Investigating the association between experiencing discrimination in healthcare settings and avoidance of healthcare services among Pacific Rainbow+ in Aotearoa New Zealand

Patrick Thomsen, Kyle Tan, Phylesha Brown-Acton, Sam Manuela, Dion Enari, Sisikula Sisifa, Sarah McLean-Orsborn, Roannie Ng Shiu, Zerlina Wong

ABSTRACT

AIM: This study aims to investigate the relationship between experiences of discrimination (ethnic/race-based, gender and sexuality-based discrimination) in a healthcare setting, and healthcare services avoidance in Pacific Rainbow+ in Aotearoa New Zealand.

METHODS: This study draws from a sample of Pacific Rainbow+ (Pacific cisgender sexuality minorities [n=239] and Pacific transgender and non-binary [n=126]) individuals taken from the Manalagi Survey. Multivariate logistic regression analyses were performed to test for a relationship between predictors based on respondent self-reported experiences, within a healthcare setting in Aotearoa New Zealand, of discrimination (race/ethnic discrimination or racism, sexuality and/or gender diversity—homophobia/transphobia and heterosexism) and outcome variables (avoiding healthcare and mental health services).

RESULTS: Discrimination based on ethnicity/race was more highly reported by both cisgender sexuality minorities and the transgender and non-binary groups in our sample, with this typology of discrimination also associated with increased odds of healthcare services avoidance. Discrimination based on race/ethnicity was further associated with increased likelihood of mental health service usage. On average, cisgender sexuality-diverse respondents reported 1.15 instances of listed forms of discrimination, and this nearly doubled for transgender and non-binary respondents. Notably, when the overall number of discriminatory exposures increased by a single point, respondents had an approximate 60% odds ratio (OR) of healthcare avoidance.

CONCLUSION: This study affirms findings of much research that describe discrimination (multiple forms) as a common experience for Rainbow+ individuals while seeking out healthcare services. Further, it reveals that these experiences have a predictive impact on the likelihood of Pacific Rainbow+ avoiding healthcare services. While this study's cross-sectional nature limits the ability to infer causality, these findings do underscore the importance of undertaking more intersectional research into the drivers and inhibitors of healthcare-seeking behaviours and healthcare service usage of Pacific Rainbow+ in Aotearoa New Zealand.

Pacific peoples are estimated to make up 8.9% of the Aotearoa New Zealand population.[1] While Pacific peoples are an integral part of New Zealand society, alongside Māori, they consistently experience poorer health and wellbeing outcomes than other ethnic groups such as Pākehā (New Zealand European) and Asian New Zealanders.[2] Much research identifies multiple factors underpinning persistent disparities in health and wellbeing among Pacific peoples and Māori in Aotearoa New Zealand, with both structural and interpersonal racism predicting adverse outcomes, which negatively impact healthcare service use.[3,4]

Discrimination (in multiple forms) negatively impacts health outcomes and healthcare avoidance among different minority groups.[5–7] Rainbow+, an inclusive term used in Aotearoa New Zealand to encompass gender- and sexuality-diverse individuals who identify as, or a combination of, (L)esbian, (G)ay, (B)isexual, (T)ransgender, (Q)ueer, (I)ntersex, (A)sexual, and in the Pacific context (M)āhū, (V)akasalewalewa, (P)alopa, (F)aʻafafine/faʻatama, (A)kavaine, (F)akafifine, (F)akaleiti/leiti (LGBTQIA+ MVPFAFF+) consistently experience multiple forms of discrimination in schools, workplaces, places of worship, at home and when seeking healthcare services.[8–12] Experiencing overt and subtle forms of discrimination (specifically homophobia/transphobia and heterosexism) has negative impacts on the health and healthcare-seeking behaviours of Rainbow+ individuals.[13–15]

2026 Feb 13; 139(1629). ISSN 1175-8716
https://www.nzmj.org.nz/
©PMA

In Aotearoa New Zealand, one in 10 Rainbow+ young people (14–26 years old) reported they had been treated unfairly by a healthcare professional because of their Rainbow+ identity, with gender-diverse Rainbow+ young people reporting a rate 3.5 times higher than cisgender sexuality-diverse respondents.[8] For gender-diverse Rainbow+ individuals, data from Counting Ourselves report over a third of respondents (36%) avoided seeking out healthcare services due to worry about disrespect or mistreatment as a gender-diverse (transgender or non-binary) person.[12] Furthermore, Pacific Rainbow+ youth who completed the Youth 19 survey were more likely to forego healthcare than their Pākehā counterparts,[10] and nearly half of gender-diverse youth who completed the Identify survey reported facing difficulties in accessing healthcare services.[8] Sixty percent of Pacific Rainbow+ individuals that completed the Manalagi Survey indicated they had experienced discrimination in a healthcare setting in Aotearoa New Zealand, with discrimination associated with race or ethnicity (racism) more highly reported than discrimination associated with their Rainbow+ identity.[16]

International literature demonstrates how gender-diverse individuals avoid healthcare due to perceived discrimination, seek medication without doctor's supervision, find it difficult to access relevant medications or do not disclose their identity to their doctors.[17–19] In the United States, some Rainbow+ individuals avoid healthcare due to anticipated discrimination related to their gender identity.[20] This pattern of avoidance is also highlighted in studies that investigate healthcare interactions experienced by gender-diverse individuals, where such negative interactions compel them to avoid seeking healthcare altogether.[21] This avoidance leads to delays in necessary care and can have adverse outcomes for patients and families.[22] The mental health of Rainbow+ people, in places like North Macedonia as an example, is hindered by societal stigmatisation and discrimination, which exacerbates barriers to accessing mental health services.[23]

Considering local and global research findings highlighting the negative impact discrimination has on Rainbow+ health outcomes and healthcare-seeking behaviours, and given that local research shows that both Pacific and Rainbow+ individuals in Aotearoa New Zealand may experience discrimination in healthcare settings, we hypothesise an association between reported experiences of discrimination in healthcare settings and healthcare avoidance. In that, higher levels of reported discrimination experienced in healthcare settings by Pacific Rainbow+ individuals in Aotearoa New Zealand are likely to be associated with healthcare service avoidance.

Methods

The Manalagi Survey instrument

Data used to test our hypothesis are derived from the Manalagi Survey.[16] The Manalagi Survey design, research procedure and associated documents were reviewed and given ethical approval by the Southern Health and Disability Ethics Committee under approval number 2021 EXP 10986. The Manalagi Survey—structured around pillars of Pacific wellbeing (family as foundation, physical health, mental health, spiritual health, other identity factors, with culture as the roof engaging with context, time and space) articulated in the Fonofale Model of Pacific Wellbeing[24]—was co-designed with Pacific Rainbow+ individuals across Aotearoa New Zealand through 11 community consultation meetings held in eight cities.[16,25,26] The survey was administered online and was available for Pacific Rainbow+ individuals and allies to complete from February 2022 to August 2022. Those who indicated that they were allies were branched to a separate survey for friends, family and allies. Criteria for inclusion in the Manalagi Pacific Rainbow+ sample required respondents to be able to give informed consent, be at least 15 years of age, be a resident in Aotearoa New Zealand at the time, and identify as both a Pacific person and as sexuality- or gender-diverse.

Participants

The survey collected 757 preliminary responses. The final sample for this study comprised 396 respondents after excluding those who did not complete beyond the demographic section (*n*=91); did not indicate their sexual or gender identity (*n*=7); identified as allies (*n*=234); were 14 years old or younger (*n*=3); were not currently residing in Aotearoa New Zealand (*n*=10); and did not have Pacific whakapapa (genealogy) (*n*=16). For the purposes of this study, Māori were not included. While Māori are part of the Pacific family, they hold tangata whenua and mana whenua status as the Indigenous people of Aotearoa New Zealand; thus, research pertaining to Māori Rainbow+ communities is regarded as a distinct domain that should be led by Māori. As non-Māori, it is not appropriate nor ethical for this research and

research team to claim, use or publish Māori data in the Aotearoa New Zealand context.

Table 1 presents the demographic details of the Pacific Rainbow+ respondents categorised by sexuality-diverse respondents labelled as 1) cisgender sexual minorities (*n*=239), and gender-diverse respondents labelled as 2) transgender (*n*=60) and non-binary (*n*=66). All respondents were counted only once within these categories. Most participants fall within the young adult and adult age ranges, come from large cities like Auckland and Wellington and earn below NZ$59,999.

Measures

Demographics

Rainbow+. Participants were asked, "Do you identify as part of the Pacific Rainbow+ community?" Response options provided were "yes" or "no". We then asked those who selected "no" if they were "questioning", "an ally" or "neither". Participants who were questioning their identity

Table 1: Demographic characteristics of the Manalagi sample.

Demographic variables	*n* (%)	*n* (%)
	Cisgender sexual minorities (*n*=239)	Transgender and non-binary (*n*=126)
Age		
15–20 years	34 (14.2)	17 (13.7)
21–29 years	90 (37.7)	57 (46.0)
30–39 years	65 (27.2)	34 (27.4)
40–49 years	34 (14.2)	9 (7.3)
50–59 years	13 (5.4)	4 (3.2)
60+ years	3 (1.3)	3 (2.4)
Region		
Auckland	158 (66.1)	71 (57.3)
Wellington	36 (15.1)	23 (18.5)
Canterbury	18 (7.5)	8 (6.5)
Waikato	13 (5.4)	6 (4.8)
Other	14 (5.9)	16 (12.9)
Pacific whakapapa		
Samoan	115 (50.9)	47 (43.1)
Cook Island	17 (7.5)	12 (11.0)
Tongan	12 (5.3)	11 (10.1)
Other	28 (12.4)	11 (10.1)
Multi-ethnic	54 (23.9)	28 (25.7)
Personal income (NZD)		
<$40,000	85 (36.3)	56 (47.5)
$40,000–$59,999	37 (15.8)	22 (18.6)
$60,000–$89,999	62 (26.5)	28 (23.7)
≥$90,000	50 (21.4)	12 (10.2)

were grouped as part of the Rainbow+ sample, while those who identified as "an ally" or "neither" were excluded.

Gender. Participants were asked two sets of questions about their gender. First, a multi-select, single-item question: "Which of these statements apply to your gender identity?" Response options included "I am cisgender", "I am transgender", "I am non-binary" and "None of these apply". Participants were categorised into three categories: cisgender, transgender or non-binary. A total of 77 participants selected "None of these apply". Speculatively, it is possible that this high number is due to respondents not understanding the cisgender/transgender terminology or not wanting to conform to a prescribed Western gender classification, as much has been written on the incongruence between Indigenous Pacific Rainbow+ gender expressions (cultural identities) and the LGBTQIA+ classification (sexuality and gender diverse).[25,26,28]

In cases where respondents selected "None of these apply" or it was unclear if a respondent should be categorised into one of our pre-determined categories, we referred to the response for the open-ended question "How do you describe your gender?" For example, respondents who selected "None of these apply" but wrote responses such as "Woman mostly, but gender fluid" and "Fa'afafine" were classified as non-binary. Respondents who were cisgender but categorised as Rainbow+ due to being sexuality diverse (LGB) were grouped as cisgender sexual minorities.

Pacific whakapapa (genealogy). Participants were asked, "Which Pacific Island group(s) do you identify with/whakapapa to? Select as many as apply." The options provided were: Cook Islands, Fiji, Kanaka Maoli (Hawaii), Kiribati, Niue, Papua New Guinea, Rotuma, Samoa, Solomon Islands, Tahiti, Tokelau, Tonga, Tuvalu, Vanuatu and not listed. Examples of non-listed Pacific Islands include Pitcairn, Marquesas and Norfolk. These responses were collated into a nominal variable to be used as a covariate in the regression models. A "multi-ethnic" category was created to encompass those who selected more than one Pacific ethnicity.

Region. We asked participants, "Where in Aotearoa New Zealand do you live?"

Income. We asked participants, "What is your approximate personal annual income?"

Predictors

Healthcare discrimination: Participants were asked, "Have you ever experienced any of these types of discriminatory behaviours at your general practitioner's (GP's) office, a medical clinic or hospital in Aotearoa New Zealand before? Check all that apply." A definition was provided for "microaggressions" to indicate "the everyday, subtle, intentional—and oftentimes unintentional—interactions or behaviours that communicate some sort of bias toward historically marginalised groups." Refer to Table 2 for the classified response options for different forms of discrimination: ethnic/racial, gender and other.

We generated an "Overall discrimination" variable by summing all reported experiences of discrimination in a healthcare setting. The index ranges from zero to 15. A response of one indicates that participants reported experiencing one of the discriminatory behaviours assessed. In Table 2, we report the average number of

Table 2: Healthcare utilisation and experiences of the Manalagi sample.

	Cisgender sexual minorities; ***n*** **(%)**	**Trans and non-binary;** ***n*** **(%)**
Have you ever avoided seeing your GP, or going to a medical clinic or hospital because of fear for your safety, or repercussions in any way? (Discrimination, violence or visa status etc.)	42 (17.6)	32 (26.0)
In the last 12 months, how many times have you sought help from mental health support services (i.e., counsellors, helplines, etc.?)	67 (30.9)	44 (37.0)
Ethnic/race-based discrimination		

Table 2 (continued): Healthcare utilisation and experiences of the Manalagi sample.

Felt you were treated differently from patients who were Pākehā	53 (22.2)	38 (30.6)
Experienced microaggressions based on your ethnicity	53 (22.2)	27 (21.8)
Experienced microaggressions based on your race	37 (15.5)	18 (14.5)
Gender-based discrimination		
Experienced microaggressions based on your gender	12 (5.0)	17 (13.7)
Subjected to transphobic comments	1 (0.4)	14 (11.3)
Misgendered by staff	7 (2.9)	34 (27.4)
Had your dead name used despite asking for your gender-affirming name to be used	0	16 (12.9)
Refused treatment based on your gender	1 (0.4)	4 (3.2)
Other discrimination		
Experienced microaggressions based on your sex	6 (2.5)	8 (6.5)
Experienced microaggressions based on your characteristics	25 (10.5)	17 (13.7)
Subjected to homophobic comments	7 (2.9)	13 (10.5)
Refused treatment based on your sex	1 (0.4)	6 (4.8)
Refused treatment based on your sexual orientation	2 (0.8)	1 (0.8)
Felt you were treated differently from patients who were cisgender and straight-presenting	3 (1.3)	24 (19.4)
Had your symptoms minimised	66 (27.6)	33 (26.6)
Overall discrimination (0 to 15) (mean; standard deviation)	1.15 (1.63)	2.18 (2.88)

discriminatory experiences for each gender group.

Outcomes

Healthcare avoidance. We asked participants, “Have you ever avoided seeing your GP, or going to a medical clinic or hospital because of fear for your safety or repercussions in any way (e.g., discrimination, violence or visa status, etc.)?” This question was adapted from the Counting Ourselves[12] and Identify[8] surveys, with final wording confirmed by Pacific Rainbow+ communities in survey testing.[16]

Seeking mental health support. We asked participants, “In the last 12 months how many times have you sought help from mental health support services (i.e., counsellors, helplines, etc.)?”

We adapted this question from Honour Project Aotearoa[27] and the Counting Ourselves Survey,[12] with final wording approved through community consultation and testing.[16] The responses were binarised as "yes" or "no".

Data analysis

All statistical analyses were conducted in IBM SPSS Statistics v30. First, we conducted descriptive analyses of the predictor and outcome variables for the two respective gender groups. We strategically limited our analysis to two gender groups in this study due to the low number of affirmative responses observed in preliminary analyses for predictor variables specific to transgender and non-binary sub-groups. This decision was made to avoid overestimating odds ratios, which could introduce bias resulting from small sample sizes.[29] Subsequently, multiple sets of multivariate logistic regression analyses were performed to ascertain the extent of association between each predictor on various types of discrimination, and the two outcome variables: healthcare avoidance and mental health support. These analyses were conducted using generalised linear models and adjusted for the effects of demographic variables (age, Pacific whakapapa, region and income). Regression analyses were undertaken only for variables with at least 20 participants reporting a discriminatory experience to guarantee sufficient statistical power for identifying a true difference. Statistical significance was determined at an alpha level of $p<.05$.

Results

Table 2 outlines the patterns of health and mental health care utilisation and experiences. Nearly one in five cisgender sexual minorities, and more than a quarter of transgender and non-binary respondents, have avoided accessing healthcare due to fears for their safety or potential repercussions. Multivariate findings in Table 3 indicate that Rainbow+ participants (both cisgender sexual minorities; transgender and non-binary) who had experienced ethnic/race-based discrimination including being treated differently from their Pākehā counterparts ($p<.001$) and experiencing ethnic-based microaggressions ($p<.01$) had increased odds of avoiding health services.

Transgender and non-binary respondents with prior exposure to misgendering in healthcare settings were significantly more likely to avoid seeking healthcare services ($p<.05$). Cisgender sexual minority respondents who had experienced microaggressions based on their presenting characteristics ($p<.01$), or had their symptoms minimised by healthcare staff ($p<.01$), also reported elevated odds of healthcare services avoidance. Transgender and non-binary respondents who felt they were treated differently from their cisgender counterparts ($p<.001$) or had their symptoms minimised ($p<.001$) were significantly more likely to avoid healthcare services.

Cisgender sexual minorities respondents reported experiencing 1.15 instances of the listed forms of discrimination, while transgender and non-binary respondents reported nearly double with 2.18. When the overall number of discriminatory exposures increased by one point, it was estimated that both cisgender sexuality minorities as well as transgender and non-binary respondents had an approximate 60% increased likelihood of avoiding healthcare.

Nearly one-third of cisgender sexual minorities respondents, and more than one-third of transgender and non-binary respondents, sought mental health support in the past year. For cisgender sexual minorities, those who had experienced race-based microaggressions ($p<.05$) were significantly more likely to report having sought mental health support (see Table 4). Transgender and non-binary respondents who reported ethnic ($p<.01$) or race-based ($p<.001$) microaggression had significantly higher odds of seeking mental health care services. Further, transgender and non-binary participants who faced symptoms being minimised reported increased odds of mental healthcare service utilisation ($p<.001$). A one-point increment in discriminatory exposure predicted a 60% heightened likelihood for transgender and non-binary respondents to seek mental health care services.

Discussion

Our multivariate regression analysis demonstrates that discrimination (racism and homophobia/transphobia and heterosexism) reported by both Pacific cisgender sexual minorities and transgender or non-binary Rainbow+ individuals in Aotearoa New Zealand within a healthcare setting is associated with increased healthcare avoidance. These results align with international literature reporting Rainbow+ groups experiencing high levels of discrimination in healthcare settings (Australia),[18] as well as similar associations among

Table 3: Multivariate regression of healthcare avoidance of the Manalagi sample adjusting for age, region, ethnicity and income.

	Cisgender sexual minorities (OR)	Transgender and non-binary (OR)
Ethnic/race-based discrimination		
Felt you were treated differently from patients who were Pākehā	6.21 [2.72–14.17]***	10.63 [3.15–35.86]***
Experienced microaggressions based on your ethnicity	3.18 [1.45–7.00]***	7.63 [2.19–26.60]**
Experienced microaggressions based on your race	3.02 [1.28–7.13]*	-
Gender-based discrimination		
Experienced microaggressions based on your gender	-	-
Subjected to transphobic comments	-	-
Misgendered by staff	-	3.00 [1.05–8.58]*
Had your dead name used despite asking for your gender-affirming name to be used	-	-
Refused treatment based on your gender	-	-
Other discrimination		
Experienced microaggressions based on your sex	-	-
Experienced microaggressions based on your characteristics	4.31 [1.63–11.42]**	-
Subjected to homophobic comments	1.41 [0.14–14.32]	-
Refused treatment based on your sex	-	-
Refused treatment based on your sexual orientation	-	-
Felt you were treated differently from patients who were cisgender and straight-presenting	-	18.88 [5.04–70.70]***
Had your symptoms minimised	3.10 [1.41–6.82]**	12.54 [3.64–43.11]***
Overall discrimination	1.56 [1.26–1.92]***	1.59 [1.27–2.00]***

OR = odds ratios.
Note that we only conducted regression analyses for discriminatory variables with more than 20 affirmative responses. We used a dash to indicate variables that were omitted from assessment. *p<.05; **p<.01; ***p<.001.

Table 4: Multivariate regression of seeking mental health care among the Manalagi participants adjusting for age, region, ethnicity and income.

	Cisgender sexual minorities (OR)	Transgender and Non-binary (OR)
Ethnic/racial-based discrimination		
Felt you were treated differently from patients who were Pākehā	1.26 [0.61-2.60]	8.64 [2.78-26.87]***
Experienced microaggressions based on your ethnicity	1.16 [0.55-2.43]	7.67 [2.18-26.95]**
Experienced microaggressions based on your race	2.57 [1.14-5.79]*	-
Gender-based discrimination		
Experienced microaggressions based on your gender	-	-
Subjected to transphobic comments	-	-
Misgendered by staff	-	1.34 [0.49-3.65]
Had your dead name used despite asking for your gender-affirming name to be used	-	-
Refused treatment based on your gender	-	-
Other discrimination		
Experienced microaggressions based on your sex	-	-
Experienced microaggressions based on your characteristics	2.14 (0.85-5.43)	-
Subjected to homophobic comments	-	-
Refused treatment based on your sex	-	-
Refused treatment based on your sexual orientation	-	-
Felt you were treated differently from patients who were cisgender and straight-presenting	-	-
Had your symptoms minimised	2.00 [0.99-4.06]	7.31 [2.63-20.35]
Overall discrimination	1.14 [0.95-1.38]	1.60 [1.36-2.05]**

OR = odds ratios.
Note that we only conducted regression analyses for discriminatory variables with more than 20 affirmative responses. We used a dash to indicate variables that were omitted from assessment. *p<.05; **p<.01; ***p<.001.

Rainbow+ individuals reporting incidences of discrimination in healthcare settings and increased healthcare avoidance in Thailand (gender-affirming healthcare avoidance)[17] and the United States.[19] However, some measures (i.e., minimisation of symptoms) may be associated with both racism and homophobia/transphobia and have not been meaningfully disentangled in our analysis. The most significant predictors of healthcare avoidance among Pacific Rainbow+ related to being treated differently from Pākehā and experiencing microaggressions based on ethnicity and race.

For transgender and non-binary respondents, other predictors of healthcare avoidance were more significant than for cisgender sexual minorities; namely, misgendering by staff and a belief that they were treated differently than cisgender or straight-presenting patients. While having symptoms minimised could be associated with healthcare avoidance, transgender and non-binary respondents reported significantly higher odds ratios (statistically significant) of seeking mental health care based on minimisation of symptoms than cisgender sexual minorities respondents (not statistically significant).

Respondents were also more likely to access mental health services if they had experienced ethnic or race-based discrimination. This is an important finding, as it highlights the way discrimination impacts Pacific Rainbow+ individuals on two axes of difference: race/ethnicity *and* sexuality and/or gender diversity. Furthermore, our findings indicate that experiences of discrimination have a cumulative effect on healthcare avoidance for Pacific Rainbow+. An increment of a reported discriminatory experience—based on gender or ethnicity/race—could increase the odds of healthcare avoidance by nearly 60%.

Limitations

In the present study, we were required to collapse the diverse gender identities within Pacific Rainbow+ communities into Western categorical frameworks due to analytical constraints, including a small sample size. As a result, we were unable to meaningfully examine gender-group differences within our sample, despite existing research indicating such differences in healthcare utilisation.[12] Further, our regression findings are limited by the cross-sectional nature of the data, which restricts our ability to infer causality. While our results suggest that experiences of discrimination may contribute to healthcare avoidance and increased use of mental health services, alternative explanations remain plausible. For example, it is equally possible that individuals within Rainbow+ communities who avoid healthcare and rely more heavily on mental health services are more likely to report discrimination in healthcare settings. Nevertheless, this reverse hypothesis continues to underscore the critical importance of addressing ethnic and sexuality as well as gender diversity-based discriminatory practices experienced by Pacific Rainbow+ communities within healthcare settings.

Conclusion

Our findings affirm research that details high levels of discrimination experienced in the lives of Rainbow+ individuals both in Aotearoa New Zealand and abroad. For Pacific Rainbow+ respondents in this study, experiences of discrimination (racism, homophobia/transphobia) had a negative predictive effect on healthcare service use. Further analysis shows that discrimination related specifically to race and/or ethnicity had a stronger predictive effect than sexuality- and gender-based discrimination. For transgender and non-binary respondents, being treated differently from cisgender patients was also a strong predictor of healthcare service avoidance. Our analysis also shows that experiences of racial and ethnic based discrimination (racism) also increased the likelihood of mental health service usage among respondents. While findings of the study are limited by the cross-sectional nature of the data and the statistically strategic decision to collapse Pacific gender and sexuality diversity into narrower Western gender and sexuality categories, the intersectional complexity of the Pacific Rainbow+ experience with the Aotearoa New Zealand healthcare system needs further investigation and research. This will help provide further nuanced data and evidence to better support this multiply marginalised cohort's comfortability with, and usage of, services provided by the Aotearoa New Zealand healthcare system.

COMPETING INTERESTS

Nil.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the support of the Knowledge Hub in the Faculty of Medical Health Sciences at Waipapa Taumata Rau, The University of Auckland, for providing additional support to the Manalagi research team.

The Manalagi Project is funded by the Health Research Council of New Zealand.

Ethics approval for this project was granted by the New Zealand Southern Health and Disability Ethics Committee under approval reference 2021 EXP 10986.

As the dataset contains sensitive information shared by Pacific community members, the dataset is not publicly available. However, requests from researchers will be considered on a case-by-case basis; please contact the corresponding author if you wish to use the Manalagi dataset.

AUTHOR INFORMATION

Patrick Thomsen, PhD: Senior Lecturer, Senior Research Fellow, Global Studies and Pacific Health, Faculty of Arts and Education/Faculty of Medical Health Sciences, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand; Associate Professor and Associate Dean Pacific, University of Otago Wellington, Wellington, New Zealand (March 2026).

Kyle Tan, PhD: Research Fellow, Faculty of Māori and Indigenous Studies, University of Waikato, Hamilton, New Zealand.

Phylesha Brown-Acton: Executive Director, F'INE Pasifika Aotearoa Trust, Auckland, New Zealand.

Sam Manuela, PhD: Senior Lecturer, Faculty of Science, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand.

Dion Enari, PhD: Associate Professor, Nga Wai a Ta Tui—Māori and Indigenous Research Centre, School of Healthcare and Social Practice, Unitec, Auckland, New Zealand.

Sisikula Sisifa, PhD: Lecturer, Faculty of Business and Economics, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand.

Sarah McLean-Orsborn, PhD: Lecturer, Centre for Pacific Studies—Faculty of Arts and Education, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand.

Roannie Ng Shiu, PhD: Senior Research Fellow, Pacific Health, Faculty of Medical Health Sciences, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand.

Zerlina Wong: BGlobal Researcher, Global Studies—Faculty of Arts and Education, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand.

CORRESPONDING AUTHOR

Patrick Thomsen, PhD: Senior Lecturer, Senior Research Fellow, Global Studies and Pacific Health, Faculty of Arts and Education/Faculty of Medical Health Sciences, Waipapa Taumata Rau, The University of Auckland, Auckland, New Zealand; Associate Professor and Associate Dean Pacific, University of Otago Wellington, Wellington, New Zealand (March 2026). E: patrick.thomsen@auckland.ac.nz

URL

https://nzmj.org.nz/journal/vol-139-no-1629/investigating-the-association-between-experiencing-discrimination-in-healthcare-settings-and-avoidance-of-healthcare-services-am

REFERENCES

1. Stats NZ Tatauranga Aotearoa. 2023 Census population counts (by ethnic group, age, and Māori descent) and dwelling counts [Internet]. Wellington, New Zealand: Stats NZ Tatauranga Aotearoa; 2024 May 29 [cited 2024 Oct 11]. Available from: https://www.stats.govt.nz/information-releases/2023-census-population-counts-by-ethnic-group-age-and-maori-descent-and-dwelling-counts/.
2. Ryan D, Grey C, Mischewski B. Tofa Saili: A review of evidence about health equity for Pacific Peoples in New Zealand. [Internet]. Wellington, New Zealand: Pacific Perspectives Ltd; 2019 Jul [cited 2025 Feb 12]. Available from: https://www.pacificperspectives.co.nz/publications.
3. Talamaivao N, Harris R, Cormack D, et al. Racism and health in Aotearoa New Zealand: a systematic review of quantitative studies. N Z Med J. 2020 Sep 4;133(1521):55-68.
4. Harris R, Cormack D, Waa A, et al. The impact of racism on subsequent healthcare use and experiences for adult New Zealanders: a prospective cohort study. BMC Public Health. 2024 Jan 9;24(1):136. doi: 10.1186/s12889-023-17603-6.
5. Kcomt L, Gorey KM, Barrett BJ, McCabe SE. Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. SSM Popul Health. 2020 May 28;11:100608. doi: 10.1016/j.ssmph.2020.100608.
6. Puhl RM, Heuer CA. The stigma of obesity: a review and update. Obesity (Silver Spring). 2009 May;17(5):941-64. doi: 10.1038/oby.2008.636.

7. Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. Am J Public Health. 2003 Feb;93(2):200-8. doi: 10.2105/ajph.93.2.200.
8. Fenaughty J, Alansari M, Besley T, et al. Identify survey: community and advocacy report. Identify Survey Team; 2022.
9. Peiris-John R, Farrant B, Fleming T, Bavin L, Archer D, Crengles S, et al. Youth19 Rangatahi Smart Survey, Initial Findings: Access to Health Services [Internet]. New Zealand: Youth19 Research Group, The University of Auckland and Victoria University of Wellington; 2020 p. 19. Available from: https://static1.squarespace.com/static/5bdbb75ccef37259122e59aa/t/5f72eb4e6df42c5960e64d1a/1601366890806/Youth19+Access+to+Health+Services+Report.pdf
10. Tiatia-Seath J, Fleming T, Sutcliffe K, et al. A Youth19 Brief: Pacific Rainbow young people [Internet]. New Zealand: The Youth19 Research Group, Te Herenga Waka—Victoria University of Wellington and The University of Auckland; 2021 [cited 2025 Feb 12]. Available from: https://static1.squarespace.com/static/5bdbb75ccef37259122e59aa/t/60dd11a05fc4a74bf0de3e7a/1625100708894/Pacific+Rainbow+Youth19+Brief.pdf.
11. Thomsen P, Mclean-Osborn S, Ainea H, Verner-Pula A. Examining the State of Health Research on Pacific Rainbow Communities in New Zealand; Literature Review. PacHealthDialog. 2021 Jun 22;21(7):449-57.
12. Veale J, Byrne J, Tan KKH, et al. Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand [Internet]. New Zealand: Transgender Health Research Lab; 2019 [cited 2021 Jan 20]. Available from: https://researchcommons.waikato.ac.nz/handle/10289/12942.
13. Brown LK, Veinot TC. Discrimination in Healthcare and LGBTQ + Information and Care-seeking Behaviors. Proceedings of the Association for Information Science and Technology. 2021;58(1):405-9.
14. Jones KP, Peddie CI, Gilrane VL, et al. Not So Subtle: A Meta-Analytic Investigation of the Correlates of Subtle and Overt Discrimination. Journal of Management. 2016;42(6):1588-613.
15. Mendoza-Perez JC, Ortiz-Hernandez L. Association Between Overt and Subtle Experiences of Discrimination and Violence and Mental Health in Homosexual and Bisexual Men in Mexico. J Interpers Violence. 2021 Dec;36(23-24):NP12686-NP12707. doi: 10.1177/0886260519898423.
16. Thomsen P, Brown-Acton P, Manuela S, et al. The Manalagi Survey Community Report: Examining the Health and Wellbeing of Pacific Rainbow+ Peoples in Aotearoa-New Zealand [Internet]. Auckland, New Zealand: The Manalagi Project Team; 2023 [cited 2025 Feb 12]. Available from: https://www.manalagi.org/_files/ugd/b7eedf_7a214bf6e78349f084581c5f2b68bf2d.pdf.
17. Boonyapisomparn N, Manojai N, Srikummoon P, et al. Healthcare discrimination and factors associated with gender-affirming healthcare avoidance by transgender women and transgender men in Thailand: findings from a cross-sectional online-survey study. Int J Equity Health. 2023 Feb 13;22(1):31. doi: 10.1186/s12939-023-01843-4.
18. Bretherton I, Thrower E, Zwickl S, et al. The Health and Well-Being of Transgender Australians: A National Community Survey. LGBT Health. 2021 Jan;8(1):42-49. doi: 10.1089/lgbt.2020.0178.
19. Lerner JE, Martin JI, Gorsky GS. More than an Apple a Day: Factors Associated with Avoidance of Doctor Visits Among Transgender, Gender Nonconforming, and Nonbinary People in the USA. Sex Res Soc Policy. 2021 Jun 1;18(2):409-26.
20. Casey LS, Reisner SL, Findling MG, et al. Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. Health Serv Res. 2019 Dec;54 Suppl 2(Suppl 2):1454-1466. doi: 10.1111/1475-6773.13229.
21. Paine EA. What Happens during Healthcare Interactions to Compel Gender Nonconforming LGBTQ People to Avoid Healthcare? [Internet]. The University of Texas at Austin; 2018 Oct [cited 2024 Apr 8]. Available from: http://hdl.handle.net/2152/68691.
22. Stein GL, Berkman C, Acquaviva K, et al. Project Respect: experiences of seriously ill LGBTQ+ patients and partners with their health care providers. Health Aff Sch. 2023 Sep 26;1(4):qxad049. doi: 10.1093/haschl/qxad049.
23. Stojanovski K, King EJ, Bondikjova V, Mihajlov A. Stigma shapes lesbian, gay, bisexual, transgender, and queer person's mental health and experiences with mental health services in North Macedonia. Glob Public Health. 2022 Jun;17(6):857-869. doi: 10.1080/17441692.2021.1896767.
24. Pulotu-Endemann K. Fonofale Model of Health [Internet]. Massey University; 2009 [cited 2025 Feb 12]. Available from: https://d3n8a8pro7vhmx.cloudfront.net/actionpoint/pages/437/attachments/original/1534408956/Fonofalemodelexplanation.pdf?1534408956.
25. Thomsen P, Brown-Acton P. Manalagi and Community Engagement: Designing and Delivering Meaningful Wellbeing Research with Pacific

Rainbow+ Communities. In: ‘Ilai’u-Talei C, Faleolo R, Manuela S, Enari D, editors. Untangling notions of Pacific wellbeing across the trans-Tasman diaspora. Singapore: Springer Nature; Forthcoming.
26. Thomsen P, Brown-Acton P. Manalagi Talanoa A Community-Centred Approach to Research on the Health and Wellbeing of Pacific Rainbow LGBTIQA+ MVPFAFF Communities in Aotearoa New Zealand. PacHealthDialog. 2021 Jun 22;21(7):474-80.
27. Pihama L, Green A, Mika C, et al. Honour Project Aotearoa. 2020; Te Kotahi Research Institute.
28. Thomsen, P. Research “Side-Spaces” and the Criticality of Auckland, New Zealand, as a Site for Developing a Queer Pacific Scholarly Agenda. New Zealand Sociology. 2022 Jan 1;37(1), 120-142.
29. Nemes S, Jonasson JM, Genell A, Steineck G. Bias in odds ratios by logistic regression modelling and sample size. BMC Med Res Methodol. 2009 Jul 27;9:56. doi: 10.1186/1471-2288-9-56.