

The wildest dreams and the Asian gaze

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Earlier this year, I received an email from Liz Beddoe suggesting I read the article “Smashing the patriarchy to address gender health inequities: Past, present and future perspectives from Aotearoa (New Zealand)” written by Came et al. (2021). The article was creative, about cutting-edge feminist health research, investigating power relations between patriarchy and gender health inequity over four decades and imagining a better future for women. Being a healthcare professional working during the Omicron pandemic, reading such an article was a breath of fresh air and reflecting on its contents made my gaze wander with curiosity over a few interrelated gender health topics. All three authors, Associate Professor Heather Came, Dr Anna Matheson, and Associate Professor Jacquie Kidd, shared their personal stories in the article. I very much appreciated the hopes and aspirations projected by those intimate narratives. Since I am an ethnic minority here in Aotearoa New Zealand, this article made me want to explore how we, Asian women, are doing in Aotearoa New Zealand in relation to our health. My curiosity got me wondering if there is such a thing as *feminism* in Asia, or if there is such a thing as a feminism in Aotearoa New Zealand that contributes to minority women’s health. This commentary essay is about a personal and professional reflection on the article written by Came et al. (2021) through my meandering gaze, with the realisation that I don’t even know how to say “feminism” in my first language.

Background

In 2007, one of the most respected scientific international climate panels, namely the Intergovernmental Panel on Climate Change (IPCC), published their fourth report (IPCC, 2007). For the people who were interested

in environmental issues, or for people who were simply wanting to survive through climate change, this “Fourth Report” was a bomb. In other words, it was groundbreaking. The report basically stated (with evidence) that climate change was man-made (probably the first time to acknowledge it formally), and the impacts of climate change (given the speed of erosion at that time) would be most dire in Asia, Africa and the Pacific Island nations. The report also alerted us that we didn’t have much time at all if we wanted to reverse the consequences expected (IPCC, 2007). To me, the message presented by the report was very clear. It was very concise and comprehensive—you could not have misinterpreted it. What the report said was consistent with what I and my community in Japan have witnessed over the last decade or so. Although typhoons are annual seasonal events, and communities have lived through them for hundreds of years and thousands of seasons, the force of recent typhoons seems to have become more intense—beyond what we have previously experienced.

Back in 2008, I was a first-year social work student in Auckland and was in the social policy class. The coastal environment was the topic I had chosen for the policy analysis assignment. When I spoke from my own experiences that climate change was a social issue because it would worsen the existing social issues, everyone in the class laughed. One of the smartest students in the class tried to calm others down by saying “don’t laugh, this is what Ai believes!” I didn’t think it was just my belief, it was my lived experience that had grown into my passion for helping others who were in need. Because, from where I stand, to this day, life is hard. In the class in 2008, most social work students were women, Pākehā women to be exact, who

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probably had not seen any intense typhoons, nor had they lost any family members in the environmental calamity. I was only one of a few migrant students in the entire class then; I felt very embarrassed. This experience got me wondering if the classmates would have laughed if the comments had come from a person (say a middle-aged Pākehā man), who had a proper university degree, not just a person with lived experiences.

Gaze is a concept that originated in filmmaking terms to describe the frame of the picture, or in this case, a *standpoint*, which is widely applied in feminist analysis (Mohanty, 2003; Rahmanipour et al., 2019). Everyone has a different standpoint, depending on where you are coming from and who you are. Multiple realities exist in this world, particularly in this post-modern world. In the classroom in 2008, I was unable to be sure about my own knowledge and experience, because I desperately wanted to fit into the dominant culture.

In 2022, I am a part-time postgraduate student staring at the Zoom screen, trying to engage in discussion in class. The lecturers emphasised several times during the discussion that “there are no right and wrong answers, just try to articulate your points”. I know, for sure, that what I said in 2008 in the social policy class wasn’t wrong, but the learning environment made me feel like I had said something wrong. Particularly over the last few years, climate change and its impacts have become mainstream knowledge. Young people have initiated climate strikes and demanded that the government address global warming (Sumihira, 2019). There is nothing new about climate issues, though—not new to where I stand as an Asian woman. The awareness about climate change in this community might have changed dramatically in the last few years. In the Zoom class, I could hear Taylor Swift’s song “22” in the background of one of my classmates’ screens. Although the song was about age, being 22 years old, the words “we’re happy, free, confused

and lonely at the same time” (Swift, 2021) sounded like a precise phrase to describe 2022 so far.

Asian health in Aotearoa New Zealand

Asia refers to the region from the far east of Mongolia to the far West of Afghanistan. The Asian region is considered to be one of the most culturally and linguistically rich areas on the planet (Ameratunga et al., 2008). In Aotearoa New Zealand, the Asian population has grown to become the third-largest ethnic group, based on the 2018 Census (Statistics NZ, 2020). Almost 20% of young people aged 15-29 years in Aotearoa New Zealand are Asian (Peiris-John et al., 2022).

The majority of Asians in Aotearoa New Zealand were born overseas. While it is considered that the process of migration can have an impact on health and wellbeing (Abubakar et al., 2018), information about Asian health has been somewhat invisible here. Some scholars point out that the statistics seem to be insufficient, or suffer from inadequate analysis (Ameratunga et al., 2008; Liao, 2019). Health statistics of the Asian population tend to be projected as healthier than other ethnic groups sometimes; however, the data tend to be missing a detailed analysis. For instance, health research often refers to *Asian* as an aggregated group, although there are significant variables amongst sub-groups. In comparison to Chinese, Indian people tend to have a higher prevalence of diabetes and cardiovascular disease. In essence, aggregated data often camouflage the details of Asian health status (Liao, 2019; Peiris-John et al., 2022).

The “healthy immigrant effect” was highlighted in some Asian health studies. Liao (2019, p. 32) explains that “[h]ealthy immigrant effects” refer to the process of immigration requirements in which candidates need to present a good state of health, work skills and employment

opportunities in order to move to Aotearoa New Zealand. At the same time, some scholars have called attention to the data which reveal that, overall, Asians have significantly low usage of health services—as though they were afraid to be sick (Ameratunga et al., 2008; Liao, 2019). For instance, Asians in general, showed lower usage of ACC, disability services, residential care, and mental health services. The lowest enrolment with primary health care was also highlighted. The low rate of usage cannot be simply interpreted as though there is no demand (Liao, 2019). From my experience, it was very difficult to find literature that describes why Asians have a lower rate of health service usage, therefore, I searched for more specific explanations.

Asian women's health

Around the year 2008, I stopped wearing feminine clothes, because I felt unsafe doing so. It seemed there was unhealthy attention directed towards Asian women in the community at that time. I did not know what to do about, or where to report, harassment. A Swedish study in 2008 showed that Asian women in Sweden were also more likely to encounter less favourable sexual experiences such as unwanted touching. The majority of Asian participants in the study disclosed encounters involving inappropriate sexual comments made by men in public, and some women reported that they chose to stop wearing dresses in order to cope with those disheartening comments against their appearance (Lindblad & Signell, 2008). It was good to know that I was not alone.

At about the same time, the Victoria University of Wellington carried out a study in 2010 about New Zealanders' attitudes towards Asian migrants, and the study reported that about half of New Zealanders believed Asian migrants were driving New Zealand in an unpleasant direction. The same study reported that the majority of New Zealanders held an untruthful false belief that Asian migrants had brought

more crimes to the community. The actual data showed only 2.5% of the incarcerated population was identified as Asian in 2010 (Girling et al., 2010). Nearly a quarter of Asians in this study reported experiences of discrimination and racism—it was a lot higher than for any other ethnic group (Girling et al., 2010).

An Aotearoa New Zealand scholar, Associate Professor Rachel Simon-Kumar, highlighted in her study in 2009 how media contributed to constructing the negative images of Asian females in Aotearoa. It was reported that a period in 2002 showed a rapid rise of interest in Asian females' sexual health. Several headlines such as "Asian Shame", "Multiple-abortions not uncommon for Asians", and "student troubles" broadcasted throughout the media, projected the image that young Asian students' sexual practices were "reckless and risky" (Simon-Kumar, 2009). In her study, Simon-Kumar (2009) investigated and reported that the actual data showed that the Pākehā women had the highest number of abortions in Aotearoa New Zealand. However, the higher rate of abortions amongst Asians was noted, the majority of service users were married older females in contrast to how the media presented it. The number of abortions in younger Asian women was, in fact, the lowest.

Gender-based violence is a major public health issue as well as the most prevalent human rights issue (Langer et al., 2015). Amongst the Organisation for Economic Co-ordination and Development (OECD) countries, Aotearoa New Zealand has the highest rate of family violence (Hager, 2020). Violence creates significant negative health consequences including low self-esteem, post-traumatic stress disorder, and self-harm (Langer et al., 2015). A number of studies, such as the Lancet report (Langer et al., 2015), Ministry of Social Development (MSD) report (2010), Simon-Kumar et al.'s (2017) study and Rahmanipour et al.'s (2019) study, underscored the vulnerability of migrant

women to family violence. MSD's report (2010) highlighted that migrant women, particularly Pacific peoples and Asians, were at a higher risk of relationship-related homicides. Some Asian cultures suppress women for speaking up about family violence, which perpetuates these unhealthy behaviours. The risks have been highlighted however, family violence statistics about minority women are less comprehensive nor accurate (Simon-Kumar et al., 2017). The recurrent theme here is, that Asians seem to be invisible in the health research and policy-making sphere. It is clear that more detailed Asian health data are needed in order to be able to support the community. This has got me thinking further, as to why the voices of Asians seem to be absent in addressing our own issues.

The Youth 2000 survey (<https://www.youth19.ac.nz/>) is a local study that aims to capture the current state of secondary school students' health and wellbeing. Since the survey in 2000, Asian youths have shown a trend that they tend to miss out on healthcare for various reasons. The latest Youth 2000 survey with Eastern and Southern Asians provided a detailed analysis, reporting that Asian adolescents reported the highest rate of being treated unfairly by healthcare professionals (Peiris-John et al., 2021). More concerningly, 33% of East Asian females reported severe depressive symptoms, 17% witnessed violence at home, 50% of young Asian women did not feel safe in their neighbourhood, and one in five girls had experienced an unwanted sexual touch or sexual activity in the last 12 months. Those numbers were much higher than for young Pākehā women (Peiris-John et al., 2021). Reading this report made me feel helpless knowing that nothing has changed since 2008 when I felt unsafe living in my own community.

Ministry of Health statistics on the cervical screening carried out between 2005 and 2015 showed that Asians have had the lowest rate of attendance (Ministry of Health, 2019).

Gao et al.'s (2008) study based on Chinese women living in Auckland also showed the lowest rate of 45%, compared to the national level of 73%. Cervical cancer is preventable and curable if detected earlier, like any other cancer, although, about 50 women die from it in Aotearoa New Zealand each year (Ministry of Health, 2022a). The World Health Organisation (WHO, 2020) launched the Cervical Cancer Elimination Strategy in 2020. There is a chance that cervical cancer may be able to be eradicated. Those numbers and data, on how frequently Asian women experience unwanted sexual attention, how negatively the Aotearoa New Zealand society perceives Asian migrants, how much risk Asian migrant women are at of family violence, how badly young Asian are missing out on healthcare due to racism, and how many Asian women are avoiding cervical screening, seem to me screaming out for help that Asian communities must be recognised and their needs to be met in a better way. But instead, it almost feels like the Asian communities' voices were silenced, as though their side of the stories do not exist or do not matter. Looking back in the little social policy class in 2008, my stories and my experience did not matter in terms of defining what social issues in Aotearoa New Zealand and what social policies ought to be. My gaze wanders to see if that is what Asian communities in Aotearoa New Zealand are experiencing. Therefore, there are no further data attached to it.

I only recently learned about "an unfortunate experiment" carried out in the National Women's Hospital in Auckland between the 1960s and 1980s by reading Came et al.'s (2021) article. In this clinical experiment, a Pākehā male physician enrolled women in his clinical trial to prove his belief about carcinoma-in-situ without informing and gaining consent from participants. During this period, women with carcinoma-in-situ were inadequately treated by him despite a high risk of developing cancer in later life. Some women passed away as an outcome (Coney, 1995). The research started in 1965

and did not end until the lead physician's retirement in 1982, although there were opposing opinions about the unethical nature of his research (Coney & Bunkle, 1987).

The original article was published in *Metro* magazine, both authors were women (Coney, 1995). Not long after the *Metro* article was published, the Ministry of Health ordered an investigation of the case. The inquiry was led by a female District Court Judge Dame Silvia Cartwright in 1987. Judge Cartwright's report responding to the event brought about significant changes in healthcare in New Zealand which are relevant to the present day. The Health Commissioner was established as one outcome as well as a hospital ethical committee to approve all clinical research and trials. The Health Commissioner launched the Code of Patient's Rights which stated that a patient has a right to informed consent for any tests or treatments. The report also included offering treatment to all the women participating who showed signs of disease. Interestingly, the Minister of Health at that time who initiated establishing National Cervical Screening Programme was also a woman, Hon Helen Clark (Coney, 1995).

Knowing about those women's existence, including those who passed away as an outcome of the unethical experiment has changed my attitude towards cervical screening forever. I am not going to take an accessible screening programme for granted. The original article, "an unfortunate experiment" highlighted the narratives of women who underwent this experiment. It feels like their stories would have been unheard of if these two women had not decided to write about it. At the same time, the Came et al. article motivated me to look at how the health status of Asian women has been invisible here in Aotearoa New Zealand.

Women's movements in Asia

In 2022, we call our prime minister by her first name, Jacinda. In her recent commencement speech in the USA, she

mentioned a fellow woman prime minister, Benazir Bhutto, who in 1988, became the first female prime minister in the Islamic nation. Benazir was the first female prime minister in Asia. Jacinda quoted Benazir in her speech, "Democracy can be fragile" (Ardern, 2022). I know exactly what this statement meant. Asia has lived through critically fragile periods with antagonistic political agendas such as dictatorships, wars, and colonisation. Needless to say, my home country Japan has played a large part in damaging the continent.

Considering feminist advocacy on healthcare, I realise that I hardly know anything about women's movements in Asia. Came et al. (2022) narrated that one of the authors' grandmothers fled to New Zealand as a refugee. I am aware that learning about women's history in Asia can be somewhat uncomfortable. For example, learning in depth about sexual slavery in Japanese military services during World War II (Mackie, 2004) would be devastating. My grandmother was born in Manchuria in China which was, at the time, occupied by the Japanese Military. She was able to attend school rarely for various reasons, including the fact that education for women had not been a priority in Asia, and it is the case to this day in some ways. My grandmother had no qualifications but she was able to speak both Japanese and Mandarin. My gaze wandered over what my grandmother might have seen at that time; I wondered if she saw herself as a coloniser while she learned to speak the local language.

The second wave of feminism was criticised particularly for being ethnocentric (Mann & Huffman, 2005). The work of African American women, for example, is not as well-known as that of the male leaders. The American Civil Rights Movement grew rapidly after Rosa Parks refused to sit in the area that was designated for black people in the bus in 1955. Alongside of well-known advocates such as Malcolm X and Martin Luther King Jr., women advocates

such as Linda Brown who fought for equal education also contributed to the movement (History, Art & Archives, U.S. House of Representatives, 2008).

As an outcome of the critique of white feminism (Cree & Philips, 2019), third-wave feminism brought minority perspectives, such as Black feminism, to the front (Mann & Huffman, 2005). Some scholars argue that the political perspectives of women of colour had existed long before the emergence of third-wave feminism. For instance, the Combahee River Collective is a Black Feminist organisation formed in 1974, and its statement released in 1977 (and reprinted in 2019) emphasises that its focus was to promote overall women's wellbeing and solidarity including sexual minorities such as lesbians (Combahee River Collective, 2019). There is some evidence that women in the Black Panther Party used to study womanhood in communist Asian nations such as Vietnam and China, in order to build a strong allyship between men and women in the party (Young, 2019). I could not find any clear indications of the existence of allyship between white women and minority women.

Where I stand as an Asian woman in 2022 feels like an intersection of delicately woven connections and history. There are multiple perspectives and realities existing within me. As feminist scholar Mohanty (1988) once described it, the minority feminism in the Western country I live under and within the Western gaze in Aotearoa New Zealand. At the same time, I will always be Japanese, and I may come across as the residue of the dominant culture within Asia (Mohanty, 2003). Perhaps similar to how Black Feminism started, Asian womanhood may have sought connections and allies with men instead of "othering" from the beginning. Western feminism often expresses views that oppose manhood or patriarchy; however, Asian perspectives on women's issues have sought alliance and solidarity with men. Under the fragile democracy or

dictatorships, seeking allies was considered a necessity (Roces, 2010). But I could find limited evidence of an alliance between minority women and Caucasian women overall—it got me thinking that feminism is still for people of European descent.

I am the first person to obtain a postgraduate degree in my family, and clearly, it did not occur in a vacuum. In the classroom in 2008, I did feel powerless and invisible. I did not think I could survive another course of study. Powerlessness made me doubt the value of my own experience and knowledge (which is often called internalised racism), putting the dominant culture before your own. You may say that I had an identity crisis.

Social work and the social determinants of health

We are very blessed in Aotearoa New Zealand that we have a lot of Indigenous and minority scholars locally. Learning about te Tiriti o Waitangi taught me that two distinct interpretations can exist simultaneously, and it takes ongoing negotiations and commitment to have it right for both parties. It taught me that I need to speak up for my own opinions if I wanted others to see where I stand.

My first job as a health social worker was in South Auckland, and I did not leave this very first job for almost 10 years. I acknowledge that the role and the experiences I have had with this community have shaped who I am today, personally and professionally. The significance that made my "becoming" possible, I believe, was a strong presentation of minority culture, including Māori and Pacific Island culture in the locality. Their embracing culture literally welcomed me as who I was. When I started working as a new graduate then, racism was more visible than it is now. I ended up writing my master's thesis about climate change in collaboration with the Pacific Island Communities in Auckland.

On racism, one of the original members of Polynesian Panthers, Dr Melani Anae (2020, p. 170) wrote "Identity Verse":

I am a Samoan, but not a Samoan.
 To my aiga in Samoa, I am a papalagi.
 I am a New Zealander, but not a
 New Zealander.
 To New Zealanders, I am at worst a “bloody
 coconut”, at best a “Pacific Islander”.
 To my Samoan parents, I am their child.

Although I was not born in New Zealand, I can relate to the sense expressed in her writing. No doubt racism challenges who you are, and your identity. I certainly had a moment doubting my own experience. “The story of a mighty pen” is well-known amongst a community of colour in Aotearoa New Zealand, alongside Polynesian Panthers’ influences. In 1978, a young Niuean man was arrested by police officers on Karangahape Road simply because he had three plastic combs in his pocket. Police officers accused this young Polynesian man of stealing; however, he worked in a comb factory and combs were given by his employers. The following morning, a Pākehā law lecturer from the University of Auckland who read the story on the paper presented himself to a police station, with a pen with the University of Auckland logo. At the police station, he reported that he stole a pen from his workplace. Of course, the law lecturer did not get arrested (Chapman, 2021).

Stories like this are still strongly relevant to where I exist in Aotearoa New Zealand. Similar to how I experienced the learning environment in 2008, the dominant culture seems to define what the current reality is—it did not matter what this Niuean man was actually doing. He was probably just heading home after a long shift at work. I remembered this story because this was another example that the minority’s reality was ignored, regardless of the well-established fact that we live in a post-modern world. We know that multiple realities exist, in theory, but the dominant culture still tends to decide what is right and wrong for us minority anyway. It made me wonder if racism would impact on men and women differently. I wondered, would

Pākehā feminism have different opinions about this?

At this present time, we are aware that social stress, including racism and sexism, impact one’s health outcomes significantly. For instance, chronic stress, attributed to experiencing racism can exhaust one’s physiological responses to stress which often results in cortisol overload for a long period of time (Marmot & Wilkinson, 2005). Cortisol overload could lead to Type 2 diabetes (Marmot & Wilkinson, 2005). Moreover, physiological stress responses over time can make one’s blood platelets stickier, therefore, increasing the risk of stroke and blood clots (Marmot & Wilkinson, 2005). The bodily stress reaction is a signal sent from the brain. While the brain is occupied by dealing with chronic stress, often one’s brain experiences a delay in responding to infectious diseases (Marmot & Wilkinson, 2005). No wonder some ethnic groups experience disproportionate poor health status statistics. The prevalence of hospitalisation due to Covid-19 experienced by Māori was 1.4 times worse while that of Pacific Islanders was almost twice that of Pākehā (Ministry of Health, 2022b). The data in Aotearoa New Zealand project that Māori people have about 10 years shorter life expectancy to this day. We have enough evidence to prove that injustices in our community are a reality. I am a social worker raised by “the village”, and I am no longer comfortable being a bystander.

I am not convinced, in my reality, that the patriarchy is the first thing that we need to smash right at this moment as Asian women. We, Asians, firstly need to be seen and heard, for the young generation who are suffering more than ever. I am not here to recommend any easy answers. The original article by Came et al. (2021) presents their research results, which indicates that Māori women hope for culturally appropriate healthcare to be mainstream in the future—I do truly hope this notion includes other minority women in Aotearoa New Zealand, because, I am begging for alliances to feel safe to be ourselves, to

express our needs and challenges, and to be okay to exist. It is exhausting always having to defend myself. My gaze wanders again, and asks, how would the picture look if feminism included the minority who are voiceless, and what if feminism and patriarchy make an alliance instead of smashing each other? Are we able to appreciate differences between us, and different opinions then, instead of offending each other?

Conclusion

This commentary essay was inspired by the article written by Came et al. (2021), “Smashing the patriarchy to address gender health inequities”. While learning about how Western feminism impacted on women’s health advancement locally and internationally, the original article made my mind wander through transnational imagination. The article also made me realise that I knew only very little about my own roots, and womanhood studies in Asia. Smashing patriarchy may not be my wildest dream at this time. I tend to think there may be something more out there in the future when I smash my own internalised biases and find a safe space to be an authentic self. I do think that the Niue man was just carrying the combs which were given to him. And I know that my experience with natural disasters are real. I do hope that our realities are recognised as true as those from the dominant culture as the postmodern theories state and are being taught elsewhere. The original article by Came et al. (2021) got me to reflect and think further about what feminism really means. The local data show that Asian women could do better, in terms of their health, with more recognition and opportunities to have safe spaces to express their challenges.

Note

¹I obtained the data from the Ministry of Health website <https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics#hospitalisations>, and applied prevalence calculation

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