

Literature Review

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Examining the State of Health Research on Pacific Rainbow Communities in New Zealand: Literature Review

Patrick S THOMSEN, Sarah MCLEAN-ORSBORN, Hollyanna AINEA, Allyssa VERNER-PULA

ABSTRACT

Introduction: Pacific Rainbow/Queer Communities (PRCs) in New Zealand (NZ) have had scant attention paid to the specificities of their health and wellbeing needs in research. Recently, the Health Research Council of NZ funded its first Pacific-specific PRC project (The Manalagi Project) executed through the University of Auckland's Centre for Pacific Studies. This paper reports a literature review conducted to ascertain the current state of health research on PRCs, Rainbow/Queer and Pacific communities' health in NZ.

Methods: A scoping review was conducted where relevant public health database search engines were accessed, which included PubMed and Medline to explore both national and international health research pertaining to PRCs, Pacific communities and Rainbow/Queer communities. Additional Google searches were undertaken to identify more 'grey' material such as reports, websites, other relevant government sources, as well as non-profit organisation and educational resources not visible via scientific databases.

Findings/Outcome: The review identified published journal articles (n=20), books (n=1), reports (n=25) and theses (n=3) as well as other documents relevant to the study, such as websites and news articles pertaining to PRCs in NZ and abroad. It reveals a severe paucity of health research focused on PRCs domestically and internationally. Although more research is being conducted into the space of Pacific communities, as well as Rainbow/Queer communities, research that is PRC-focused is urgent and critical at this time.

Conclusion: Both Pacific and Rainbow/Queer communities in NZ are socially marginalised, thus experience a raft of health challenges represented by a racist and cisnormative heterosexist health system. This literature review reveals a lack of understanding around the nuances that exist when these experiences intersect and coalesce in the body and experience of PRC members. It has identified a significant gap in Pacific health research that exists in NZ and abroad that urge us to frame future research to also be intersectionally-informed to capture the unique needs and context of PRCs.

Key words: Pacific Health Research; Pacific Rainbow Health; Manalagi Project; Queer/Rainbow Health; MVPFAFF; LGBT

INTRODUCTION

Pacific peoples account for 8.2% of New Zealand's (NZ) national population and are the fastest growing ethnic group in the country.¹ Despite this, little is known regarding the shape and experiences of Pacific Rainbow Communities (PRC) with healthcare services in NZ. Currently, our [L]esbian [G]ay [B]isexual [T]akatāpui [T]ransgender [I]ntersex [Q]ueer [A]sexual+ (LGBTTIQA+) people are not accounted for in the Census. A further complication being that many

Corresponding author: Patrick S Thomsen

patrick.thomsen@auckland.ac.nz

Maori and Pacific Studies, Faculty of Arts, University of Auckland, New Zealand

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PRC members do not identify as LGBTTTQIA+ as there are Pacific-specific non-normative gender and sexuality identities/framings that exist (see MVPFAFF).²⁻⁴ Therefore, this literature review is designed to explore prior research that is attuned to PRCs experiences with NZ's healthcare system. It identifies the current state of Rainbow/Queer and Pacific health research in NZ, speaks to existing knowledge gaps on PRC health, ultimately suggesting the need for a more intersectional research approach into the health and wellbeing of PRCs in NZ.

METHODS

A scoping review⁵ was undertaken to explore both national and international health research pertaining to PRCs. Relevant public health database search engines were accessed, which included PubMed and Medline in addition to Google Scholar and Jstor. Due to the paucity of research about PRCs, literature pertaining to non-Pacific Rainbow communities in general were also reviewed. Thus, international literature was included where there was a focus on comparative communities. The search terms for the review were Pacific health, Rainbow health, LGBTTTQIA+ health and MVPFAFF health. Each relevant piece of literature was selected by title and abstract as depicted by the search engines, based on the inclusion of the key words: gender, sexuality or health care. Most of the relevant literature found and presented here was published between 2008 – 2020. Additional Google searches were undertaken to identify more 'grey' material such as reports, websites, other relevant government sources, as well as non-profit organisation and educational resources not visible via scientific databases. The scoping review entailed the identification of recurring themes and subthemes. These themes were used to structure this article including the identification of gaps and further areas of potential research. Literature that was reviewed for this paper include published journal articles (n=20), books (n=1), reports (n=26) and theses (n=3) as well as other documents relevant to the study, such as websites and news articles pertaining to PRCs in NZ and abroad.

Literature Review

Rainbow Health

Estimated to account for 6% to 15% of NZ's total population,⁶ Rainbow communities in NZ do not form one conspicuous group, instead, are made up of individuals who come from diverse and varied ethnic, socio-economic, class, cultural and age backgrounds.⁷ Contemporary research generally suggests that the effects of

marginalisation and discrimination are inextricably linked to the overrepresentation of LGBTTTQIA+ peoples in NZ with poorer health outcomes.⁸

Due to a raft of social stigmas, it is well documented that Rainbow/Queer peoples are more likely to experience adverse mental health disorders, higher rates of psychological and mental distress and more likely to engage in risk related behaviours compared to the general population.⁸⁻¹⁰ Rainbow/Queer New Zealanders are 19% less likely to report being satisfied with life, while experiencing an increased likelihood of moderate to severe anxiety, depression and/or psychological distress; these concerns start at a young age with the Youth 12 survey reporting same-sex or both sex attracted students as three times more likely to experience symptoms of depression, self-harm, suicidal ideation and attempts as opposite attracted students.¹¹⁻¹² The Youth19 survey shows similar findings for transgender and diverse gender students, reporting 57% of participants have experienced depressive symptoms and self-harmed, while one in five have attempted suicide.¹³ The Counting Ourselves survey shows similar health outcomes from transgender and non-binary individuals in NZ, with 71% of participants reported as having experienced high or very high psychological distress in the immediately preceding four weeks, almost nine times higher than the general population. Alongside this, over the course of their lifetime, more than three quarters of transgender and non-binary individuals had seriously thought about attempting suicide, while more than a third had attempted, with 12% of those attempts coming in the previous year.¹⁴⁻¹⁶

An important factor identified is the lack of mental health services that adequately address issues specific to Rainbow/Queer populations. Instead, it has been found that mainstream services often perpetrate and reinforce heteronormative and homonegative attitudes and beliefs.^{14,15,17} As relayed in research by Semp and Read, mental health services actively reproduce a culture of heteronormativity in many different, inadvertent ways.¹⁸ These services unwittingly frame non-normative sexualities or genders as problematic, abnormal or inferior. This has led to a 'don't ask, don't tell' culture within mental health services in NZ toward Rainbow/Queer peoples, which initially aimed to remove assumptions about the sexuality of a patient but has had the side effect of replicating heteronormative and homonegative notions in mental health services.¹⁷⁻¹⁸ This suggests then that mainstream providers do not understand how one's sexual

and gender identity may impact their wider socialisation, how they are perceived within societal structures, the marginalisation they may face as a member of the Rainbow community and what burden this takes on their personal mental health.¹⁷

International scholarship suggests that this is a common experience for Rainbow/Queer communities outside NZ. Research from the Canada Psychiatric Association suggests that LGBTQ+ peoples are hesitant to engage with mental health services for fear of homophobia from healthcare providers, inadequacies in Queer identity healthcare knowledge and understanding, or being flat out refused care.¹⁹ This reluctance also exists here in NZ, where there are no publicly funded Rainbow-specific mental healthcare services. As many Rainbow/Queer peoples feel their Rainbow/Queer identity is central to who they are as a person, the services they engage with must actively validate their identity.²⁰ However, the severe lack of explicitly Rainbow/Queer-friendly services has meant that Rainbow/Queer patients feel discouraged from seeking help, due to a number of factors, including anticipating having to justify their identity in the face of homophobic practitioners, expectations of being misunderstood and a lack of sensitivity toward Rainbow peoples' personal experience of sexuality and gender identity struggles, or the impacts of marginalisation from wider society.¹⁷

While accessibility to good quality healthcare remains a prevalent issue for LGBTQI+ peoples, healthcare professionals' cis-heteronormative attitudes further disempower Rainbow/Queer communities from addressing their health needs.²¹ Multiple studies in NZ point out transgender and non-binary people are often uncomfortable disclosing their gender identity with their General Practitioner (GP), while also being more susceptible to inconsistent or disrespectful treatment from health professionals due to their gender identity; including the refusal to use preferred gender pronouns.^{15,21,22} This also sits in line with international research where transgender peoples in America reported being more likely to face barriers and denials of equal treatment in the healthcare system.²³ As well as this, Youth 12 tells us that non-heterosexual students are less likely to utilise healthcare services, but more likely to experience difficulties when doing so in comparison to their heterosexual peers.¹⁴ While the Youth 19 survey found that 55% of transgender and diverse gender participants were unable to access health care, and 31% of same-or multiple-sex attracted students were unable to access healthcare when they needed it.

¹³ This is a significant indicator of how cis-heteronormative attitudes in healthcare disadvantage Rainbow/Queer peoples, regardless of age and gender.

Due to limited funding and urban demands for gender affirming surgeries, Rainbow/Queer peoples embedded in rural areas of NZ are further marginalised from accessing appropriate healthcare services.²⁴ Within Rainbow communities, it is the transgender community who bears the brunt of these health inequities. Transgender patients are more likely to experience significant delays in accessing medical care, with many relaying their experience of waiting months for treatment, only to be told these services are not available to transgender people.²⁵ As well as this, limited availability, accessibility and high expense of gender affirming healthcare remains a prevalent barrier for Rainbow peoples wishing to pursue this treatment.²⁶⁻²⁷ Limited funding and urban demands for these services further marginalises any Rainbow/Queer peoples who live rurally.²⁷⁻²⁸ Limited practitioner understandings of gender affirming services and services available to Rainbow/Queer peoples, coupled with the racism inherent to the health system in NZ²⁹⁻³¹ suggests a bias toward the health and wellbeing needs of the cis-gendered Pākehā population.³²⁻³⁴

Pacific Health

Pacific peoples are NZ's most youthful, yet fastest growing population with a median age of 23.4 years, largely centred in highly urbanised areas including Auckland, Wellington, and Christchurch.³⁵ Although there is a large amount of literature that promotes the diversity of Pacific peoples in NZ, the current health system has not been successful in solving a myriad of issues that relate to poor health outcomes for its Pacific peoples.³⁶ Alongside Māori, data shows that Pacific peoples are more likely to have lower life expectancies compared to any other ethnic groups in NZ.³⁷ Based on data collected from the 2013 census, the Ministry of Health reported high diagnosis rates of non-communicable diseases, 10% of Pasifika peoples over the age of 15 were diagnosed with diabetes and were more likely to develop chronic illnesses as adults.³⁷ In terms of obesity, Pacific peoples have three times the average diagnosis rate in comparison to the general population.³⁸ Severe obesity rates for Pacific peoples reveal social inequities that indicate health interventions are not working for Pacific communities in this area.³⁶ Furthermore, Pacific peoples are more likely to develop unhealthy habits such as smoking, binge drinking, physical inactivity and substance abuse.³⁹

The peripheral treatment of Pacific people in healthcare is directly associated with the monocultural and Western healthcare practices in NZ.⁴⁰ There is strong evidence that suggests determinants of Pacific health outcomes are complex and exist from a multitude of socioeconomic and cultural influences. These determinants include, but are not limited to, higher levels of deprivation, overcrowded housing, unemployment, cost, communication issues, transportation, lack of health literacy, and cultural stigma.^{39,41} From a Pacific perspective, Pacific peoples have often felt a lack of personal connection with healthcare providers and services, who tend to be 'cold and calculative.'⁴² This can start young, as demonstrated in the Youth 19 survey, which found that 25% of Pacific youth were likely to forgo access to health care when needed or wanted.¹³ Indigenous Pacific health is promoted through social, physical, mental, environmental, and spiritual wellbeing; absence of one aspect, or 'pou' (pillar) will deteriorate the wellbeing of an individual.⁴³ Moreover, Pacific peoples value collectivity; healthcare systems in NZ focus on individuality and do not view health holistically, leading Pacific people to feel portrayed as 'consumers' in 'hostile' services that, by design is unable to enhance Pacific health and wellbeing in meaningful ways.^{42,44,45} Thus, Pacific peoples are discouraged from seeking help and utilising healthcare services, leading to the deterioration of Pacific health.

'Te Rau Hinengaro: The New Zealand Mental Health Survey', NZ's most comprehensive national mental health epidemiological study found that Pacific people's poorer health status is not just limited to physical aspects of health, but that Pacific peoples experience a nearly 5% higher rate of adverse mental health (25%) in comparison to the rest of the general population (20.7%).^{46,47} Furthermore, Pacific people most commonly reported lifetime mental disorders such as anxiety, depression and substance abuse disorders. Pacific females were more likely to experience an adverse mental disorder, whereas males had higher rates of substance use disorders.⁴⁸ In addition, Pacific peoples experience high rates of suicidal ideation, attempting suicide at three times the rate of the general population.⁴⁹

These outcomes are often made worse by the widespread stigma that exists within Pacific communities toward mental illness. Research shows Pacific peoples are more likely to hold negative attitudes and beliefs towards those who suffer from mental illness and are less likely to interact with or show empathy towards those who suffer from mental health issues.⁵⁰ This

creates a complex coalescence of marginalisation and internalised stigmatisation for communities burdened by a poor state of mental health and further encumbered by a culture that renders these issues invisible. As posited by Faalogo-Lilo, this stigma restricts people from addressing mental health issues, worried they may be perceived as weak, as a burden, or as having let their family down, due to Pacific beliefs that emphasise the importance of reliance on family to get through difficulties.⁴² Furthermore, this stigma also exists in other locations where diasporic Pacific communities are embedded. Samoan Americans as an example, have communicated a belief that mental illness is not an acceptable subject to address in Samoan culture, labelling anyone who suffers from mental health issues, including their families, as 'cursed.'⁵¹

Despite high rates of suffering from severe mental health disorders, the Pacific community in NZ are also the least likely to access mental health services, and overall, Pacific peoples are 35% less likely to receive mental health treatment than the general population.⁴⁸ This is partially due to mainstream mental health services in NZ - much like physical healthcare services - not being attuned to the cultural specificity that allows Pacific peoples to be understood, as mainstream clinical approaches do not sit comfortably with Pacific community values and relational approaches to care.⁵¹ This is due to a number of factors, including contrasting Western and Pacific value systems, which have led to differing framings of what mental health and mental illness look like between cultures.^{42,52} In other words, community health issues are often perceived as either insider stigma, or outsider framing based on Eurocentric standards of health. It is likely that this will consistently manifest poor health outcomes, if these misconceptions and stigmas are not broken, addressed, and unpacked.⁵³

Pacific Rainbow Health

Despite the dearth of studies on Pacific Rainbow Health in New Zealand health research, a handful of projects do acknowledge the intersecting identities of PRCs. Counting Ourselves found that transgender and non-binary Pacific people were at a higher risk of experiencing gender-based violence within the domestic sphere, at an increased risk of engaging in risk related behaviours, while also being more likely to be treated unfairly at a hotel, restaurant or theatre and avoid essential services like the bank or the doctor.¹⁵ These findings although extremely insightful suffered from small Pacific sample size (4% of respondents were Pacific), where Pacific respondents had the highest dropout rate in the

Counting Ourselves survey. This pattern is also repeated in the Youth 12 survey where just 3.9% of Pacific participants identified as being attracted to the same or both sexes.¹⁴⁻¹⁵ Ultimately, these surveys are unable to capture the depth and nuances of PRC worlds, let alone their experiences with healthcare. This lack of intersectionally-informed research risks health interventions being designed that miss the needs of important sections of Pacific communities.

There is strong evidence to suggest that geography of PRC peoples further impacts their engagement with mainstream healthcare providers. The overwhelming majority of both Rainbow/Queer and Pacific communities reside in, or are more likely to migrate to urban areas, with Auckland acting as the centrepiece for Rainbow/Queer and Pacific healthcare services.^{27,28,35,60,61} However, the urban demand for healthcare services poses a variety of challenges for PRC peoples who live rurally. For example, if a Pacific trans person was living in rural Taranaki and needed treatment for gender affirming surgeries, they would need to travel to Auckland. To ensure these services are available throughout the country, more consideration should be taken on the geographical barriers to PRCs health and the consistency of healthcare services.⁶²

It can be assumed through prior literature that it is likely that those who exist at the Rainbow-Pacific intersection are at an elevated risk of discrimination because of their double minority status. International studies confirm that this 'extra layer of marginalisation' strongly resonates with people of colour who identify Queer or Rainbow.⁶³⁻⁶⁶ Within a Pacific context, stigma against PRCs is well-documented, but within Rainbow/Queer communities, Pacific voices are often overpowered by cisgendered, gay European men.⁶⁸ This doubled layer of marginalisation reflects a double marker of discrimination, for those who exist in both communities which are both consistently positioned as experiencing low health outcomes in comparison to the general population. This is a nuance that existing health research in NZ is not so attuned to.

DISCUSSION

This literature review reveals that very little research exists that focus specifically on the health and wellbeing of PRCs in NZ. As such, a more intersectional approach to health research will need to be taken to get a stronger gauge of the state of PRCs' health and wellbeing in NZ.

Intersectionality was coined by Black feminist scholar, Kimberlee Crenshaw, to examine how the multidimensional, combinative factors of a person's many subsumed identity points may lead to unique forms of marginalisation in society that does not account for the point at which these stigmas meet.⁵⁴⁻⁵⁷ Intersectionality is important in this context, as it teaches us to be attentive to the unique ways members of Rainbow communities *and* Pacific communities in NZ may experience multi-layered forms of marginalisation as a product of intersecting forms of stigma. Quite often, when literature explores the health and wellbeing of Pacific and Rainbow peoples, there is an urge to treat both populations as isolated communities, with both communities frequently described as being more likely to experience poor health, in comparison to the general population.^{10,11,14,15,46,58} While this does allow investigators to provoke discussion on the needs of both communities, these conversations often overlook the unique contours of an experience that is both ethnically Pacific and Rainbow/Queer. To date, very little intersectionally-focused research has taken place in the health context in New Zealand. The latest being the Honour Project Aotearoa¹⁵ and the newly HRC funded Manalagi Project.⁵⁹

CONCLUSION

This paper shines a light on the lack of information on Queer and Rainbow Pacific health and wellbeing in NZ. The stigmatisation of PRC in NZ remains a prevalent issue for the NZ healthcare system. This literature review suggests that more health research needs to be positioned at the intersection of Pacific and Rainbow communities. The newly funded Manalagi Project by the Health Research Council will help to form a clearer picture of the needs of this often-neglected part of NZ's Pacific population.

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AUTHOR INVOLVEMENT:

The lead author led the shaping of the article, methods used, concept, data acquisition, analysis and interpretation. They give final approval and

agree to be accountable for all aspects of this work. SO did data collection, synthesis of data and helped analysis and interpretation. HA undertook large data collection activities, helped synthesis of data and provided analysis and interpretation support. AP undertook data collection, supported synthesis of data analysis and interpretation. All authors gave final approval and agreed to be accountable for all aspects of this work.

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