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Centre for Development Studies

Working Paper No. 5 / 2011

Sexual Health and 'Asian' and 'Pacific' Young People from Auckland Diasporas

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June 2011



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Foreword

Youth sexuality troubles health policymakers and the public in many parts of the world. Yet, youth themselves see this quite differently even as they are confronted with the converging multiple crises of a scarcity of paid work, the rising costs of food, health care and education, and elusive opportunities for political participation. For young people, especially marginalised groups of young people and young people in developing countries, sexual and reproductive health and rights are a critical place to start. This would allow for young people to re-frame the debate around sexuality as 'positive' and to shift interventions away from coercive policies and towards improving the wider development context for young people in areas such as job creation and access to contraception.

This annotated bibliography provides a timely and insightful review of the state of published knowledge on 'Asian' and 'Pacific' young people in New Zealand. Young people of Asian and Pacific descent are connected in many and various ways – especially through popular media and family and communities - with the neighbouring regions of Asia and Pacific. Understanding the state of knowledge of the literature on young people in New Zealand will also contribute to encouraging more research on young people in the developing countries nearby.

I am delighted that Cath Conn¹ was able to co-ordinate this work with a development studies MA graduate, Natalie Redstone.² She has demonstrated her intellectual robustness by transferring her development experience in Africa to Aotearoa. I am sure the future research will be better informed by this work as we work towards more respectfully capturing the voices of young people.

Dr Yvonne Underhill-Sem

Director, Centre for Development Studies

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Preface

Young New Zealand adults, Louisa Allen argues, desire their sexuality to be viewed as a “positive part of youthful identity,” rather than a problem to be managed (Allen, 2005: 390; Allen, 2011). Young adults should be viewed as agents, who already have significant sexual knowledge, are able to make their own sexual decisions and who have a right to information which “supports positive sexual experiences” (Allen, 2005: 390). This position, based on paradigms which are alternative to the status quo of youth sexual health research, argues for eliciting young people’s voices and perspectives to increase our understandings; and as part of an agenda to enable and empower young people to make informed and proactive choices about their sexuality (Allen, 2005; Allen, 2011). A further challenge to the status quo of research and policy is captured by Sue Jackson’s assertion that an understanding of “how social and cultural factors operate to influence young people’s sexual behaviour is paramount to the development of effectively targeted sexual and reproductive health programmes” (Jackson, 2004: 125). This annotated bibliography is underpinned by these two sets of concerns reflected internationally in critical youth sexual health research. That is, the need for greater attention to young people’s voices, perspectives, and agency in relation to their sexual health; and a concern for the importance of the diverse, complex and contextualized social environments experienced by young adults (Aggleton and Campbell, 2000). Yet, despite years of calls for alternative approaches, and some progress (Ingham and Aggleton, 2006), research and interventions still largely neglect young people’s voices and socially diverse experiences (Vaughan, 2010).

My own research agenda arose from these twin concerns in relation to young women’s experiences of HIV/AIDS in Africa. This is reflected in a recent study of young Ugandan women’s vulnerability in an environment of voiceless norms (Conn, 2010). The study, located among the Basoga people of Eastern Uganda, found that young women are disadvantaged by the intersection of gender and age, amongst other dimensions of their vulnerability. Despite good levels of knowledge of HIV/AIDS they face considerable and diverse socio-cultural barriers to their sexual agency in a challenging environment of poverty and educational limitations. The research describes the key role played by the social environment, and the added complexity of combined traditional norms and social change in a changing society, with powerful external forces. This often shapes and complicates young Ugandan women’s ability to make choices, including those relating to safer sex. Young women expressed an awareness of social and gendered roles, yet resistance to harmful norms and frustrated personal expectations in relation to their sexual lives.

In the research young Ugandan women's representations were analyzed against a critical framework of global HIV prevention paradigms. HIV prevention measures in the context are based on "behaviour change communication", typically framed in the message "Abstain, Be Faithful and use a Condom" (Karim et al, 2009). This for many young people across Africa and internationally has been translated into abstinence-only programmes (Mabala, 2006). Yet, the implications of what young Ugandan women say is that their situation militates against the prevalent concept of individual protective behaviours, confirming it as inadequate for HIV prevention in relation to their needs. The study concluded, reflecting other findings, that current HIV prevention programmes are blueprints which are overly-medicalised, much influenced by harmful external forces such as the linkage between US funding and abstinence programmes, and which exclude the voices of young women (Reddy, 2005; Cohen, 2008). Also, that there is a serious lack of attention to creating receptive social environments, including a failure to address and even reinforcing of harmful assumptions, such as stereotyping of young women and lack of action on high levels of sexual violence. The study adds to current calls for radical alternatives to HIV prevention, underpinned by empowerment paradigms, building opportunities for young women's voices in the spaces of schools and communities. But, and reflecting a new agenda in HIV prevention (see, Campbell, and Cornish, 2010; Campbell, Cornish, et al, 2010), it also calls for actions to occur through the mechanism of wider and more radical, social movements.

The bibliographic exercise here is concerned with similar themes of lack of attention to diverse social contexts and young voices in relation to sexual health research. It shows that Asian and Pacific young people's voices and experiences are notably absent in New Zealand academic and government sexual health policy and research; which are overwhelmingly quantitative and generalised (with some noteworthy exceptions as discussed throughout this paper). As a result there is an overlooking of key contextual differences. Yet, diversity shapes the significant disparities in sexual health outcomes and experiences of young Aucklanders. The bibliography highlights the need for greater participatory and contextualized approaches, reflecting a continuing movement internationally in favour of a paradigm shift in youth sexual health/sexuality research and policy. Here it needs to be one which reflects the unique and dynamic characteristics of Auckland's diverse youth.

Dr Cath Conn, May 2011

Honorary Research Associate, Centre for Development Studies

Introduction

The aim of this annotated bibliography is to bring together research conducted over the last decade which looks at the sexual health and wellbeing of young people among diasporic ethnic groups in New Zealand; with a particular emphasis on Auckland 'Asian' and 'Pacific' communities. A review of these documents shows that an increased focus on the sexual health of Pacific and Asian young people is not only important, but necessary, if we are to address health inequalities and meet their sexual health needs. While providing an overview in relation to this study group, this introductory section will critically discuss key terms and concepts from the sexual health literature. In this way, we aim to shed some light on the complexities inherent in the study of young people's sexual health and contribute to further work in this area.

The limited and over-generalised nature of much of the research gathered here suggests the need for a more contextualised understanding and approach to young people's sexual health. Employing a contextual approach enables researchers to take into account the complexity of young people's experiences; framing young people as embedded within wider complex cultural and historical contexts. These contexts interact with material and structural conditions to shape and influence young people's experiences (Beals, 2006). Framing young people within a contextual understanding allows for an exploration of the way in which factors of culture, ethnicity, gender, class and age intersect and shape young people's experiences of sexuality and sexual health in often vastly differing and conflicting ways (Jackson, 2004).

The concept of 'intersectionality', recently applied in the social sciences (Phoenix and Pattynama, 2006), serves as a useful framework for the study of young people's sexuality. Linked to a contextual approach, intersectionality highlights the complex and mutually reinforcing relationship between differing determinants of health such as age, gender, ethnicity and class. Employed by researchers interested in issues of inequality, intersectionality recognises the relational nature of multiple dimensions of social identity, and the way in which these intersect to shape young people's health

outcomes and experiences (Hankivsky and Christoffersen, 2008). The advantage of an intersectionality approach is that it helps in conceptualizing and informing about the complex and heterogeneous circumstances faced by young people, including the circumstances that contribute to inequality, rather than reducing their experiences to a single dimension at a time (Phoenix and Pattynama, 2006). In this way, rather than exploring the sexual health of Pacific and Asian young people in reference to their ethnicity alone, we can look at the way in which gender intersects with ethnicity and with age (amongst other dimensions such as social class) to position young people in particular conditions which in turn shape their health (McCall 2005). This is valuable given the highly unequal nature of sexual health outcomes among young people from differing ethnic groups in Auckland.

Young People from Auckland Diasporas

New Zealand is a multi-cultural society, within which the number of people identifying with countries from Asia and throughout the Pacific has been rapidly increasing over the last 20 years, with Asian and Pacific people now making up a large and integral part of the overall population (Reid et al., 2008; Wright and Hornblow, 2008; Ho, Au, Bedford and Cooper, 2002). This is particularly apparent in Auckland which is the country's most ethnically diverse city. Around 67 percent of Asian people in New Zealand live in the Auckland region, which is also home to 65 percent the country's total Pacific population (Yeung and Henrickson, 2004; Statistics New Zealand, 2010a). Despite these demographic realities however, there continues to be a significant lack of Auckland specific material which looks at the sexual health and wellbeing of these populations.

New Zealand's Asian population is highly diverse and represents the country's fastest growing ethnic grouping. According to the New Zealand census the number of those identifying as Asian more than doubled between 1991 and 2001 (Reid et al., 2008). These numbers continued to rise throughout the 2000s, with Asian people now making up 8.8 percent of the country's total population³ (Reid et al., 2008; see also Ho, Au, Bedford and Cooper, 2002; Scragg and Maitra, 2005). Importantly, a

³ This percentage is expected to further increase to 15 percent by 2020 (Abbot and Young, 2006).

large proportion of New Zealand's Asian ethnic groups are young. In 2001 it was estimated that half of all Asian New Zealanders were under the age of 24⁴ (Ho, Au, Bedford and Cooper, 2002: 22). In Auckland, twenty percent of the Asian population are under the age of 14, with another 20 percent aged between 14 and 24 (Asian Public Health Project Team, 2003). Asian young people are believed to constitute 16.9 percent of all secondary students in the Auckland region (Ministry of Education, 2008).

New Zealand's Pacific population is also overwhelmingly young and growing quickly. Comprising only 0.1 percent of the country's resident population in 1945, the number of Pacific New Zealanders has now increased to 6.9 percent and is projected to grow to around 12 percent by 2051 (Wright and Hornblow, 2008; see also Statistics New Zealand, 2010b). Overall, young people of Pacific descent, born in New Zealand, constitute over 50 percent of the total Pacific population (Friesen, 2000). Indeed, 60 percent of Pacific people are under the age of 30 (Counties Manukau, 2006). In the Auckland region, it is estimated that between 25 and 40 percent of all secondary school students identify as Maori or Pacific (Elliot and Lambourn, 1999:510).

It is important to think critically about the way in which young people are constructed and defined, as this can shape their role and how they are perceived in sexual health efforts. Terms such as youth, teenagers, adolescence and young people are often used interchangeably to describe both the whole group and various sub-groups within the age range of 10 to 24⁵. These categories however do not have fixed, natural or uncontested meanings. Rather, the way in which we think about and define young people is culturally and socially relevant, changing across cultures, spaces and over time (see Coleman, 2007; Patel Stevens et al., 2007; Beals, 2006). Over the last 30 years popular conceptions of adolescence have been largely

⁴ According to the 2001 New Zealand census, half of all Koreans and Cambodians were under 24 years of age. Within the country's Chinese, Indian and Vietnamese ethnic groups, the proportion of young people aged under 24 years is 45%, 43% and 48% respectively; compared with 36% in the total New Zealand population (Ho, Au, Bedford and Cooper, 2002: 8).

⁵ This is the age group which is typically considered as a focus for sexual health concerns and sexuality education (WHO 2006). Preventing HIV/AIDS in young people: a systematic review of the evidence. Technical Report Series 938. Geneva, World Health Organisation.

dominated and framed by developmental psychological knowledge (Patel Stevens et al., 2007; Beals, 2006). Within this paradigm young people are predominantly defined in relation to what they are not. They are seen as neither children nor adults. Rather, they are in a period of in-between and change, transitioning into adulthood while also maintaining child-like characteristics (Vasudevan and Campano, 2009; Patel Stevens et al., 2007; Beals, 2006; Mcleod, 2003; Lesko, 2001). Conceptualised in opposition to adulthood, adolescence is believed to be characterised by a series of age-specific biological and social stages, as young people move gradually into maturation (Beals, 2006; Mcleod, 2003). This period is commonly constructed as one of turbulence, vulnerability and risk. Positioned as not-yet-adults, young people are often perceived as irrational, irresponsible, hedonistic and unstable⁶ (Coleman, 2007; Lesko, 2001).

Sexual health discourse has been largely influenced by the biomedical model. Emphasis is placed on the physiological development of adolescence and the way in which this influences risk-taking and unpredictable behaviour. Biological theories depict young people as being “captive in their body, out of control because of raging hormones and newly developed rational thinking” (Beals, 2006: 36). Despite the heterogeneity of young people’s experiences, biological dimensions of their development are considered to be natural, inevitable and universal. All young people are believed to follow a similar “developmental blueprint, from a less to a more complex organisation of physiological, cognitive, emotional and psychological attributes” (Mcleod, 2003: 420). This discourse commonly leads to adolescence being framed as a deficit and problematic phase (Vasudevan and Campano, 2009; Patel Stevens et al., 2007; Furstenberg, 2000). Young people are simultaneously seen as vulnerable and in need of protection, and as problematic and unpredictable; needing containment, monitoring, regulation and restriction (Vasudevan and Campano; Beals, 2006). Furthermore, biomedicine lends itself to expert-led approaches rather than those which involve people; as such young people are less likely to have voice in such efforts.

⁶ See for example Davis and Lay-Yee (1999) who, while discussing early sexual activity among young people, characterise adolescence as a fragile period of transition into adulthood largely informed by potential risk taking behaviour.

Psychological and biological constructions continue to dominate the way in which young people are conceptualised within New Zealand public health policy and research (Beals, 2006; Vasudevan and Campano, 2009). While biological dimensions of adolescence can be theoretically useful, particularly in providing a framework for discussing differences between young people and adults, they are also significantly problematic. As Mary Bucholtz (2002) suggests, while “the emphasis on adolescence as a universal stage in the biological and psychological development of the individual usefully highlights selfhood as a process rather than a state, it also inevitably frames young people primarily as not-yet finished human beings” (Bucholtz, as cited in Beals, 2006: 35). This construction of young people as ‘lacking’ or incomplete can have the effect of rendering them invisible and voiceless. Considered immature and irresponsible, young people are rarely given the opportunity to enter into meaningful dialogue regarding issues of significance to them (Beals, 2006). They are not considered to be political agents, and as a result they are marginalised and excluded from participating in public life and social policy (Coleman, 2007; Beals, 2006). In regards to sexual health policy and education, this can lead to an exclusion of young people’s perspectives and participation in outlining policies and educational interventions which directly affect them (Allen, 2005; Women’s Health Action Trust, 2008).

A number of studies in sexuality education by Louisa Allen of Auckland University encapsulate this tension. Allen (2005) explores young people’s perspectives about what they believe constitutes ‘effective’ sexual health education. A central finding of her research is that young people desire for their sexuality to be viewed as a “positive part of youthful identity,” rather than a problem to be managed (Allen, 2005: 390). Those young people surveyed wanted to be recognised as legitimate sexual subjects; agents who already have significant sexual knowledge, are able to make their own sexual decisions and who have a right to information which “supports positive sexual experiences” (Allen, 2005: 390; see also Women’s Health Action Trust, 2008). This resonates with the findings of other international researchers who suggest that “it is only with a sense of sexual agency that young people can actively make decisions that are likely to support their sexual health and well-being” (Allen, 2005: 390). Allowing young people a voice and incorporating their views renders their knowledge as legitimate. As such, it positions them as sexual agents rather

than merely subjects of adult intervention and policy. This paradigm is one of empowering young people to be able to make informed and proactive choices about their sexuality, with sexual health education meeting the information needs which young people themselves consider most relevant.

Sexual Health, Sexuality and Young People

Highly publicised increases in the poor sexual health outcomes of New Zealand's young population have brought sexual health policy and initiatives to the forefront of the country's public health agenda⁷ (Jackson, 2004; Women's Health Action Trust, 2008). The concept of sexual health, as outlined by the New Zealand government and associated ministries, relates predominantly to issues of early or unintended pregnancy, sexually transmitted infections (STIs) and abortion; all of which are considered to be markers of unsafe sexual activity (Ministry of Health and Ministry of Pacific Affairs, 2004). Third only to the United States and Britain, New Zealand has one of the highest rates of teenage pregnancy and sexually transmitted infections (STIs) in the OECD (Ministry of Health, 2003; Ministry of Health, 2001; Moor, 2004). Rates of chlamydia are thought to be at epidemic levels, particularly among 15-19 years olds, with levels of gonorrhoea also swiftly increasing⁸ (Braun, 2008; Ministry of Health, 2003). Rising rates of abortion among New Zealand's young people suggests a significant proportion of teenage pregnancies are unwanted⁹ (Jackson, 2004; Moor, 2004). This relates to research which suggests that young people are becoming sexually experienced at an increasingly younger age, with around one-

⁷ This led to the development of the Ministry of Health's 2001 'Sexual and Reproductive Health Strategy: Phase One.' Positioning positive sexual and reproductive health as a government priority, this strategy recommended a cross-sectoral, long-term and holistic approach as the way forward; taking into account the country's wide range of diverse ethnic and cultural groups (Women's Health Action Trust, 2008).

⁸ As the Women's Health Action Trust (2008) asserts, "these statistics sit alongside New Zealand's appalling rates of sexual violence with young women particularly at risk; disturbing research indicating the lack of safety and inclusion for same-sex-attracted and gender diverse students in New Zealand's schools; New Zealand's youth suicide rate, which although improving remains high; and persistent negative attitudes towards the sexual and reproductive health needs of people with disabilities" (Women's Health Action Trust, 2008: 1).

⁹ Nationally, the greatest number of performed abortions occurs among those aged between 20 and 24. This is also the age group which has experienced the greatest rate of increase in abortions over the last decade (Moor, 2004).

third of young people sexually active before the age of 16¹⁰ (Jackson, 2004; Collins, 2000). This increases the likelihood of teenage pregnancy and poor sexual health outcomes among young people (Jackson, 2004).

The New Zealand government champions the importance of monitoring the health of all New Zealanders, as well as inequalities between ethnic groups, as central to the New Zealand Health Strategy (Ministry of Health, 2006). Despite this however, very little has been done to determine, monitor and research the sexual health status of Pacific, and especially Asian, young people (Abbott and Young, 2006, Abbott et al., 2003; Rasanathan et al., 2006). This could be partly explained by the overall dominance of biomedical research within the public health literature, which tends to be highly quantitative and generalised in nature (see our discussion above) (Jackson, 2004). In addition, while Chinese and Indian people have been settled in New Zealand for almost 150 years, they have historically been marginal groups (Rasanathan et al., 2006: 212). This marginalisation has been characterised by the overall lack of attention given to Asian communities in government research and policy.

Changes in government migration policy in the late 1980s, lead to significant increases in the number of East and South East Asian people migrating to New Zealand. This has been mirrored by an expansion and increased recognition of Asian needs in public health and other government research. However, what research has been done remains quantitative and broad. Young Asian and Pacific people continue to remain invisible and voiceless throughout both government and academic sexual health policy and research (Ministry of Health, 2006; Abbott and Young, 2006; Scragg and Maitra, 2005; Jackson, 2004). In a range of Ministry of Health and other government reports for example, "Asian and European data are often merged, or the former consigned to a residual 'other' (non-Maori, non Pacific, non-European) category" (Abbott and Young, 2006: 1). As Abbott and Young (2006) have noted, this relative absence of Pacific and Asian sexual health in New Zealand

¹⁰ According to Moor (2004), national data has found that "women who first have sex at a relatively younger age are more likely to do so without using any form of contraception, than women who first have sex at a slightly older age" (Moor, 2004).

research and policy “has been matched by a vacuum in public and personal health services policy and practice” (Abbott and Young, 2006: 1).

It is well documented that those who are most at risk of negative sexual health outcomes, such as unwanted pregnancy and STI infection, are young people between the ages of 15 to 24 (Ministry of Health, 2002). The young and increasing demographic nature of both Asian and Pacific communities adds significant weight to the need to pay further attention to the sexual health and wellbeing of young people within these ethnic groups. This becomes even more important given the considerable disparities in health outcomes of Asian, and particularly Pacific people, in comparison to other ethnic groups in New Zealand. Pacific people are overwhelmingly disadvantaged in regards to health outcomes and socioeconomic status, with a large proportion of the population living in conditions of increasing deprivation¹¹ (Counties Manukau, 2006; Wright and Hornblow, 2008). This is particularly notable when looking at the sexual health of young Pacific people. Rates of chlamydia, gonorrhoea and syphilis are disproportionately high among the young Pacific population (Ministry of Health, 2008; McNicholas et al., 2001; Ministry of Health, 2001). This is coupled with an over-representation of Pacific young people in the country’s teenage pregnancy statistics.¹² Preceded only by Maori, Pacific young people have the second highest rate of teenage pregnancy in the country, at a rate of 488 births per 1000. This is 75 percent higher than the national average (Ministry of Health and Ministry of Pacific Affairs, 2004; Ministry of Health, 2001; Moor, 2004).

There are also significant disparities in the sexual health outcomes of young Asian people. Young Asian women, for example, have the highest rate of abortion to known pregnancies in the country, with a rate of 364 per 1000 pregnancies (Ministry of Health, 2001; Moor, 2004). This relates to figures which suggest that abortion is the second leading discharge condition for Asian people between the ages of 15-24

¹¹ Pacific people of all ages have significantly higher hospitalisation rates as well as higher rates of mortality due to diabetes, respiratory diseases and stroke. These higher rates of hospitalisation are particularly prominent among Pacific children. Furthermore, the average life expectancy of Pacific people is 5 to 8 years less than that of European and other groups (Counties Manukau, 2006).

¹² The Ministry of Health and Ministry of Pacific Affairs define ‘teenage pregnancy’ as the rate of pregnancy, including “live and still births, induced abortions and (an estimate of) spontaneous miscarriages, among females aged 10-19 years” (Ministry of Health and Ministry of Pacific Affairs, 2004: 46).

(Yeung and Henrickson, 2004). Recent research has also begun to highlight issues of a lack of access to, and knowledge of, sexual health services within particular Asian ethnic groups in New Zealand¹³ (Scragg and Maitra, 2005; Rasanathan, Ameratunga and Tse, 2006; Yeung and Henrickson, 2004). This was illustrated in the *Youth 2000* study, where it was found that “15 percent of young Chinese people reported accessing no healthcare at all; over three times the rate reported by their European peers” (Rasanathan, Ameratunga and Tse, 2006: 4; see also Ameratunga et al., 2008). A range of factors have been identified as acting as barriers to health care among New Zealand’s Asian population. These include cost, language barriers, limited information about health services, a reliance on cultural healers and a lack of culturally appropriate community support programmes (Scragg and Maitra, 2005; Ameratunga et al., 2008).

These disparities and needs significantly underscore the need for further research about the sexual health needs and outcomes of young people from both Pacific and Asian communities. However, it is important to think critically about how this research is framed, so that services and policy are based on an attention to issues of ethnic heterogeneity, social dimensions such as gender and culture, as well as the participation of young people. This requires an examination of the potential limitations and problems which can ensue from the generic use of the terms ‘Asian’ and ‘Pacific’ within public health policy and also the way in which concepts of adolescence shape sexual health policy and public health research; with a view to involving young people in relation to their own sexual health. As eluded to above, the complex and problematic way in which young people are commonly conceptualised and defined has important consequences for sexual health policy and research. Throughout the sexual health research gathered here, young people are largely denied the opportunity to narrate their own stories and “speak from the actual places that shape their understandings and experiences” (Coleman, 2007: 41). Research, typically involving the use of surveys or structured interviews conducted from the

¹³ The 2002 New Zealand Health Survey found that Asian participants were less likely to have a usual health practitioner, and to have visited a general practitioner in the last 12 months, than all other main ethnic groups. Similarly, Asian women were less likely than Europeans to have had a mammogram, and less likely than Europeans and Maori to have had a cervical smear in the last 3 years (Scragg and Maitra, 2005).

perspective of the 'expert' adult, does not allow for participation from young people (Jackson, 2004).

This becomes particularly problematic when looking at the sexual health of minority or diasporic ethnic groups. Discussions regarding young people seldom take into account wider structural, cultural or historical factors which impact their experiences and behaviour. There is a common tendency to homogenise young people into a singular generalised group, overlooking differences such as culture, ethnicity, gender and class (Coleman, 2007; Patel Stevens et al., 2007; Beals, 2006; Lesko, 2001). The voices of Pacific and Asian young people for example are notably absent from any of the studies outlined here. Furthermore, even within those studies which look predominantly at either young 'Asian' or 'Pacific' sexual health, the voices of particular ethnic groups within these wider 'catch-all' categories are consistently overlooked. In this way one could argue that by virtue of being both young and part of an ethnic minority in New Zealand, Asian and Pacific people are made doubly invisible and voiceless.

Gender and Sexual Health of Young People

An exploration of the effect of gender on sexual health is also notably absent from the research and policy documents gathered here. In particular, there is very little analysis of the way in which gender intersects with ethnicity, culture and age to shape the way in which young people experience sexuality in differing ways. Gendered identities are not fixed, but are socially and institutionally constructed, shifting across cultures, spaces and over time (Pattman, 2005; Stewart, 1999). Gender is configured around socially normative values, standards and "norms of what it means to be masculine and, by default, feminine" (Stewart, 1999; 276). Gendered identities of femininity and masculinity are not only learned, but "are things that we do or perform; partly forged through the language we use to describe ourselves and others" (Pattman, 2005: 498). These gendered identities, norms and practises powerfully shape the way in which men and women experience sexuality and sexual health in different ways. This is exemplified by the fact that 70 percent of those diagnosed with Chlamydia in New Zealand are young women; with those most

at risk young women between the ages of 15 and 19 (Women's Health Action Trust, 2008: 1).

While issues of gender are explored within the wider New Zealand sexual health literature, there is almost no gender analysis in those studies exploring the sexual and reproductive health of young Asian and Pacific people. Yet, as Tupuola (1998) suggests, ethnicity, "culture and gender play significant roles in the ways in which different populations make sense of adolescence" (Tupuola, 1998). As a fluid and socially constructed category, gendered norms and values intersect with ethnicity in particular ways; varying considerably across differing contexts and cultures. However, dominant conceptions of young people often fail to take into account gendered differences and the way in which these influence "personal and ethnic identity formation for ethnic minority youth" (Tupuola, 1998). Young people's identities are complex and shifting (Tupuola, 1998). The absence of gender in sexual health policy and research lends itself to the problematic homogenisation of young Pacific and Asian people's identity formation and experiences. Recognition of the universalising assumptions inherent in sexual health research is needed if we aim to address the wide range of factors contributing to sexual health inequities among New Zealand's young ethnic minority population.

Ethnicity and Auckland Diasporas

The use of the term 'Asian' as an ethnic category within New Zealand's public health sector is a relatively new phenomenon. It gained momentum throughout the 1990s, alongside the country's rapidly increasing Asian population, as an addition to already established categories of Maori, Pacific and Pakeha/European. It is important to recognise the significance of this shift to the inclusion of 'Asian' people in public health research and policy. Up until the 1990s, the country's Asian population were most commonly relegated to the category of 'other' within the New Zealand census. The needs and interests of Asian New Zealanders were rarely, if ever, given much attention in official government reports or policy (Rasanathan et al., 2006). Thus, the adoption and prioritisation of the category of 'Asian' in 1996 needs to be recognised for promoting "greater interest in the health needs of East, South and Southeast Asian peoples in New Zealand" (Rasanathan et al., 2006: 222). However, like most

ethnic categories the term 'Asian' does not have a fixed, neutral or uncontested meaning. Many scholars have noted the problematic nature of employing ethnic categories in health research and policy, particularly in regards to definition and measurement, and this is especially significant with the use of the term 'Asian' as a catch all ethnic grouping (Rasanathan, Craig and Perkins, 2006).

A brief examination of the Statistics New Zealand census data and definition of 'Asian' illustrates the extreme diversity of those ethnic groups included within this category. This definition incorporates peoples from throughout East, South and Southeast Asia, including those from countries as varying as Cambodia, Pakistan, India, Korea, China, Laos, Vietnam, Philippines, Bangladesh, Japan and Thailand, to name a few. Encompassing around half of the world's population, those included under the umbrella of 'Asian' differ greatly with regards to language, culture, values, history, migration experiences and socio-economic status (Abbott and Young, 2006). This vast diversity significantly calls into question the usefulness of defining 'Asian' as a single ethnic group, particularly in regards to health research, targeting and policy (Rasanathan, Craig and Perkins, 2006). As Vasil & Yoon (1996) assert,

It is difficult to view the great variety of peoples of the different countries of Asia as Asians. There is no substantial and easily definable Asianness that is represented by them. Together they all do not constitute a collectivity. Asia is too large and diverse to be able to develop much beyond an essentially geographical entity (as cited in Ho, Au, Bedford and Cooper, 2002: 22).

It is commonly accepted that rather than a fixed biological and genetic category ethnicity is a psychocultural identity; dependent on factors such as shared origin, history and language as well as collective solidarity and cultural practises (Rasanathan, Craig and Perkins, 2006). As such, it is problematic to assume all those gathered under the category of 'Asian' share the same health outcomes and requirements. As Rasanathan and colleagues (2006) suggest, "any category is only successful if it identifies a group with relevant similar attributes...[thus] for a category (ethnic or otherwise) to be useful for analysis and service provision in health, it must group together a set of people with similar determinants of health" (Rasanathan, Craig and Perkins, 2006: 218). The diversity of those groups encompassed by the

term 'Asian' means that they also have very different and unique health outcomes and needs. Collecting people together under the generalised term of 'Asian' may limit the chances of identifying and addressing the particular needs of different communities (Workshop Organising Team, 2005). Furthermore, significant heterogeneity can be obfuscated with the averaging of data, potentially rendering the particular health needs of individual groups invisible (Ministry of Health, 2006).

Even within more visible ethnic groups, such as Chinese or Indian, there are significant differences which can have important impacts on health. There are large discrepancies, for example, between those who have recently migrated and those who have been settled in New Zealand for long periods of time. Migratory history has affects on acculturation, language experiences and community cohesion which can in turn influence access to services, education and socioeconomic status; all of which significantly influence health (Rasanathan, Craig and Perkins, 2006). Furthermore, while some ethnic communities in New Zealand may identify with the term 'Asian', for others it is a term which has been largely imposed upon them. This lack of identification can be problematic with regards to the targeting of public health services set up particularly for 'Asians' (Workshop Organising Team, 2005).

These issues can be similarly applied to the use of the term 'Pacific' within public health policy and research. New Zealand's Pacific population is made up of people from countries as varying as Samoa, the Cook Islands, Niue, Tonga, Tokelau, Papua New Guinea, Vanuatu, Fiji, Solomon Islands, Tuvalu, Kiribati, Nauru, and French Polynesia (Wright and Hornblow, 2008). As such, and contrary to popular conception, there is no homogeneous 'Pacific' community in New Zealand. Rather, Pacific peoples "align themselves variously along ethnic, geographic, church, family, school, birthplace, or occupational lines" (Ministry of Education, 2001, as cited in Wright and Hornblow, 2008: 22). The use of the catch-all term of 'Pacific' does not adequately take into account differences in socioeconomic status, language, migratory experiences, history, culture and values among differing Pacific ethnic groups; all of which significantly contribute to health outcomes. Furthermore, as discussed above, culture and gender play significant roles in the ways in which different populations make sense of sexuality and adolescence. Papering over these differences, using pan-ethnic labelling, means that key factors contributing to sexual

health are ignored. This needs to be addressed if we are to challenge the serious sexual health inequalities found both within and between ethnic sub-groups in Auckland.

Conclusion

There has been a greater inclusion of Asian and Pacific ethnic groups within New Zealand policy and research over the last decade. However, as the research gathered in this annotated bibliography would attest, there continues to be significant gaps in knowledge and approach. In particular, Asian and Pacific young people's voices and experiences remain notably absent. The research that has been conducted is overwhelmingly generalised and quantitative. As such there is a tendency to overlook and omit key cultural, historical and contextual differences which shape the sexual health experiences of young people in Auckland in different ways (Jackson, 2004). This is coupled with the ongoing homogenisation of various ethnic sub-groups within New Zealand through the use of generalised pan-ethnic labelling. As discussed above, this obscures significant differences found within and between Pacific and Asian subgroups, leading to a 'papering over' of diversity which shapes sexual health outcomes and experiences (Rasanthan et al, 2006).

Consequently, there is a need for an increased contextual and intersectional approach to young people's sexual health research. There is currently very little emphasis on exploring the ways in which social categories of class, gender and age intersect with ethnicity to inform young people's sexual identities and health in particular ways. This is highly problematic given the cultural and ethnic diversity of Auckland and the significant health disparities found among ethnic groups within the city. An intersectionality approach to research, which takes into consideration the different contexts and dimensions of sexual health as well as the relationships between dimensions (Phoenix and Pattynama, 2006), is crucial if we are to begin to address inequality and to meet the diverse health needs of all ethnic communities within Auckland.

The significant gaps identified in the current research suggest a need for a shift in the methodological approach to young people's sexual health in New Zealand to one

that is more participatory. The absence of young people's voices and perspectives can be partly attributed to the dominance of conceptions of adolescence which frame young people as lacking, irresponsible or incomplete, as well as overly expert-driven approaches (Mcleod, 2003). As such, young people are rarely given the opportunity to enter into meaningful dialogue regarding issues of significance to them. Participatory approaches to young people's sexual health research would involve opening up spaces for young people to shape the research agenda. A greater use of participatory research would require a move away from perceiving young people as merely passive objects of knowledge (Percy-Smith, and Thomas, 2010). Instead, young people need to be framed as political and sexual agents, thus positioning their perspectives, views and needs as central to a research agenda. This has been found to contribute to enabling young people (Ingham and Aggleton 2006; Kafewo 2008; Allen 2011) to make informed and proactive choices about their sexuality, with interventions meeting the needs which young people deem relevant.

Outline of the Annotated Bibliography

The resources in the following annotated bibliography have been separated into four parts. They are organised in relation to sexual health needs; New Zealand policy; current interventions; current research and methods; and theoretical and methodological issues. For the purpose of relevancy, the resources gathered in this bibliography include those published between the period of 1998 and 2010. A brief synopsis of each resource is provided, highlighting the main points and argument. Section One includes all those studies and resources which outline the current status of sexual health needs for young Pacific or Asian people in New Zealand. Section Two includes those resources which outline the New Zealand government and related ministry's policy towards the study group. The third section gathers together resources which look at what interventions have been implemented with the study group to date. Section four pulls together all current research which looks at Pacific and Asian young people's sexual health. Lastly, section five includes a range of research examining some of the wider theoretical and methodological issues inherent in studying Pacific and Asian adolescent sexual health in New Zealand.

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Annotated Bibliography

1.1. Sexuality Needs and Trends

Helu, S., E. Robinson, S. Grant, R. Herd and S. Denny. 2009. *Youth '07 The Health and Wellbeing of Secondary School Students in New Zealand: Results for Pacific Young People*. Auckland: The University of Auckland.

This report presents selected findings from Pacific secondary school students who took part in New Zealand's second nationally representative youth health and wellbeing survey conducted in 2007. The findings in this study are compared to those found in the first *Youth 2000* survey which was conducted in 2001. While exploring the health of Pacific young people as a whole, the report looks separately at the sexual health of Samoan, Cook Island, Tongan and Niuen ethnic sub-groups within this pan-ethnic category. The study provides information on Pacific young people's sexual activity, contraception use, sexual orientation and experiences of sexual abuse. Overall, key findings of this study suggest that there has been an increase in the number of Pacific students who reported ever having had sex; increasing from 35% in 2001 to 45% in 2007. When compared to New Zealand Europeans, condom and contraceptive use was much lower among Pacific students, with 66% of sexually active Pacific students reporting that they use contraception. This is compared to 87% of New Zealand Europeans.

Mila-Schaaf, K., E. Robinson, D. Schaaf, S. Denny and P. Watson. 2008. *A Health Profile of Pacific Youth: Findings of Youth 2000: A National Secondary School Youth Health and Wellbeing Survey*. Auckland: The University of Auckland.

This report presents selected Pacific findings from New Zealand's first nationally representative youth health survey, *Youth 2000*, which was conducted in 2001. It discusses the findings of Pacific young people according to two age groups: those students 14 and under, and those 15 and over. While the report focuses on all aspects of Pacific young people's health, there is a particular section which looks at

sexual health. In particular, it provides information about pregnancy, sexual activity, contraception use and sexually transmitted infections. Key findings suggest that Pacific students aged 14 and under are more than twice as likely to report ever having sex, when compared with NZ European students of the same age. Furthermore, Pacific students aged 15 and over were more likely to report that they did not use contraception the last time they had sex compared to Pakeha students. There were also significant differences in the rates of pregnancy reported between Pacific and Pakeha students. Pacific young people aged 15 and over, were more than twice as likely to report a pregnancy as Europeans.

Ministry of Health. 2008. *Pacific Youth Health: A Paper for the Pacific Health and Disability Action Plan Review*. Wellington: Ministry of Health.

This paper draws on recent New Zealand studies of Pacific young people with the aim of developing an information and evidence based profile of Pacific youth health. The health of Pacific young people is prioritised in the New Zealand government's *Pacific Health and Disability Action Plan* (MOH, 2008). This paper is one of a series of reports prepared for the review of this plan. It is divided into sections which explore health determinants, protective factors, risk factors, health outcomes and interventions as they relate to Pacific young people. Sexual health and sexuality is discussed within each of these sections, providing a comprehensive overview of issues such as Pacific youth pregnancy, rates of sexual activity, family planning, sexual abuse, sources of sexual health information, STIs, interventions and sexual health programmes. Drawing together what little New Zealand research has been conducted on Pacific young people, this report provides a useful overview of available data and trends, while exploring the wide range of complex social, economic and cultural determinants which influence Pacific youth health.

Ministry of Health and Ministry of Pacific Island Affairs. 2004. *Tupu Ola Moui: Pacific Health Chart Book*. Wellington: Ministry of Health.

The reduction of health inequalities and the promotion of positive health outcomes among the Pacific population is one of the key goals of the New Zealand government

and its *New Zealand Health Strategy*. This *Pacific Health Chart Book* represents the first comprehensive review of Pacific health since 1996. The report identifies priorities and attempts to provide a stock take of the health needs of the Pacific population. The aim is to map a way forward towards reducing the significant inequalities in health outcomes for Pacific people in New Zealand. Like the *Asian Health Chart* book, the report has a section specifically dedicated to the health of young Pacific people; within which it briefly outlines issues of sexual and reproductive health. As a largely quantitative study, it outlines rates of teenage pregnancy, birth and abortion as well as STI infection among young Pacific people aged 15 and 24. Key findings suggest that Pacific young people's pregnancy and birth rates are approximately twice as high as the rest of the total population. However, abortion rates are significantly lower than the national average. The focus on young people's sexual health within this report is brief, however it provides a useful overview of national Pacific health data for those interested in exploring the issue further.

Ministry of Health. 2006. *Asian Health Chart Book 2006*. Wellington, New Zealand: Ministry of Health.

While there has been progress in monitoring the health and wellbeing of Maori, Pacific and European New Zealanders, there continues to be a significant gap in research which looks at the health and wellbeing of New Zealand's Asian population. This comprehensive profile aims to fill this gap by "collating existing health related data for Asian peoples in New Zealand, thereby providing a barometer of the current health status of Asian New Zealanders as a baseline from which to monitor future trends" (Ministry of Health, 2006: xii). It utilises information from Statistics New Zealand, the New Zealand Health Information Service, and the New Zealand Health Survey. Taking into account the problems associated with the use of the term 'Asian' as a catch-all ethnic phrase, this report separately analyses three different ethnic groups; dividing the 'Asian' category into Chinese, Indian and 'Other' Asian groups. The report has a section on young Asian people's health (aged 15-24), within which there is a very brief overview of fertility issues within this age group.

Rasanathan, K., S. Ameratunga, J. Chen, E. Robinson, W. Young, G. Wong, N. Garret, P. Watson. 2006. *A Health Profile of Young Asian New Zealanders Who Attend Secondary School: Findings from Youth 2000*. Auckland, New Zealand: The University of Auckland.

This report is based on a secondary analysis of data from the *Youth 2000* New Zealand youth health survey. It aims to address what has been identified as a considerable gap in knowledge around the health of young 'Asian' people in New Zealand. Broken into three sections, it looks particularly at the health needs and issues of Chinese youth, Indian youth and 'Asian' youth, with a section on sexual health within each sub-category. As a quantitative study, it outlines rates of sexual intercourse and activity, pregnancy, STIs and contraceptive use as well as sexual orientation and sources of sexual health information among 'Asian' high school students across New Zealand.

1.2. New Zealand Policy

Ministry of Health. 2003a. *Sexual and Reproductive Health: A Resource Book for New Zealand Health Care Organisations*. Wellington, New Zealand: Ministry of Health.

This is one of three latest large-scale policy documents produced by the New Zealand government which outlines the country's approach to sexual and reproductive health. Providing an in-depth overview of New Zealand sexual health statistics, the report discusses the kinds of approaches which are currently working, and what needs to be considered when planning further interventions. The document aims to put into place strategies for action and has a particular section which looks at sexual health strategies for Pacific people. Within this, there is a brief discussion of factors contributing to negative sexual health outcomes among Pacific young people. In addition, it discusses potential community strategies aimed at increasing positive sexual health outcomes within the Pacific community and ways in which these could be progressed. While there is a significant focus on Maori and Pacific sexual health, there is very little discussion, and no section, on New Zealand's Asian population.

Ministry of Health. 2001. *Sexual and Reproductive Health Strategy: Phase One*. Wellington, New Zealand: Ministry of Health.

This document represents the first phase of the New Zealand government's Sexual and Reproductive Health Strategy. Outlining key sexual health issues, it aims to provide the overall direction and framework for government policy, with the goal of achieving "positive and improved sexual and reproductive health outcomes in New Zealand" (Ministry of Health, 2001: iii). It is to act as a guide for those within the Ministry of Health, the District Health Boards and the wider Health Sector in determining future plans, policies and funding decisions. It also aims to guide the second phase of this process which involves the future development of more population specific Maori and Pacific sexual health plans. The report summarises four strategic directions which are to provide a framework for the development of more detailed action plans. These strategic directions include initiatives around social attitudes, values and behaviour; personal knowledge and skills; improving services; and increasing New Zealand's evidence base and information. The sexual health and wellbeing of Maori, Pacific and, to a lesser extent, Asian young people is woven throughout this report.

Ministry of Health. 2002. *The New Zealand Youth Health Status Report*. Wellington, New Zealand: Ministry of Health.

This report was produced by the Ministry of Health in 2002 in order to support the development of *Youth Health: A Guide to Action*. It aims to provide a snapshot of the health of young new Zealanders aged 12-24 years. The report has a chapter dedicated to the sexual and reproductive health of young Maori, Pacific and Pakeha ethnic groups. However, there is no discussion or inclusion of New Zealand's Asian population. Overall, the report provides data and looks at trends in relation to rates of first sexual intercourse, frequency of sexual intercourse, contraceptive use, birth rates, teen age pregnancy, abortions and STIs.

NZ Parliamentarians Group on Population and Development. 2007. *Youth Sexual Health: "Our Health, Our Issue"*. Available at:

<http://www.fpi.org.nz/Portals/6/NZPPD/NZPPD%20Resources/NZPPD%20Youth%20Sexual%20Health%20Report%202006.pdf>

In 2006 the New Zealand Parliamentarian's Group on Population and Development (NZPPD) conducted an open hearing on youth sexual and reproductive health. The purpose of the hearing was to "provide an opportunity for key government agencies, non-governmental organisations and other individual experts to present submissions to parliamentarians around youth sexual and reproductive health issues" (NZPPD, 2006: 4). This report brings together the central messages and suggestions from the hearing and submissions. It aims to provide the government with a "baseline and framework for future monitoring and evaluation of youth sexual and reproductive health policies and services" (NZPPD, 2006: 4). The chapters are divided into a discussion of the current sexual health situation in New Zealand, what interventions are working now and what needs to change in the future. The report argues for the increased need to incorporate Pacific people's views on sexual health and culturally appropriate sexuality education into future policy development. Asian young people, and their particular sexual health issues and needs are largely absent from the discussion.

1.3. Current Interventions

Education Review Office. 2007. *The Teaching of Sexuality Education in Years 7-13*. Wellington, New Zealand: Education Review Office.

This New Zealand Education Review Office (ERO) study was conducted in 2006 in order to evaluate the quality of sexual education programmes in 100 primary and secondary schools across the country. The evaluation concluded that the "majority of sexuality education programmes were not meeting students learning needs effectively" (ERO, 2006). The report identifies two key areas of weakness 1) the poor assessment of learning outcomes in sexual health education, and 2) the failure of the current sexual health curriculum to meet the needs of ethnically diverse groups of students. The lack of incorporation of Pacific people's perspectives into sexual health education was of particular concern. Out of 84 schools, it was found that only 25 percent had "some evidence that the school was effective in providing sexuality programmes that were appropriate and inclusive of the beliefs and perspectives of Pacific students" (ERO, 2006).

Ministry of Health. 2005. *Safer Sex Evaluation Summary*. Wellington, New Zealand: Ministry of Health.

This is a report produced by the Ministry of Health which evaluates the effectiveness of the Government's safe sexual health advertising campaign, featuring the 'No Rubba, No Hubba Hubba' advertisement. Conducted throughout the summer of 2004-2005, this campaign was especially targeted towards Maori and Pacific young people between the ages of 15-19. The aim of the campaign was to raise awareness of issues around safe sex and contraceptive use. The goal was to have at least 80 percent of the target audience aware of the campaign, in the hopes of ultimately reducing New Zealand's high rate of STIs. The overall evaluation of this campaign was promising. Post campaign research found that there was a dramatic increase in the awareness of advertising about condoms, condoms use and STIs. It was also found that there was a definite change in attitudes and a contemplation of behaviour change, with half of those young people interviewed suggesting that they will use condoms in the future. Overall, the research suggests that the campaign successfully reached its target audience. It is believed that the use of hip hop culture particularly enabled its messages to be delivered to young people.

Moor, Catherine. 2004. *Sexual and Reproductive Health Issues, Programmes and Services in Counties Manukau: A Profile and Proposed Action Plan*. Auckland, New Zealand: Counties Manukau District Health Board.

This report provides an in-depth overview of sexual health issues within the Counties Manukau region in Auckland. The objective of this report is to be used as an action plan to improve sexual health outcomes, services and programmes throughout Counties Manukau. Gaining information from focus groups, interviews and local data, the plan aims to improve coordination between those providers delivering sexual and reproductive health services in the region. It looks at rates of sexual activity, teenage pregnancy, STIs, abortions and levels of prostitution in the region. In addition, it discusses the kinds of programmes and services which are being provided in the area, including sex and sexuality education, primary healthcare

service provision, contraceptive services and professional reproductive health training. The sexual health outcomes and concerns of Asian, Pacific and Maori young people are woven throughout this report. It draws on research which suggests that around half of secondary students in South Auckland fail to use contraception consistently, and that the area has a much higher teenage pregnancy rate than that of the surrounding Auckland region. The report presents a useful overview of national sexual health policy, as well as a review of current school based and community sexual health programmes and interventions available in the Counties Manukau area.

1.4. Current Research and Methods

Azariah, Sunita and Nicky Perkins. 2007. Risk Factors and Characteristics of Patients with Gonorrhoea Presenting to Auckland Sexual Health Service, New Zealand. *The New Zealand Medical Journal* 120(1252).

According to laboratory surveillance in Auckland, rates of gonorrhoea infection in the region have been steadily increasing over the last 5 years, with 53 percent of those infected between the ages of 15-24 years. This article is a report of the findings of a case-controlled study conducted in Auckland which aimed to determine some of the major risk factors for contracting gonorrhoea in the region. Participants were made up of those who had been diagnosed with gonorrhoea in the last 6 months. It was found that 50 percent of those cases were under the age of 26, and that infection was very strongly correlated with belonging to either Maori or Pacific ethnicity. Other risk factors identified were low socioeconomic status, early onset sexual activity and inconsistent condom use. Overall, while there is a strong correlation between Maori and Pacific ethnicity and gonorrhoea infection, more research is needed into the connection with ethnicity.

Collins, Barbara. 2000. Consistent or Conflicting? Sexual Health Legislation and Young People's Rights in New Zealand. *Social Policy Journal of New Zealand* 15: 1-10.

This article provides an overview and critique of legislative provisions for young people to access sexual health services and sexual health education in New

Zealand. It is noted that while legislation provides young people (of whatever age) with the rights to make their own decisions on accessing contraceptive and abortion services without parental consent, “ a contrary stance is adopted in legislation governing access to school based sexual health education” (Collins, 2000: 4). This is seen most clearly in the 1985 amendment to the Education Act 1964 which entitles parents and guardians to exclude a student, of any school age, from health education classes. Ironically they argue, this inconsistency has the potential to restrict the access of young people to information that may delay the initiation of sexual activity (and thus of contraception use), as well as preventing the need for access to abortion services. The authors argue that current legislation is sending inconsistent messages to young people on issues regarding their sexual health. Overall, it is proposed that significant changes are needed if New Zealand is going to keep up with current international developments on children’s and young people’s rights.

Craig, Elizabeth, Seini Taufa, Catherine Jackson and Dug Yeo Han. 2008. *The Health of Pacific Children and Young People in New Zealand*. Report prepared for the Ministry of Health by Elizabeth Craig. Wellington, New Zealand: Ministry of Health.

The purpose of this report is to explore the differences and inequality in health status of Maori and Pacific children and young people. With a particular section dedicated to young people’s sexual health, it explores the latest trends in teenage pregnancy and sexually transmitted infections (STI’s). The report uses data from the New Zealand Birth Registration Dataset, in order to look at teenage pregnancy in relation to New Zealand’s deprivation index. It was found that rates of teenage pregnancy progressively increase alongside the deprivation index, with the highest rates seen amongst women living in the most deprived (Decile 10) areas in the country. These rates are then broken down further on the basis of ethnicity, finding that Pacific teenage birth rates are significantly higher than those for European and Asian/Indian women, but significantly lower than for Maori women.

Dickson, N., A. Sporle, C. Rimene and C. Paul. 2000. Pregnancies among New Zealand Teenagers: Trends, Current Status and International Comparisons. *New Zealand Medical Journal* 23: 241–245.

This article examines historical trends in birth and total pregnancy rates among young people in New Zealand. In particular it focuses on ethnic differences and makes international comparisons with other nations within the Organisation for Cooperation and Development (OECD). It also discusses some of the limitations inherent within current epidemiological surveillance of teenage pregnancy rates and explores ways in which this could be improved. Contemporary empirical research indicates that the age of first sexual intercourse among young people is decreasing and that the proportion of sexually active young people at school is increasing. New Zealand's teenage pregnancy rate is the second highest in the OECD; second only to the USA. It is believed that trends in teenage births over the last 50 years reflect changes in sexual activity, contraception use and abortion.

Elliot, K.J., and A.J. Lambourn. 1999. Sex, Drugs and Alcohol: Two Peer-Led Approaches in Tamaki Makaurau/Auckland, Aotearoa/New Zealand. *Journal of Adolescence* 22 (4): 503-513.

This paper discusses two school based, peer-lead interventions aimed at supporting and empowering young people as they make decisions around sex and sexuality, as well as alcohol and drug use in Auckland. The two projects explored include the Peer Sexuality Support (PSS) Programme and the Alcohol and Other Drugs Peer Education (AOD) Project which are currently being conducted in a wide range of Auckland secondary schools. Both interventions involve the training and support of selected students to “promote and provide healthy attitudes and values about sexuality and alcohol and drug use among their peers,” with the aim of reducing harmful risk-taking behaviour (Elliot and Lambourn, 1999:509). Informed by developmental psychology, the two interventions “seek to address the contemporary social issues of New Zealand youth through the integration of Bandura's Social Learning Theory and the use of positive role models”(Elliot and Lambourn, 1999: 509). The article emphasises the importance of encouraging positive risk taking among young people as a means of curbing high rates of STI's and adolescent

pregnancy. It looks particularly at the need to take into account the varying cultural values and dimensions of Maori, Pacific and Asian people, with the aim of fostering a more holistic approach to health.

Evolve. 2005. *African Youth Health and Well-Being: Participatory Action Research Project*. Wellington, New Zealand: Victoria University of Wellington.

This is a report based on a project conducted by Victoria University in Wellington. Using participatory research methods, the authors attempt to assess some of the core issues and concerns identified by African young people living in the region. The study aims to “strengthen the well-being of African youth...by identifying issues they face and developing strategies to address these issues” (Evolve, 2005). The project employed a Participatory Action Research (PAR) model which encouraged participating African young people to become partners in the research process. In this way, they are included in the implementation, design and presentation of the project. Discussions focused on a number of core issues which were identified by those young people participating as central to African young people’s health and well-being. One of these issues included sexual health, where a lack of access to appropriate sexual health resources, information, support and education, particularly for young African women, was seen as a significant problem. The report briefly discusses and suggests some actions which could be taken in response to these issues, and reflects upon the participatory process.

Goodyear-Smith, Felicity and Bruce Arroll. 2003. *Contraception Use Before and After Termination of pregnancy: Can we do it better?* *The New Zealand Medical Journal* 116 (1186).

This research aims to compare contraceptive use before unplanned conception and following post-therapeutic abortions conducted in New Zealand clinics over the years of 1995, 1999 and 2002. In particular, it examines the increasing rate of abortion among New Zealand’s Asian population. It was found that while the age of women presenting at the clinic between 1995 and 2002 were of a consistent age group (predominantly between 20 and 34 years), there has been a significant shift in

ethnicity. In 1995, 62 percent of women attending the clinic were of European decent. However, this decreased to 55 percent in 1999 and then to 33 percent in 2002. In contrast, 'Asian' women were the majority (55%) of those attending the clinic in 2002; increasing from 12% and 13% in 1995 and 1999 respectively. While this 'Asian' group included women from Korea, India, Japan and Thailand, the overwhelming majority of these women were ethnic Chinese, young, non-resident students or recent migrants. Importantly, the study also found that women attending the clinic in 2002 were much less likely to have been using contraception at conception than those in 1995 or 1999. This changing ethnic makeup is believed to reflect wider social and health provision changes within New Zealand.

Jackson, Sue. 2004. Identifying Future Research Needs For the Promotion of Young People's Sexual Health in New Zealand. *Social Policy Journal of New Zealand* 21: 123-136.

This aim of this paper is to outline some of the gaps inherent in current sexual health research in New Zealand. Two approaches are employed. Firstly, the paper reviews current New Zealand literature to identify the "research knowledge currently available to inform development of the strategy, and secondly, it draws on the findings of a scoping study that aimed to identify research needs from the perspective of those working as educators, service providers and researchers in the field of adolescent sexual health" (Jackson, 2004: 124). Overall, the author identifies an overwhelming dominance of quantitative research, as well as an over-representation of 'mainstream' samples (who are largely Pakeha, urban and heterosexual) in most of the studies which have been conducted to date. Findings from both the literature review and from the scoping study suggest the need for further qualitative research in order to illuminate "the evident gap between young people's knowledge and practice and the considerable need for more evaluation of both services and sexuality education programmes" (Jackson, 2004: 124).

Le Brun, C., E. Robinson, H. Warren and P. Watson. 2005. *Non-Heterosexual Youth: A Profile of Their Health and Wellbeing*. Auckland, New Zealand: University of Auckland.

This is a quantitative report based on the *Youth 2000* survey which explores the health and well-being of non-heterosexual school based young people in New Zealand. It analyses non-heterosexual data taken from 114 secondary schools from around the country. In particular, it looks at the sexual awareness of non-heterosexual students, rates of same sex or both sex attraction, coming out, emotional health and family. The report has a brief section on ethnicity, and found that students who identified themselves as Pacific or Asian were more likely to identify as non-heterosexual.

Ministry of Health. 2003b. *Asian Public Health Project Report*. Wellington, New Zealand: Asian Public Health Project Team, Ministry of Health. Available at: [http://www.moh.govt.nz/moh.nsf/0/75bfd2b5a42841b5cc256ce2000d5475/\\$FILE/Asian%20Public%20Health%20Project%20Report.pdf](http://www.moh.govt.nz/moh.nsf/0/75bfd2b5a42841b5cc256ce2000d5475/$FILE/Asian%20Public%20Health%20Project%20Report.pdf)

This report is a response to an increasing concern regarding the lack of attention and assessment of health issues facing Asian communities in Auckland. Representatives from the Asian community approached the Ministry of Health's Public Health Directorate in 2002 requesting that the health needs of Asian people in Auckland be considered in developing public health strategies. This report provides the first comprehensive local analysis of Asian health status and underlying issues in the region. Its purpose is to "compile available information on Asian public health needs to assist decision-makers, programme planners and other interested parties to better respond to the increasing public health needs of Asian people living within Auckland" (Ministry of Health, 2003: 5). Focusing solely on the Auckland region, it gives a demographic profile of the Asian population; looks at the socioeconomic status and health of Asian people in the region; and takes a stock take of existing health services and organisations. The report has a brief section on sexual and reproductive health and identifies high rates of abortions and STIs as an issue for Asian people. It is estimated that abortion is the second leading discharge condition for young Asian people between the ages of 15-24 in the Auckland District health

board area. While there is not a large section on Asian young people's sexual health, this report offers a comprehensive Auckland-specific overview of the health of Auckland's Asian community; identifying a wide range of gaps in our understanding and providing a guide for future health research and action.

Nash, Roy. 2002. Sex and Schooling: The Sexual Activity of Young People and its Implications for Education. *Gender and Education* 14(2): 149-165.

This article looks at shifts in sexual behaviour among young people in New Zealand and discusses the consequences of this for education. In particular it looks at early sexual behaviour among high school students from differing socio-economic and cultural backgrounds. Employing a socio-psychological framework, the article attempts to discuss changing patterns of sexual activity "with reference to familial strategies of reproduction dependent on educational success" (Roy, 2002: 163). Two shifts in young people's sexual behaviour are discussed in depth. Firstly, it explores evidence that early sexual activity is becoming decoupled from its association, especially among girls, with alienation from school and disenchantment with education. Secondly, it looks at the way sexual activity is becoming decoupled, particularly by working-class young women, from relationships of affection and friendship with males.

Ulugia-Veukiso, Analosa. 2008. What's God Got To Do With Sex? : Exploring the Relationship Between Patterns Of Spiritual Engagement And The Sexual Health Activities Of Samoan Youth. MA Thesis, Massey University, Auckland, New Zealand.

It is well documented that there are significant disparities in regards to the sexual health outcomes of young Pacific people in comparison to other ethnic groups in New Zealand. This thesis aims to explore the sexual health and wellbeing of young Samoan people, with a particular focus on the "relationship between patterns of spiritual engagement and sexual health activities of Samoan youth attending secondary school in New Zealand" (Ulugia-Veukiso, 2008: ii). Employing data from the *Youth 2000* survey, this research begins to explore the notion that spiritual

engagement can act as a protector for young people from health risk-taking behaviours. The *Youth 2000* survey involved approximately 10,000 secondary school students from around the country, 646 of whom identified as Samoan. This thesis extracts, discusses and compares data from this survey which relates to the spiritual engagement and sexual health activities of Samoan and New Zealand European students. The study finds that while church attendance is not a significant predictor of sexual health activity, spiritual engagement seems to play an important protective role. Overall, the study indicates a pattern of association of spiritual engagement on the sexual health practises of Samoan youth. This reinforces the central importance of spirituality in the lives of the New Zealand Samoan community. As well as a discussion of the policy implications of this research, this thesis has a comprehensive literature review which would be of assistance to those interested in young Pacific sexual health.

Yeung, Polly Ho Yi and Mark Henrickson. 2004. *A Pilot Study of Knowledge and Access to Sexual Wellbeing Services of Chinese Women Living in New Zealand*. In the Inaugural International Asian Health Conference. Auckland, New Zealand: School of Population Health.

There is an increasing amount of research being developed alongside New Zealand's rapidly growing 'Asian' population. However, this has been largely been concentrated around issues of adaptation and acculturation within the wider 'Asian' community, and there is little, if any, research which looks at the sexual and reproductive health of particular 'Asian' subgroups. This pilot research project aims to address this lack of data by exploring factors which impact Chinese immigrant women's access to and knowledge of sexual health services. The purpose of this study is to "identify the level of understanding of sexual wellbeing among Chinese women who are new to New Zealand; examine common and cultural barriers to service utilization; and to determine predictors of their help-seeking behaviours" (Yeung, Yi and Henrickson, 2004: 69). While this research does not focus on young people exclusively, almost one third of those interviewed fall between the ages of 18 and 25. Age, and in particular youth, is identified as a significant factor in knowledge of contraceptive choices and the likelihood to seek further information on all sexual

wellbeing issues. Chinese women who were aged 18 to 25 were found to have the lowest level of contraceptive knowledge and were least likely to seek more information regarding their sexual health. The results of this research significantly challenge commonly held assumptions which emphasise traditional beliefs and practises as barriers to awareness and knowledge of sexual wellbeing. Instead, the study suggests that it is demographic attributes such as age and length of residency which are the most influential determinants of health care access. Overall, the findings suggest that it is young Chinese women that are more at risk regarding their sexual wellbeing. These results are consistent with other studies in which abortion is the second leading discharge condition for Asian people in the 15-24-year-old age group.

1.5. Theoretical and methodological Issues

Simon-Kumar, Rachel. 2009. The 'Problem' Of Asian Women's Sexuality: Public Discourses in Aotearoa/New Zealand. *Culture, Health & Sexuality* 11(1): 1-16.

The reproductive and sexual health of young Asian women has, over the last decade, become an increasingly prominent and publicised social 'problem' within the New Zealand public health sector. Dominant discourses within the media and public health circles largely point to cultural values, migrant experiences, and a lack of knowledge as explanations for rising incidences of unsafe sex and abortions among the country's young Asian population. This article aims to critically assess and deconstruct these discourses and accepted public perceptions which continue to inform public policy. It focuses particularly on those discourses surrounding young Asian women's abortion. Employing a feminist approach, it explores the way in which social and cultural values inform particular kinds of "knowledges about what are 'normal' and 'pathological' sexual practices" (Simon-Kumar, 2009: 1). It offers challenges to these assumptions and cultural biases, arguing that in order to understand sexual practises it is important to query the cultural lenses that are used to describe and define them. Alternative perspectives cultural appropriateness is far more than overcoming language barriers in service delivery. It is about recognising the multiplicity of perspectives in the public domain.

Rasanathan, K., D. Craig, and R. Perkins. 2006. The Novel Use of 'Asian' As an Ethnic Category in the New Zealand Health Sector. *Ethnicity and Health* 11 (3): 211–227.

This article explores and problematises the novel use of 'Asian' as a catch-all ethnic category within the New Zealand health sector. While the use of the term 'Asian' is a new phenomenon within New Zealand state sector policy and research, it does not have a fixed, natural or uncontested meaning. The most commonly used definition of 'Asian' within the New Zealand state sector derives from Statistics New Zealand, and includes peoples from East, South and Southeast Asia. Encompassing around half of the world's population, those included under the umbrella of 'Asian' differ greatly with regards to language, culture, values, history, migration experiences and socio-economic status. This vast diversity significantly calls into question the usefulness of defining 'Asian' as a single ethnic group, particularly in regards to health research, targeting and policy. The term 'Asian' does not differentiate a group of people with shared characteristics in terms of health status or needs. As such, it can result in the high health needs of certain groups within this category being masked or the inappropriate targeting of services.

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