


# Sexual and Reproductive Health Knowledge, Attitudes, and Self-Efficacy Among Young Adult Filipino American Women

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## Abstract

**Introduction:** Little is known about Filipino American women's (FAW) sexual and reproductive health (SRH). The purpose of this study was to examine the SRH knowledge, attitudes, and self-efficacy among young adult FAW. **Method:** This was a qualitative, descriptive interpretive design. Four focus group interviews and one individual interview were conducted. Purposive sampling was used for this study. Inclusion criteria were female, Filipino American, between the ages 18 and 24 years old, and be able to understand and speak English. **Results:** Twelve participants ( $n = 12$ ) were recruited. Three themes emerged from this study: (a) sources of SRH information; (b) influence of cultural values, religion, and intergenerational factors; and (c) facilitators of and barriers to women's health services. **Discussion:** Themes emerged from the content analysis identifying SRH disparities within the Filipino American community, which may inform future interventions and research on this topic.

## Keywords

Filipino American women, Filipino American, Filipina, sexual and reproductive health, health disparities, clinical areas, Asian American, qualitative, research methods, women's health, sex education, young adult

## Introduction

The immigration pattern of Filipinos reflects the geopolitical history of the Philippines and the United States, with 4.1 million Filipino Americans (Fil Ams) representing the third largest Asian subgroup (Budiman & Ruiz, 2021; U.S. Census Bureau, 2018). Filipino American women (FAW) comprise the larger share of this population at 2,249,263 (U.S. Census Bureau, 2018). Despite representing one of the fastest-growing ethnic populations in the United States, there is a dearth of disaggregated research examining the health of Fil Ams (dela Cruz et al., 2002, 2013). The paucity of studies specific to sexual and reproductive health (SRH) of FAW is even more profound. A PubMed database search for recently published studies between the years 2016 and 2021 using the key term "Filipino American women" resulted in seven studies. Little is known about FAW's SRH except that they have more adolescent pregnancies than other Asians (Javier et al., 2010). Filipinos are a unique group from other Asian subgroups because of their colonial history with Spain and the United States and due to the predominance of Catholicism influencing their strong moral objections to premarital sex, contraception, and abortion (Chung et al., 2005; Okazaki,

2002). Due to the scarcity of recent literature on Fil Ams, examining the published literature on Asian Americans over time becomes necessary (Gong et al., 2003).

## Literature Review

The monolithic term "Asian" represents more than 20 countries in East and Southeast Asia and the Indian subcontinent (Budiman & Ruiz, 2021). Despite the heterogeneity among Asian and Pacific Islanders (APIs), and APIs being the fastest-growing racial/ethnic group in the United States, researchers often have overlooked APIs, as clinicians perceive this population as having minimal health concerns, partly due to the "model minority" myth (Shih et al., 2019; Trieu et al., 2013). When studies have included APIs, they

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often have involved a small, limited sample size and often aggregate research data to represent the API umbrella (Ansari-Thomas et al., 2020; Trinh & Kim, 2021). Combining data gives a false sense of reassurance that API subgroups have all done well uniformly. For example, studies have reported APIs have a lower pregnancy rate, are less likely to engage in sexual intercourse, and have fewer sex partners (Grunbaum et al., 2000; MacDorman et al., 2002; Schuster et al., 1998); however, when data on API subgroups were available and disaggregated, risks varied widely between the groups (Gordon et al., 2019). For example, disaggregated data showed the percentage of Chinese students between 11th and 12th grades who were sexually active was 13% compared with 32% of Filipino students (Horan & DiClemente, 1993). In California, where Fil Ams represent 87% of the state's APIs, Fil Ams have the highest pregnancy rate among California's six largest API subgroups (Weitz et al., 2001). Weitz et al. (2001) reported, compared with White adolescents, Fil Am adolescents were more likely to request to obtain a pregnancy test but no other services from their health care providers, suggesting they were sexually active but not using contraception. As previously mentioned, there is a large gap in research on this topic and this specific population. Studies published more recently with disaggregated data highlighting these SRH disparities among Fil Ams were not found. The primary aim of this study was to gain a better understanding of the factors that contribute to the SRH knowledge, attitudes, and self-efficacy among young adult FAW.

## Method

### *Research Design, Setting, and Recruitment*

This study employed a qualitative descriptive interpretive approach (Elliott & Timulak, 2021). This methodology is indicated when there is little knowledge that exists on the topic (Thorne, 2016). Interpretive description allows for the examination of a phenomenon "with the goal of identifying themes and patterns among subjective perspectives, while also accounting for variations between individuals" (Hunt, 2009, p. 1285). Purposive sampling was used for this study. To be eligible, individuals had to identify as female, Filipino American, between the ages 18 and 24 years old, and be able to understand and speak English. After receiving university Institutional Review Board approval, recruitment information was disseminated for 3 months, from December 2020 to the end of February 2021 through a Filipino student organization at a university located in New Jersey. Although recruitment occurred through the student organization's member listserv, Facebook page, and Instagram account, participation in the study was not limited to students from the student organization's university. Those interested in participating in the study followed a website link or scanned a QR code on a flyer attached to the recruitment email and included

on the social media posts. The link took potential participants to an electronic consent form through Qualtrics, a secure online survey tool. After agreeing to be part of the study, participants were then routed to a list of dates and times for focus group interviews. Due to social distancing restrictions because of the COVID-19 pandemic, the university was closed for nonessential purposes; therefore, all four focus group interviews and one individual interview could not be held face to face and were facilitated virtually. The confirmation email sent to participants included a link for the interview. Each participant received a US\$25 Visa gift card electronically for their participation in the study.

### *Sample*

All focus group interviews and one individual interview were conducted between January and February 2021 with young adult FAW. Participant demographics are listed in Table 1. All participants ( $n = 12$ ) self-identified as Fil Am between the ages of 18 and 24 years. Ten participants were born in the United States and the other two moved to the United States as an infant or toddler. All of the participants attended primary, secondary, and post-secondary schooling in the United States. Except for three participants who recently graduated college, the other nine were currently enrolled in a university pursuing their postsecondary education. Most participants ( $n = 9$ ) identified as having been raised in a Roman Catholic household, but six pointed out that this was their parent's religion and that they were no longer practicing. Other participants ( $n = 3$ ) stated they were agnostic, a person who holds the view that the existence of God is unknown (Armstrong, 2017). As qualitative research experts have recommended, recruitment and interviews of FAW continued until theoretical data saturation was attained after the fifth interview wherein no new information was obtained and the gathered information was enough to answer the research question/s (Miles et al., 2014).

### *Data Collection*

The principal investigator (PI), an experienced interviewer and qualitative researcher, led all the discussions. There were four focus group interviews with two, four, three, and two participants, respectively, and one individual interview wherein additional scheduled participants did not show up. A core list of open-ended, semi-structured questions was used from the United Nations Development Programme, United Nations Population Fund, WHO, and the World Bank's Special Programme of Research Development and Research Training in Human Development's "Asking Young People About Sexual and Reproductive Behaviours" (Ingham & Stone, 2001) interview guide. The researchers identified questions addressing sources of information, sexual experience/inexperience, contraceptive use, and utilization of SRH services. These core questions were aligned with the three

**Table 1.** Participant Demographics.

Participant	Age	Birth country	Current residence	Level of schooling at the time of interview	Religion
Focus Group 1					
1	22	United Arab Emirates, moved to the United States at age 2	United States	Graduate school	Roman Catholic
2	21	United States	Japan	Junior (undergraduate)	Roman Catholic
Focus Group 2					
3	24	United States	United States	Recent college graduate	Agnostic
4	20	United States	United States	Junior (undergraduate)	Roman Catholic
5	23	United States	United States	Recent college graduate	Agnostic
6	22	United States	United States	Senior (undergraduate)	Roman Catholic
Focus Group 3					
7	18	United States	United States	Freshman (undergraduate)	Roman Catholic
8	22	United States	United States	Recent college graduate (undergraduate)	Roman Catholic
9	20	United States	United States	Junior (undergraduate)	Agnostic
Focus Group 4					
10	22	Korea, adopted as an infant	United States	Junior (undergraduate)	Roman Catholic
11	21	United States	United States	Senior (undergraduate)	Roman Catholic
Individual interview					
12	20	United States	United States	Junior (undergraduate)	Roman Catholic

main areas that the researchers aimed to study: knowledge, attitudes, and self-efficacy related to SRH. The complete interview guide can be found in Table 2. All interviews were conducted via WebEx, a secure, online video conferencing platform. Interviews ranged from 60 to 90 min in length and were audio-recorded.

### Analysis

Audio files from all the interviews were transcribed verbatim by a professional transcription service. Careful consideration of participant privacy and confidentiality were of high priority as sensitive, candid information was shared during interviews; thus, no identifiers were included in the final data reporting. Participant names were replaced with pseudonyms to protect their identities. Transcripts were uploaded to NVivo, a secure web-based application for managing, organizing, and analyzing qualitative data. Inductive content analysis was used to develop initial codes and themes (Stemler, 2015). The three research team members, who are experts in young adult health and sexual and reproductive medicine, aimed to become immersed in the data by conducting multiple initial readings of the transcripts. Line-by-line coding of each transcript was conducted, and the process of open coding process was initiated by writing down notes in the margins to explain the content (Elo & Kyngäs, 2008; Polit & Beck, 2018). Words and phrases relevant to the research question were identified, and coding decisions were discussed until full agreement was reached between researchers. Throughout this process, a codebook was developed iteratively. Next, codes were grouped under broader inductive

themes with the purpose of deepening understanding and generating knowledge. Tables were created to summarize key themes, prevalence of the themes, comparison between the data, and illustrative quotes from interviews. Tables were used to identify patterns and salient concepts within the data. Analysis of the four focus group interviews and one individual interview yielded three major themes: (a) sources of SRH information (knowledge); (b) influence of cultural values, religion, and intergenerational factors (attitude); and (c) facilitators and barriers to women's health care services (self-efficacy).

## Results

### *Theme 1: Sources of SRH Information (Knowledge)*

Initial and subsequent sources of information on SRH were varied among participants.

*Parents—Mothers, in Particular.* Participants perceived their parents to be hesitant with addressing SRH topics. All participants, except one, stated their mother, not their father, was the primary person in their household from whom they expected information about bodily changes. Their mothers presented information in a straightforward, matter-of-fact way and did not elaborate about the physiology of changing bodies. Mothers also avoided conversation related to the psychosocial adjustments in adolescence. Discussions about puberty with their mothers were brief, practical, and limited to how to use a sanitary pad and wear a bra. Kristine, a college junior,

**Table 2.** Focus Group Interview Guide.

## Sources of information

1. How have you found out about relationships, sex, and contraception?
2. How knowledgeable do you feel about sexual matters?
3. Whom or what do you rely on for information? Whom or what are the most important sources to you?
4. Did your parents (elders) ever tell you about sex or discussed any matters related to sex with you?
5. Why did you think your parents (elders) have never spoken to you?
6. Would you have liked your parents (elders)/other family and community members to be more open?
7. How important are parents (elders)/other members of your family/community as sources of information?
8. Have relationships, sex and/or contraception ever been spoken about in high school? College?
9. What information has been given out in high school? College?
10. When finding about relationships, sex, and contraception what role have your friends played?
11. How important are friends as a source of information?
12. What issues do you talk about?
13. What role has the media played in informing you about relationships, sex, and contraception?

## Sexual experience: first intercourse

15. Can you describe your first experience of sexual intercourse?
16. Did you use any method of contraception?
17. How was this contraception usage/non-use decided?

## Sexual inexperience

18. Why do you think you haven't had sex yet?
19. Reason(s) why first intercourse has yet to occur
20. Do you feel under pressure **not** to have sex?

## Sexual experience: subsequent sexual behavior

21. Have you had more than one sexual partner?
22. How would you describe your relationships?

## Contraceptive use and protective practices

23. Which forms of protection against pregnancy and STIs do you generally use?
24. Which forms of protection against pregnancy and STIs have you used?
26. How sure are you that you would use contraception to prevent pregnancy in the future?
27. What have been the reasons for not using protection?
28. To what extent do you think about any risks involved with sex?
29. Are you fearful of pregnancy?
30. Are you fearful of STIs?

## Use of sexual and reproductive health services

31. Can you list for me all the places and people you know of which young adults like yourself are able to visit and talk to, to find out about relationships, sex, contraception, and STIs?
32. Have you ever been to any services for help and advice about relationships, contraception, STIs, sex?
33. What are the general feelings about the services you have accessed?

Source. Adapted from Ingham & Stone (2001).

Note. STIs = sexually transmitted infections.

shared her recollection of her mother's summation of puberty: "“Oh, your boobs are going to get bigger, so we'll start buying bras now.' Other than that, that's it.” Another participant said she did not learn about puberty at school because her mother refused to sign the consent form for her to attend the special session in health class. She believed her mom held “traditional values.” She said, “I wasn't taught about puberty. I had to learn it myself. My first instance is the day I actually got my period. That's when my mother decided to tell me.” When her period started, she was confused, panicked, and told her mother, “Mom, something's happening.” Her mother did not verbally respond but instead “checked (the underwear).” She continued: “She left the house and got pads and taught me how to put it on. Then she said, ‘That's how periods work.’

And then I never understood why girls got periods . . . I wish my mom had signed those consent papers.”

When it came to discussing sex, contraception, sexually transmitted infections (STIs), pregnancy, and abortion, parents were silent. Despite desiring to have open dialogue with her mother, another participant relied on the internet instead. She stated, “I wish I had learned it from my mom. She just didn't want to talk about it . . . I played it by ear until something goes wrong. . . then it's straight to Google, but never to my mom.”

One participant appreciated her mother's openness to discussing contraception: “She never hid that. I would watch her take her birth control pills.” She stated her mother's motivation behind this transparency was apprehension of



becoming pregnant as a teenager because her *tita* (mother's older sister) "got pregnant at 16."

**School.** Many participants who attended Catholic school shared these religious schools did not cover puberty or sex education at all. If the school did include SRH in their curriculum, students learned mainly about abstinence and avoiding sex before marriage. Delilah, a 20-year-old college junior, went to an all-girls Catholic school where this message was clear. She said, "Basically, we were just told, 'Don't do it.' Just preserve your innocence and purity as much as possible."

Participants who attended public school learned about puberty primarily in health or biology class in elementary and middle school. Carmina, a 24-year-old recent college graduate, recalled, "The girls had the girl teacher and the guys, the guy. They went over anatomy in more detail. I guess I should give them more credit, I learned plenty from school." They were taught through lectures, handouts, charts, and several mentioned being taught how to put a condom on a banana. Four participants disclosed they were already sexually active by the time their schools provided sex education in their curricula during their sophomore and junior years of high school.

**Friends.** Friends and classmates at school were a convenient source of information, especially related to menarche and sexarche. When participants were younger and did not have access to the internet, friends, specifically non-Filipino friends, were their source for information. Because SRH topics were not openly discussed at home, participants stated they were particularly curious when peers brought up these topics at school. Alina, a 22-year-old graduate student, was unaware other parents were more open to talking about sex. She stated that when a friend shared that their parents had "the talk" with them, Alina said, "I didn't understand that. These friends are not Filipino. They're mostly White. I was like, 'Oh, that's surprising to me. I didn't think that your parents would actually have that conversation with you.'" There were friends who "explored the waters" before they did and were a source of information when participants wanted to learn not only about sex but also relationship dynamics. June, a 20-year-old college junior, said, "I think hearing it from a close friend, it's a different experience. It's more than just a male putting his penis inside a woman's vagina . . . I feel like I learned a lot more from my friends than at school." Some participants mentioned they also had friends who were as inexperienced as them, which resulted in being in their "own boat of figuring things out" through "trial and error."

### **Family—Titas, Older Cousins, and Sisters**

Most participants mentioned *titas* (aunts), older cousins, and sisters were trustworthy sources who served as a more approachable alternative to their mother. One participant

stated, "One of my cool aunts I would go to. I feel like everyone has one (aunt) that's more chill than their mom." Another participant stated, "So much easier to approach my cousin or best friend than approaching the woman who's literally in my house." Participants were comfortable sharing their experiences candidly with these familial confidantes and felt at ease to talk openly about sex and contraception because there was already an underlying understanding.

**Internet and Social Media.** As they got older and had smartphones, participants' access to information widened. When they were "confused about something" related to SRH topics, participants turned to the internet and social media, not just for instant information at their fingertips but also to feel their experiences were valid. They used Google to search for reliable sources such as Planned Parenthood. Platforms such as Reddit, YouTube, Snapchat, TikTok, and Instagram provided entertainment, information, and a place where "other people validate the experience," which made them "feel okay, this is normal, nothing to freak out about." Participants mainly stayed away from using Facebook as they valued "creating a space where it's like [their] parents aren't there, [their] titas aren't there, [their] grandma's not there."

### **Theme 2: Influence of Cultural Values, Religion, and Intergenerational Factors (Attitude)**

Participants felt their parents' conservative Filipino values rooted in Catholicism and conventional beliefs to be the main reason SRH topics were avoided in their household.

**Duality of Cultures.** Their parents' "traditional" approach steeped in Filipino values was juxtaposed with being born and raised in the United States with less "stigma" surrounding SRH. Fenny, a 22-year-old college senior, shared their experience having traditional Filipino parents, where abstinence was emphasized "and doing it is just so looked down upon. Then the duality of having a different culture . . . Sex is normal, normal human, just be safe. It's like two different types of people." Another participant who was raised Catholic shared, "I'm not the biggest fan of the Catholic Church . . . I don't think it's a sin to have sex before marriage. I feel like masturbation is not a sin and I feel like other sex positions aren't a sin."

**Hiya and Amor Propio.** *Hiya*, which means shame or embarrassment, was an underlying thread weaved throughout parents' messages and stories discouraging sex before marriage. One participant who wanted to have a conversation about sex with her mother said the topic was "off the table" until she started seeing a gynecologist on her own. She told her mother, "'Yeah, I had sex when I was 17.' She was like, 'I thought you had a little more respect for yourself.'" Many participants shared their mothers used family members who had "children out of wedlock" as examples of the

consequences of premarital sex. Participants perceived these anecdotes as a warning to avoid bringing shame to themselves (*amor propio*) and their family. Holly, a 22-year-old recent college graduate, shared her family was “very stereotypical . . . [they said] ‘don’t have boyfriends, don’t have sex, don’t have anything before you are married.’” Holly recalled her mother reminding her of her “tita who got pregnant at 16” and her tita’s children, who were younger than her, then had children also at 16. She said, “I feel there’s a stigma. They do try to hide the babies now . . . there’s shame with having kids as a teen, but there’s also shame if you get rid of that baby.”

**Purity and Virginity.** Participants perceived concepts of purity and virginity were being emphasized throughout their young adult life. One participant said, “They expect us to be adhering to our religious beliefs as well as our cultural beliefs of waiting until marriage.” Iris, a 20-year-old junior, was raised in a religious family. She stated, “They have very traditional values and that includes not supporting having sex before marriage . . . but I’m going to do it if I want to do it.” Another participant shared, “They still think I’m a virgin. If they found out I was pregnant, I don’t even know how they would react. But, yeah, I would probably get an abortion, especially my parents being super religious.” Several participants mentioned their mothers wanted them to avoid using tampons because, in doing so, they would no longer be considered a virgin if they used them. She stated, “I think it stems from that conservative standpoint of virginity.” One participant added Asian peers also did not use tampons because “their mom sa[id] that tampons [would] make you pregnant.”

**Pakikisama and Conflict Avoidance.** The Filipino cultural value of *pakikisama* emphasizes harmonious relationship and conflict avoidance. The message participants received from their parents was, “Just don’t do it.” Most participants wanted to engage further in conversations beyond being told not to have sex but perceived parents to be unapproachable. Instead of pressing the issue with their parents, they chose to keep harmony within the family and took their parents’ lead by not discussing SRH topics. Fenny said, “I think because of the environment that they created growing up . . . it felt reciprocal that I also shouldn’t bring it up.” Another shared, “I tried to talk to her (mother) about something similar to the topic. And I remember her saying she didn’t really want to discuss it with me. I think it made her uncomfortable.” A 22-year-old participant stated that if she brought up “taboo” topics related to sex, her mother “would pretend like she didn’t hear” her.

**Focus on Success.** When SRH topics were brought up in the home, parents reframed conversations around the idea of success. The focus of the dialogue was on the consequences of pregnancy and the resulting effects of these “failures” on future success; however, parents had minimal discussion related to preventing pregnancy apart from abstinence.

Delilah said, “The number one thing my parents always told me, whenever I came back from college, whenever I leave for college . . . ‘Oh, as long as you don’t come home pregnant.’” Participants felt the weight of the pressure to succeed, especially if their parents were immigrants. One participant stated, “[I had] high expectations my whole life. . . knowing that my mom immigrated here, and she busts her butt every day so that I can afford to live and pursue my dreams.”

### Theme 3: Access to SRH Care (Self-Efficacy)

Barriers to accessing SRH services were (a) participants’ lack of knowledge about when and where to seek services, (b) parental opposition, and (c) fear of lack of confidentiality. Being under their parents’ insurance was both a barrier and a facilitator. Iris wanted to start a contraceptive. She stated, “I did some research into it. I’m still not 100% sure about how to get it. I did ask my mom if I could go on it. And she said, ‘No,’ like she seemed very opposed to it.” Parents were perceived to be opposed to contraception because agreeing to it could be interpreted as an endorsement to have sex. Participants felt they needed to avoid conflict (*pakikisama*) by not seeking women’s health services for fear and embarrassment (*hiya*) their parents would find out. Most importantly, confidentiality was a key factor in avoiding seeking women’s health care. Another participant stated, “[My mother] would’ve been able to see if I got something through our insurance. So that’s what stopped me.”

Parental support, parents’ insurance coverage, and access to a student health center facilitated obtaining services. Carmina said, “I used all my parent’s insurance, part of it was just making the decision for myself . . . while at college going to student health . . . the fact that they had a woman’s health center helped a lot.”

## Discussion

To our knowledge, this study was the first to examine the SRH knowledge, attitudes, and self-efficacy among young adult FAW. Findings from this study illuminated how deeply Filipino cultural values, religion, and intergenerational communication and interaction have influenced how FAW have sought and acquired SRH information and women’s health services. Participants wanted information not just about puberty and sex but also guidance and support for the psychosocial and emotional aspects of becoming a young adult. However, mothers rarely discussed feelings and emotions and emphasized Filipino values instead. These findings were consistent with previous research findings showing communication about SRH was limited in Fil Ams (Chung et al., 2005; Frost et al., 2016; Javier et al., 2006; Kim, 2009). Participants struggled with negotiating the duality of cultures between being born and raised in a country where topics like sex and contraception are more acceptable than in their own household. Similar to Wolf’s (1997) findings,

second-generation Fil Am youth have experienced struggles deeply tied to their relationship to their families and those children of immigrants have experienced internal and familial discord as their parents endeavor to impose their values within new social contexts living in the United States. Even though many participants shared they were no longer practicing the religion in which they grew up, their attitudes toward SRH reflected the heavy influence of Filipino cultural values deeply seated in Catholic beliefs such as purity, *hiya*, *amor propio*, and *pakikisama*. Previous studies (Martin et al., 2018; Young et al., 2015) have suggested high levels of religiosity are related to the delay of sexarche, fewer engagement in casual sex, and lower number of lifetime sex partners; however, specific questions related to this possible relationship were not explored in this study.

Results of this study showed lack of participant SRH knowledge and lack of parental support contributed to misinformation (e.g., “tampons will make you pregnant”). A general lack of preparedness for sexual decision-making was a barrier to positive healthy behaviors such as acquiring women’s health services. Participants were concerned about confidentiality issues related to being on their parents’ insurance and parents discovering that their daughters visited a women’s health provider for contraceptive needs.

Facilitators to accessing women’s health services included participant knowledge of services from peer recommendations, learning from the internet and social media, having parental support, and a mother open to discussing “taboo topics.” Some participants took advantage of having their parents’ insurance coverage and not having to pay for services. As college students, participants had access to student health centers on campus.

### Limitations/Strengths

There were several limitations to this study. First, the sample was a sample of convenience and was relatively small; therefore, conclusions from this research are not generalizable to the larger population. Second, participants were highly engaged in the educational community as they were currently enrolled or had recently graduated from college. One may assume participants were exposed to many young adults through social peer groups at their university, had easy access to information through technology, and were in proximity to student health centers. Their perspectives may not accurately represent FAW across different educational backgrounds and socioeconomic status. In addition, due to the restrictions of the COVID-19 pandemic, all interviews were facilitated virtually instead of being conducted face to face in a private space on campus as originally planned. Most participants were living at home with their parents or with roommates which may or may not have affected their candidness in answering sensitive questions. On occasion, participants used Tagalog words during

interviews. The PI, who conducted all the interviews, was born and raised in the Philippines and is fluent in Tagalog. She could not only interpret the Tagalog words but also could understand the cultural context. Another strength of the study is the cultural congruency between the participants and the PI. One participant stated, “You are the first Filipina American that I have met within my educational career . . . that ever mentioned anything about sexual and reproductive health . . . I think that very heavily impacts . . . approachability. Representation has a majority to do with that as well.”

### Implications

Findings from this study can provide better understanding of the factors influencing how young adult FAW seek and acquire women’s health information and services. These findings could have substantial impact on designing community-driven, culturally appropriate interventions to improve SRH education and increase acquisition of comprehensive women’s health care services in the Fil Am community. Health care providers, including school nurses and clinicians at university student health, working with Fil Am families should be aware SRH topics may be uncomfortable to discuss. Providers should also know young adult FAW are concerned about confidentiality, and this may be a barrier to seeking care. Further studies with a larger, more diverse sample of FAW from different generational statuses (i.e., 1st, 1.5, 2nd, or 3rd), ages, religious affiliations, and educational backgrounds are needed to better assess the role of culture, religion, and intergenerational factors. Studies on the role of parents (particularly the mothers), tias, older cousins, and sisters may provide a meaningful perspective about the transfer of knowledge, attitudes, and self-efficacy to the next generation of Fil Ams.

### Conclusion

In a population of young adult FAW, we found SRH knowledge, attitudes, and self-efficacy were deeply influenced by Filipino cultural values, religion, and intergenerational communication and interaction. Facilitators of and barriers to accessing women’s health services included participant knowledge of services, parental support, and being under their parents’ insurance.

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