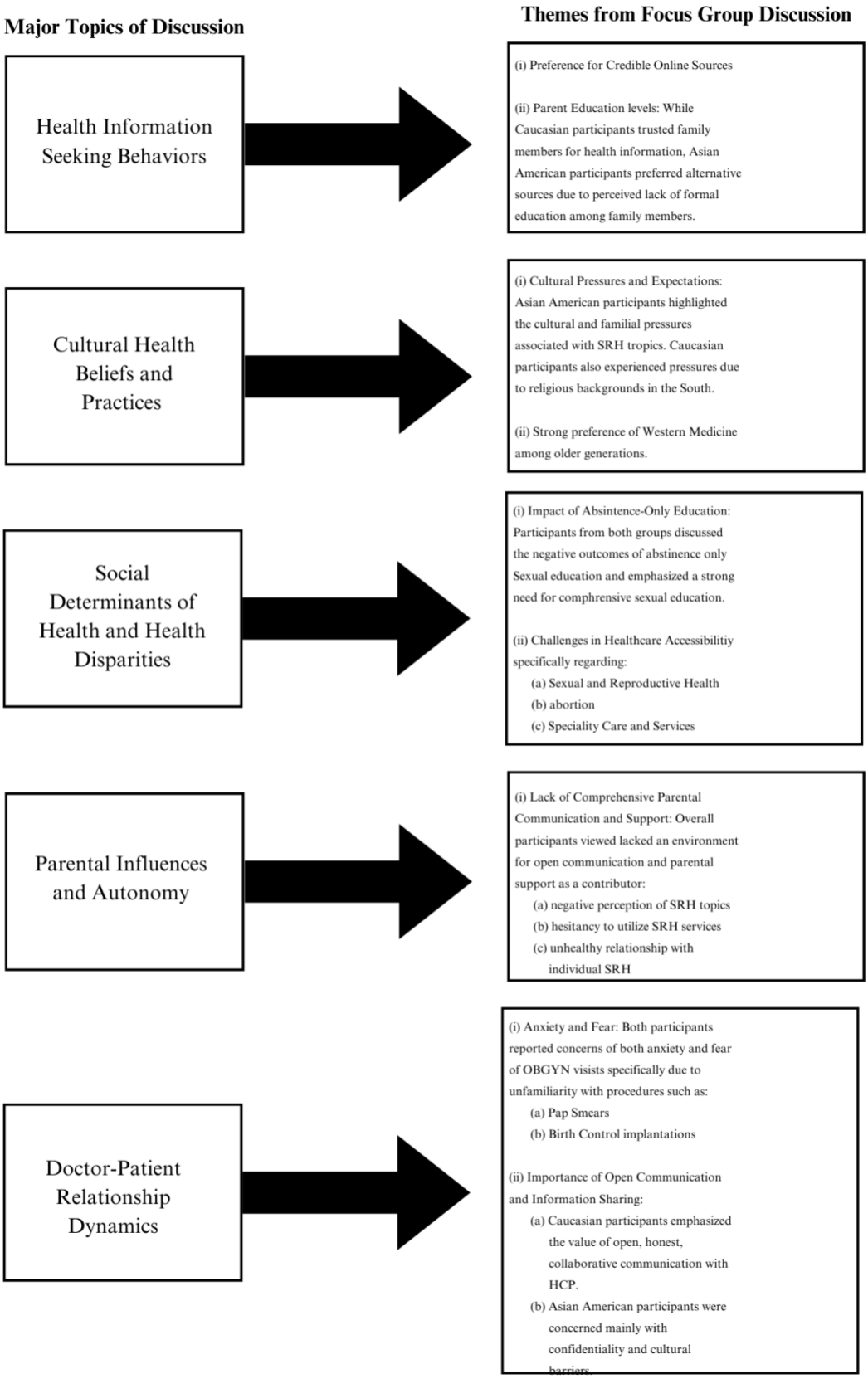
Major Topics of Discussion
Themes from Focus Group Discussion
Health Information Seeking Behaviors
(i) Preference for Credible Online Sources
(ii) Parent Education levels: While Caucasian participants trusted family members for health information, Asian American participants preferred alternative sources due to perceived lack of formal education among family members.
Cultural Health Beliefs and Practices
(i) Cultural Pressures and Expectations: Asian American participants highlighted the cultural and familial pressures associated with SRH tropics. Caucasian participants also experienced pressures due to religious backgrounds in the South.
(ii) Strong preference of Western Medicine among older generations.
Social Determinants of Health and Health Disparities
(i) Impact of Absintence-Only Education: Participants from both groups discussed the negative outcomes of abstinence only Sexual education and emphasized a strong need for comphrensive sexual education.
(ii) Challenges in Healthcare Accessibilitiy specifically regarding:
(a) Sexual and Reproductive Health
(b) abortion
(c) Speciality Care and Services
Parental Influences and Autonomy
(i) Lack of Comprehensive Parental Communication and Support: Overall participants viewed lacked an environment for open communication and parental support as a contributor:
(a) negative perception of SRH topics
(b) hesitancy to utilize SRH services
(c) unhealthy relationship with individual SRH
Doctor-Patient Relationship Dynamics
(i) Anxiety and Fear: Both participants reported concerns of both anxiety and fear of OBGYN visists specifically due to unfamiliarity with procedures such as:
(a) Pap Smears
(b) Birth Control implantations
(ii) Importance of Open Communication and Information Sharing:
(a) Caucasian participants emphasized the value of open, honest, collaborative communication with HCP.
(b) Asian American participants were concerned mainly with confidentiality and cultural barriers.

Figure 1.

DISCUSSION

Cultural Health Beliefs and Practices

Cultural norms and values surrounding sexuality and reproductive health greatly affected the health behaviors of female college students in both groups. One of the most striking contrasts between Asian American and Caucasian participants was the role of traditional cultural beliefs in shaping the perception, behaviors, and health outcomes concerning Sexual and Reproductive Health (SRH). Asian American experiences were shaped mainly by cultural, traditional, Eastern beliefs and backgrounds while Caucasian participant experiences were shaped by Southern and religious influences.

Similar to the findings of LaVeist (2003), Asian American female college students reported a common theme that revolved around avoiding preventative sexual and reproductive healthcare. Some participants mentioned their mothers and family members refusing to seek medical assistance unless the situation was urgent. Similarly, Frost and colleagues (2016) found that family SRH behaviors contributed to health habits of not utilizing preventative, consistent SRH services.

Taboos and stigmas surrounding SRH topics in both groups hindered family discussions, However, Asian American participants struggled with the various medical misconceptions and misinformation from their communities. Asian American participants said Eastern medicinal methods were favored over Western methods within their

communities, and those views often affected their accessibility to health services. Caucasian participants, however, focused on the religious and Southern stigmas and taboos surrounding SRH, such as abstinence-only education within the home and school settings. A similarity that arose from the discourse of both groups included the idea of sex guilt and shame surrounding individual sexuality.

Similar to the findings of Okazaki (2002) and Armstrong (2001), Asian American participants focused on the importance of collectivist ideals vs individualistic ideals within their culture. The participants highlighted the prevalent feelings of guilt and shame associated with individual sexuality, often attributed to the cultural emphasis on prioritizing the collective over individual needs. The belief persists that unplanned pregnancies or premarital sex could jeopardize family stability, undermine immigrant sacrifices, and disgrace the family.

Caucasian participants mentioned religious and Southern culture stigmas, taboos, and beliefs contributing to the overall idea of sex guilt and shame. Similar to the findings of Smith (2016), Caucasian participants mentioned families with strong religious backgrounds, especially in the South, contributed to stigma, sex guilt, and shame. Since premarital sex is viewed as morally wrong by many of the religions mentioned in the focus group, families with strong religious ties were more likely to treat individual sexuality with guilt and shame. This perspective was further reinforced by the societal norms prevalent in Southern culture, which further amplified the taboo around open discussion regarding individual sexuality and sexual behaviors.

Both groups highlighted the profound influence of cultural norms, values, and stigmas on their SRH behaviors and attitudes. While Asian American participants

struggled with familial pressures, misconceptions about Western medicine, and traditional beliefs, Caucasian participants navigated the challenges posed by religious and Southern influences limited by comprehensive sex education and evolving societal norms. Addressing these cultural implications is crucial for healthcare providers, to ensure that services are accessible, culturally sensitive, and effective in addressing the unique needs and concerns of these diverse populations.

Doctor-Patient Relationship Dynamics

Both groups displayed similar fear and anxiety related to the OBGYN and fear of procedures such as pap smears, while Asian American discourse indicated a larger amount of hesitancy towards doctors. Caucasian discourse portrayed a desire for a more collaborative relationship with medical professionals.

Asian American participants displayed a wider range of whether or not they went to the OBGYN when compared to Caucasian participants, the majority of whom reported going more consistently, this could be attributed to the amount of stigma, taboo, and fear of confidentiality reported by Asian American participants. While both groups shared concerns about confidentiality, Asian American participants expressed stronger reservations about open and honest communication with physicians.

The findings of the Asian American focus group discussion aligned with the findings of Zhao (2017) who found that adolescents often lie to their HCP about their sexual history or refuse hormonal contraceptives due to a fear of confidentiality. Zhao (2017) also found that Asian Americans believe their knowledge of SRH is often lacking in comparison to their Caucasian peers. This was evident in the

focus group discussions, as Asian American participants displayed more uncertainty about the recommended ages for specific SRH procedures compared to their Caucasian counterparts.

Ajjarapu (2021) underscored the value and effectiveness of cultural humility training for HCPs which further resonates with the focus group findings, pointing to a deficiency in cultural empathy among physicians. Asian American participants described negative experiences with HCP regarding discrimination and HCP adopting a condescending tone. Participants also mentioned that they felt physicians often did not fully listen to or empathize with the needs of their older family members, highlighting a lack of understanding and accommodation of their cultural context. The participants mentioned how negative experiences often impacted the way they further communicated and interacted with healthcare workers.

These insights are closely aligned with Besera (2023), in the fact that positive interactions such as feeling comfortable enough to engage in open conversations and HCP fostering an environment in which individuals feel confident enough to ask clarifying questions are crucial for positive health outcomes. It is because of these complex dynamics that Asian American participants mentioned that healthcare workers and providers did not often play a large role in their health decisions.

Caucasian participants mentioned confidentiality as well, but not to the extent that Asian American participants did. Caucasian participants were, generally, more willing to have a more collaborative relationship with physicians and their healthcare workers. Positive experiences where physicians listened and collaborated on finding suitable solutions were highlighted within the discourse of Caucasian participants.

Some participants also mentioned negative experiences, in which they felt pressured to agree to a solution without being provided with all the information. Overall, Caucasian participants wanted to include and incorporate physicians into their health decisions, but negative past experiences often hindered that. Specifically, Caucasian participants expressed that physicians needed to explain birth control options more comprehensively, rather than expecting them to have prior knowledge to form a better relationship for effective health decision-making.

Patient-physician communication dynamics are complex, marked by several barriers observed between both Asian American and Caucasian participants. The stark difference between these groups emphasizes the critical need for physicians to recognize and address cultural and individual nuances in patient communication. By training HCPs and tailoring communication methods to the specific needs, HCPs can foster trust, improve patient satisfaction, and enhance the overall healthcare outcomes of all individuals.

Parental Influence and Autonomy

Parental influence and autonomy emerged as significant themes across all discussion questions and prompts throughout the focus group sessions. Both Caucasian and Asian American participants reported strong parental influences shaping their health decisions and perceptions. Consistent with the findings of Hill (2023), parents and legal guardians played a pivotal role in molding sexual health behaviors and providing adolescents with supplemental sexual health information.

Asian American participants described limited conversations about Sexual and Reproductive Health (SRH) topics within their households, primarily due to prevailing stigmas, taboos, and traditional ideals. Many received scant preparation from their mothers regarding menstrual cycles, often navigating the challenges of womanhood independently. Even those who did discuss menstrual cycles with their mothers found these conversations lacking, focusing narrowly on practicalities.

Discussions about sexual intercourse and safe practices were largely absent, replaced by feelings of guilt and shame, particularly concerning premarital sex. Such restricted conversations intensified participants' feelings of embarrassment and discomfort, making discussions with healthcare providers challenging. As a result, many turned to the internet for supplementary health information. Nonetheless, there was a strong expressed desire among participants to foster open communication and dialogues about SRH with their future children. Familial support networks heavily influenced their health decisions, often leading them to avoid OBGYN visits due to parental apprehensions. While participants believed their parents would support them in critical situations, parental influence predominantly shaped their SRH perceptions and behaviors, often contributing to negative associations and feelings of shame.

Conversely, Caucasian participants generally reported more open dialogues with their parents, especially mothers, regarding SRH topics such as menstrual cycles and sexual intercourse. Echoing Hill's (2023) findings, those whose parents fostered an open environment for discussing SRH topics expressed gratitude. Participants whose parents refrained from open discussions often attributed it to their parents' upbringing influenced by religious factors. Notably, Caucasian participants whose parents engaged in SRH

discussions with them were more likely to access SRH services, including regular screenings and visits to OBGYNs.

Open dialogues and strong familial support networks enabled Caucasian participants to discuss their experiences more openly and comfortably. Such supportive environments also contributed to positive SRH behaviors and perceptions.
Many Caucasian participants acknowledged the role of generational stigmas and traditional beliefs in shaping their personal experiences but were generally appreciative that their parents had created environments conducive to discussing potentially uncomfortable topics.

In conclusion, parental influence significantly impacts the formation of positive or negative SRH perceptions and behaviors. Encouraging open and healthy dialogues between parents and children about SRH topics can have lasting benefits.
Addressing issues of sex guilt and shame is crucial, as these feelings can affect adolescents in later life. Furthermore, understanding generational shifts in beliefs and attitudes towards SRH is vital for future research and interventions aimed at fostering healthier SRH behaviors and perceptions.

Social Determinants of Health and Health Disparities

Regarding SDOH framework factors, both groups were asked about the effectiveness of quality, comprehensive sexual education alongside the role of income in forming health disparities. Regarding both income and education, both groups displayed valuable insights and knowledge regarding the role of education and income in contributing to the perception and quality of SRH resources.

There was an extreme amount of support for a comprehensive sexual education curriculum to be taught in school and the dangers of abstinence-only sexual education which participants were familiar with. Drawing upon their own experiences, Asian Americans emphasized the importance of addressing sexual education within schools in a way that would reduce shame and form positive perceptions regarding SRH topics, while Caucasian participants emphasized the importance of eliminating ignorance. The ineffectiveness of abstinence-only sexual education that many participants experienced going to primary schools in the South and religious private schools was generally viewed as ineffective in preventing individuals from engaging in unhealthy sexual behaviors and further resulted in negative health outcomes.

Like Decker (2022), both groups of participants in the current study concluded that comprehensive sexual education was necessary to promote positive patient health outcomes and increased utilization of SRH resources. Both groups valued the role of comprehensive sexual education in limiting and reducing health disparities due to misinformation and ignorance and deemed comprehensive sexual education necessary within schools, especially within the South.

Both groups were found to be very knowledgeable and reflective about the effects of income on health disparities, accessibility, and quality of SRH. Asian American participants reflected on their own experiences and parents' experiences regarding how income prevented accessibility to quality healthcare resources. Many participants agreed that income, in the past, has served as a barrier to accessing care and is a contributing factor to why they often do not seek preventative care. These participants displayed a

strong desire for a change in health insurance policies, noting that affordable health insurance plans are usually of poor quality or specialty care.

Caucasian participant responses reflected wealth disparities that occurred geographically within the state and in other states. Generally, both Asian American and Caucasian participants believed that income directly influenced both access and quality to healthcare services, specifically access to specialty services such as OBGYNs. Caucasian participants were reflective on the difficulty of gaining appointments at specialty services, mainly SRH services, and how the differences in wealth distribution, especially in the South served as a strong barrier.

Overall, the consensus was that Income directly influences individual accessibility and quality of SRH health care services and participants demonstrated a desire for change. Both groups of participants recognized that low-income individuals were more vulnerable to health disparities.

Information Seeking Behaviors

Both Asian American and Caucasian participants portrayed the importance of trusting reliable and credible sources when searching for health information online. Websites such as WebMD, Cleveland Clinic, Planned Parenthood, and other medical journals were mentioned, along with the importance of crosschecking sources to ensure the validity of information.

Dong et. al (2024) also mentioned that women, specifically, face a problem with disseminating information, dealing with information overload, and dealing with misinformation and misconceptions. However, the participants of this study seemed to be

knowledgeable on how to seek quality health information. Participants of both groups mentioned turning towards online sources to find health information to supplement the lack of information that was taught in both formal and informal settings. Both Caucasian and Asian American participants also value the insights from peers, however, Caucasian participants were, generally, more likely to also seek information from healthcare providers and their family members, while Asian American participants mentioned only seeking out information from family members in critical situations.

The results align with the findings of Herdt (2021), who found that levels of SRH information literacy can be hindered by religion, morality, cultural stigmas, and other sex-negative sources. While Lu et al (2022) highlighted the impact of cultural backgrounds regarding the sources of individual trust, Asian Americans acknowledged the fact that their parents did not receive formal education and instead attributed their information-seeking behaviors to their formal education, not allowing their cultural upbringings to hinder their health information seeking abilities. In contrast, Caucasian participants often mentioned the formal education of their parents and how their parents guided them in differentiating between reliable and unreliable sources.

Implications for Future Research

The findings from this research can inform and guide future research studies, policy development, and healthcare practices aimed at promoting healthier SRH behaviors and perceptions among diverse populations. Ultimately, the findings

may contribute to improved healthcare accessibility, quality, and outcomes for female college students.

This study provides a foundational understanding of the factors that influence SRH perceptions and behaviors among Asian American and Caucasian female college students. Future research could investigate the effectiveness of cultural competence training for healthcare providers to improve patient-physician communications, patient satisfaction, and trust in both healthcare providers and health institutions. The study also highlights a need for a more effective compressive sexual education. It calls for more research regarding the necessary educational programs that better equip young individuals with the skills needed to make informed health decisions. Further research also could focus on the broader social determinants of health including income, education, and geographic disparities, as well as how to combat them in a way that directly results in positive health outcomes.

Limitations

While this research endeavors to provide valuable insights into the experiences and perspectives surrounding sexual reproductive health behaviors, it is important to acknowledge and address the limitations of the study to maintain transparency and ensure a balanced interpretation of the study's findings.

Participants were recruited solely from the University of Mississippi, which potentially limits the diversity of perspectives and experiences presented within the study. Students from other institutions or geographical locations may have different backgrounds, cultures, and healthcare experiences that were not captured in the study's

findings. In addition, the study may not be broadly applicable beyond a university context. The study compared two groups -- Asian Americans and Caucasians -- so the study cannot fully represent other minority ethnic communities. Other ethnic groups with distinct cultural backgrounds and healthcare practices might offer different perspectives and insights that were not explored within this study.

Furthermore, the variability in participant comfort levels in the discussion of sexual and reproductive health topics could introduce a possible bias in the findings and results of this study. While some participants may have been more forthcoming and open to sharing their personal experiences, others might have been reserved and hesitant to share their experiences, which could result in an overrepresentation of certain viewpoints and an underrepresentation of others. This leads to the possibility of skewed results.

It is also important to note that the cultural background, assumptions, and interpretations of both the researchers and the focus group moderators could have played a role in the distortion of data or the comfort level of the participants within the focus group. Despite attempts to minimize researcher bias through a strict focus group script, the use of various focus group moderators, and multiple coders, it is impossible to eliminate this and other biases.

Lastly, since this project relies heavily on qualitative research providing rich insights into participants' experiences and perspectives, it is unlike quantitative studies in the fact that it cannot generate statistical data. Qualitative research focuses on understanding phenomena, pinpointing overarching themes, and is more up to interpretation. Acknowledging these limitations is crucial for interpreting study findings accurately and understanding their potential implications. It is essential to recognize the

inherent constraints and consider them when evaluating the significance and applicability of the study's findings in terms of the broader context.

Conclusion

This study underscores the profound influence of cultural beliefs, parental influence, and social determinants on the Sexual and Reproductive Health (SRH) perceptions, behaviors, and outcomes of Asian American and Caucasian female college students. It highlighted key differences between these two groups, including how women are influenced by their backgrounds and upbringing. It sheds light on how to tailor doctor-patient communications and services to address these cultural and individual needs more effectively.

This study illuminates the need for effective healthcare communication and support for adolescent girls and young women from both formal and informal sources, including academic institutions, healthcare institutions, and familial networks.
The findings serve as a foundation for future investigations hoping to dive deeper into specific SRH behaviors influenced by cultural context. The emergent themes and other takeaways could guide policy-making needed to enhance the quality and inclusivity of SRH education and services.

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