Exploring Adult Providers' Perceptions of Youth Sexual and Reproductive Health Promotion Using Social Media in New Zealand

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Abstract

Youth sexual and reproductive health (YSRH) is a significant public health concern in New Zealand, with the outcomes revealing persistent health inequities among young people, especially marginalised youth population groups who experience disproportionately high rates of sexually transmitted infections (STIs), unintended pregnancies, and related mental health challenges. These disparities are driven in part by structural barriers such as inadequate access to quality, culturally responsive sexual and reproductive health (SRH) services and persistent stigma associated with STIs and adolescent sexuality, predisposing them to risky behaviours and delayed care-seeking. Further, SRH providers working within traditional health promotion frameworks face significant challenges in engaging young people, who, as digital natives, are often difficult to reach through conventional health service delivery models.

The rise of digital technologies has introduced new and emerging possibilities for YSRH promotion. Social media platforms have emerged as a powerful tool for disseminating health information and connecting with young people who naturally thrive within digital environments as producers and consumers; that is, as prosumers of content. This research therefore explored the perspectives of SRH providers in New Zealand on their use of social media to promote SRH among youth, examining the opportunities, barriers, and systemic and structural factors that shape digital health promotion practices in the New Zealand context.

The study is grounded in a constructionist epistemology and uses critical theory as its theoretical framework to centre youth-adult power dynamics. As a practice-based qualitative research project, the study used semi-structured interviews and focus group discussions to explore provider perspectives on using social media as a YSRH promotion tool. Data collection was conducted in two phases between August 2022 and August 2023. Phase one involved recruiting and collecting initial data from 13 SRH providers across 10 local organisations participating in the research. This resulted in eight one-on-one interviews and two group discussions (split as two- and three-group participants, respectively). Phase two involved the presentation of preliminary findings to the participants, providing them with the opportunity to validate the results and contribute to the final research artefact. Braun and Clarke's reflexive thematic analysis approach was applied for data analysis and employed a critical youth lens to illuminate youth-adult tensions in digital health promotion practices and highlight possibilities for change. Three themes were developed, each corresponding to one of the three research questions and collectively informing the development of the artefact (an output is a requirement of the doctoral pathway chosen), a 'Youth-Adult co-design model for digital YSRH promotion'. This practical framework facilitates equitable partnerships between SRH providers and young people.

The findings revealed three key dimensions of the power relations between SRH providers and young people in digital YSRH promotion. First, SRH providers, constrained by institutional

pressures and professional norms, prioritise control through existing adult-led practice frameworks, with some expressing scepticism that social media-based SRH promotion can produce lasting behavioural change in youth. Second, the non-fluency in youth language and digital realities among adult providers creates critical barriers to authentic youth-adult relationships, affecting trust and community building. Providers demonstrated aversion to new technological possibilities due to privacy and confidentiality concerns, ethical standards, risks of misinformation, fragmented or dissenting feedback on posts and digital incompetence, all of which contrast with youth's lived realities and agency. Additionally, cultural and religious factors fuel stigma and discrimination within SRH practices, challenging inclusivity and diversity for marginalised groups such as men who have sex with men and lesbian, gay, bisexual, transgender, queer and intersex people. Third, the findings highlight promising prospects for institutionalising meaningful and authentic youth-adult partnerships as a pathway to navigate the barriers and complexities of digital disconnect and mistrust between adult providers and young people.

This study aimed to place youth at the heart of SRH promotion, establishing young people as equal partners and co-creators of change rather than passive beneficiaries. It highlights the urgent need for a policy and regulatory framework that safeguards YSRH and rights while supporting partnerships between youth and SRH providers to better navigate social media spaces, free from epistemic exclusions and autonomy restrictions. Equally important is establishing coherent communication strategies to guide how SRH messaging is conceptualised, designed, and disseminated, ensuring resonance with the diverse realities of young people. Beyond message creation, this study calls for a genuine co-creation approach that goes beyond tokenistic consultation, positioning young people as experts and collaborators throughout the full design and evaluation cycle of interventions. Finally, it reflects on the importance of flexibility and adaptability, essential qualities for reimagining youth–adult partnerships and developing inclusive, future-ready digital health promotion ecosystems.

This exegesis is complemented by a creative artefact, a 'Youth-Adult co-design model for digital YSRH promotion', which translates the research findings into a practical framework for adult providers and young people to engage collaboratively and build authentic connections. Located in Chapter 7, the artefact offers a five-step, iterative strategy (Reach, Engage, Referral, Uptake, Transformation) designed to foster a crucial mindset shift, leading to enhanced practices across social media and digital platforms that enable youth agency, particularly in New Zealand and, by extension, across international contexts.

Keywords: youth-adult co-design, youth SRH promotion, social media, critical youth theory, digital SRH promotion

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Glossary

Keywords	Definitions in relation to this study
Health promotion	The process of enabling people to increase control over, and to improve their health (World Health Organisation, 1986).
Critical Positive Youth Development (CPYD)	Applied in this study as the analytical framework that interrogates power, resists adultism, and participates in transforming the social and institutional conditions that apply to them.
Hybrid PESTEL – Ecosocial analytical framework	Through a hybrid approach, the PESTEL framework was applied as the organisational outline for discussing the macro-level structural determinants that shape youth sexual and reproductive health outcomes in New Zealand; while ecosocial theory (Krieger, 1994, 2001, 2009, 2021) was applied as the analytical framework to review the literature across these macro-level structural determinants, demonstrating the pathways of embodiment, cumulative interplay and accountability.
Young people	This applies to the theoretical population commonly referred to as 'youth' or 'young people' throughout this thesis and is engaged through critical youth theory and CPYD, and follows the Ministry of Youth Development's definition of 12 to 24 years. That is the population whose agency, and whose structural relationship to adult-controlled systems, this thesis is actually theorising.
Youth Actor	This is a young person with active social media presence and function as a voice on SRH-related topic, may be employed with public or private organisation/individual. Youth actor and youth advocate were used interchangeably across the thesis.
Youth SRH (YSRH) promotion	YSRH promotion is a carefully designed, youth-centred and participatory process that enables young people to collectively and individually increase control over the social, structural, and systemic determinants of their sexual and reproductive health outcomes within contexts shaped by adult-youth power relations through coordinated educational, policy, organisational, regulatory and environmental actions, with the explicit aim of advancing equity, rights and well-being.
Youth-centred approach	Places the development of young people's personalities and well-being at the centre of the content, organisation, and development of activities, services and programmes to achieve the best outcomes for young people.
Youth-led approach	Are fundamentally about power sharing and democratising knowledge production and decision-making, building on the capacity of young people as critical thinkers, effective leaders and active change agents in their organisations and communities.
Practice-based research	Defined as an original investigation undertaken to gain new knowledge, partly by means of practice and the outcomes of that practice. Critical to this understanding is that the basis of the contribution to knowledge in the doctoral research is a creative artefact (Candy, 2006).
Artefact / Practice-Oriented Framework	The practice-oriented artefact, the 'Youth-Adult co-design model for digital YSRH promotion', is the creative output of this study. It falls under format three thesis category, and showcases "the relationship between the central concept, key contexts, focus and methodology of the practice-oriented work, thereby setting the thesis in its relevant critical context" (Auckland University of Technology, 2026, p. 52).

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Name: Adetoun Joan Nnabugwu

Date: March 30, 2026

Artificial Intelligence Declaration

Below are mentions of the Artificial intelligence tools I used and how I have used them. I decided to create a table for each AI tool, so that their exact purpose and examples can be clearly presented.

AI Tool 1: Gemini

Specify the chapter number(s) in your research proposal/research component where AI was used.	
Chapter number(s):	**1 - 8**
Briefly explain why the AI tool was used (e.g., idea generation, summarisation, data analysis, image creation, etc.).	
Purpose of AI Use:	To check grammatical correctness and evaluate sentence structuring.
Clearly state the AI tools used.	
AI Tool(s) Used:	**Gemini and Grammarly**
Exact prompts or queries entered into the AI tool. Include all relevant variations.	
Prompts Used:	**Example 1: Sentence review for logical correctness** There is something about the second part of this sentence that is not reading right. Can you check and suggest a better way to phrase it, if so: Additionally, young people must hold adult partners, that is, SRH providers accountable by interrogating their willingness to yield authority over agenda and resources, ensuring that youth input is not solicited and ultimately overridden by adult 'expertise'(Gonzalez et al., 2020). **Example 2: Remove verbose text** Any verbose wording in this sentence, and how can it be improved? This requires recognising young people as knowledge experts of themselves and in their own right, engaging them at that level, from problem identification/definition, to planning and implementing co-designed initiatives, and its evaluation for learning and improvement of the collaboration between them.
A summary or description of the AI-generated output. (Optional: attach output in an appendix.)	
Output Received:	**Example 1 output:** The second part of the sentence feels slightly "clunky" because the phrase "not solicited and ultimately overridden" creates a minor logical knot—it sounds like you are saying their input shouldn't be solicited at all. In reality, you mean that the *solicitation* shouldn't be a mere formality that is later ignored. Here are three ways to refine the logic and flow: Option 1: Direct and Punchy (Recommended) "Additionally, young people must hold adult partners accountable by interrogating their willingness to yield authority over agendas and resources, ensuring that youth input is not merely performative and ultimately overridden by adult 'expertise' (Gonzalez et al., 2020)." • Why it works: Adding "merely performative" clarifies that while the input is gathered, the risk is that it lacks real power. Option 2: Focusing on the "Tokenism" Aspect "Additionally, young people must hold SRH providers accountable by interrogating their willingness to yield authority over agendas and resources; this ensures youth input is meaningfully integrated rather than being solicited only to be overridden by adult 'expertise' (Gonzalez et al., 2020)." • Why it works: Using a semicolon and "rather than" creates a sharper contrast between genuine engagement and the "overriding" by adults. Option 3: Streamlined for Academic Flow

"Additionally, youth must hold adult partners accountable by challenging their willingness to share authority over resources, ensuring that youth contributions are substantive and not secondary to adult 'expertise' (Gonzalez et al., 2020)."

- Why it works: It simplifies the vocabulary (e.g., "contributions" instead of "input is... solicited") to make the sentence move faster.

Example 2 output: The original sentence contains some redundant phrasing and structural "clutter," specifically around the list of activities and the final clause regarding collaboration.

Identified Verbose Phrases

- "Knowledge experts of themselves and in their own right": These two phrases mean essentially the same thing. You can use a single, stronger term like "subject-matter experts of their own lived experience" or simply "experts of their own lives."
- "Engaging them at that level": This is a filler phrase that can be integrated into the action verbs (planning, implementing, etc.).
- "And its evaluation for learning and improvement of the collaboration between them": This is the wordiest section. It can be tightened by focusing on the outcome (continuous improvement).

Refined Improvements

Option 1: The "Direct & Academic" Version

"This requires recognizing young people as experts of their own lived experiences and engaging them throughout the research cycle—from problem identification and planning to the implementation and evaluation of co-designed initiatives."

- Why it works: It uses the term "research cycle" to group the activities, making the sentence much punchier while maintaining the professional tone.

Option 2: The "Process-Focused" Version

"Effective engagement necessitates treating youth as primary knowledge experts. This involves their active participation in every phase: defining problems, planning initiatives, and evaluating outcomes to refine and improve the collaborative process."

- Why it works: By using a colon and a list, you remove the "from... to... and its" structure, which can often feel like a run-on in academic writing.

Option 3: Minimalist & Precise

"This approach mandates recognizing youth as autonomous experts, engaging them in the identification, design, and evaluation of initiatives to foster continuous learning and collaborative improvement."

- Why it works: It replaces "knowledge experts of themselves" with "autonomous experts" and simplifies the list of actions into three distinct nouns (identification, design, evaluation).

Further prompt

How about now: This requires recognising young people as experts of their own lived experiences and engaging them throughout the project lifecycle, from problem identification and planning to the implementation and evaluation of the co-designed health promotion initiatives.

AI Feedback: This version is much stronger. It is logically sound, grammatically precise, and maintains a professional academic tone. By using "experts of their own lived experiences" and "project lifecycle," you have successfully eliminated the previous redundancies.

Why it works now:

- Precision: It replaces the repetitive "experts of themselves and in their own right" with a single, high-impact academic phrase.
- Flow: The "from... to..." structure is now clearly anchored to the "project lifecycle," making the scope of engagement unmistakable.
- Clarity: Specifically mentioning "co-designed health promotion initiatives" ties the action directly to your research focus on SRH.

Describe how the AI output was used, edited, or transformed.

Post-AI Processing Methods:	Example 1: I read through the different suggestions and chose the one that most aligned with my original intent, replacing the 'clunky' word with one that was clearer and more appropriate to the idea presented in the sentence. Example 2: Taking into consideration the suggestions offered, I refined the sentence as I thought best and rewrote the revision in my own words.

AI Tool 2: Claude.AI

Specify the chapter number(s) in your research proposal/research component where AI was used.	
Chapter number(s):	**1 - 8**
Briefly explain why the AI tool was used (e.g., idea generation, summarisation, data analysis, image creation, etc.).	
Purpose of AI Use:	For summarisation and to probe my reasoning and deductions from articles I read and applied in my writing
Clearly state the AI tools used.	
AI Tool(s) Used:	**Claude.ai**
Exact prompts or queries entered into the AI tool. Include all relevant variations.	
Prompts Used:	**Example prompt:** Focus on the second paragraph and remove redundancies or repetitive facts, particularly if already covered in the first paragraph Having established the conceptual reasoning behind the choice of methodology, the "Youth-Adult Co-design Model for Digital SRH Promotion" was carefully developed from the thematic analysis of adult providers' narratives, identifying how youth engagement is currently conceptualised and practised, what challenges providers encounter and what institutional constraints they navigate. Additionally, a critical interrogation of the findings through a critical youth lens was done to reveal epistemic hierarchies, power dynamics and gaps between participatory rhetoric and structural practice. Also, scholarly materials were reviewed, and evidence that supports youth activism, health promotion models, co-design approach and CYPD processes were integrated. This contributed to the generated iterative design that reflects what current practice reveals about institutional barriers, what CYPD-informed youth voice means in YSRH promotion and what counts as authentic youth-adult partnerships architectures from the literature. The practice-based artefact was further refined based on the research participants' (adult SRH providers) feedback on the preliminary findings, their feedback on how the 'artefact' could be applied in SRH promotion, theoretical coherence checking and critical feedback from my supervisors. Being systematically descriptive of processes undertaken supports the argument of detail, articulation, and accurate presentation of how, when and why throughout the research. By making practice 'the site of research' (Candy, 2006), new knowledge on provider practice about youth conceptualisation and engagement in health promotion, application of social media and similar technology-driven platforms as a resource and navigating institutional barriers and negotiating power dynamics emerged. The study, therefore, integrates knowledge derived from practice embedded in the CYPD framework to advance practice by proposing conditions for meaningful youth voice. This positions practice beyond a mere object of study but as an active site of knowledge production, consistent with PBR methodology.
A summary or description of the AI-generated output. (Optional: attach output in an appendix.)	
Output Received:	**Revised Second Paragraph (Redundancies Removed)** Here's your paragraph streamlined and tightened: The Youth-Adult Co-design Model for Digital YSRH Promotion was developed through systematic synthesis of: (1) thematic analysis findings revealing how providers currently conceptualize

youth engagement, what challenges they encounter, and what institutional constraints they navigate; (2) critical interrogation of findings through CYPD to reveal epistemic hierarchies, power dynamics, and gaps between participatory rhetoric and structural practice; (3) literature evidence on youth activism, health promotion co-design models, and CYPD operationalization; and (4) iterative refinement based on participant feedback on preliminary findings and artefact applicability, theoretical coherence checking, and supervisor consultation. This systematic process demonstrates that the artefact emerged from methodologically grounded synthesis rather than ad hoc application of findings. By positioning practice as 'the site of research' (Candy, 2006), new knowledge emerged about how providers conceptualise youth engagement, navigate institutional barriers, and negotiate power dynamics—knowledge that is integrated with CYPD principles in the artefact to propose conditions for meaningful youth voice in digital YSRH promotion. This positions practice as an active site of knowledge production, consistent with PBR methodology.

What Was Removed/Changed

Removed Redundancies:

1. **"Having established the conceptual reasoning behind the choice of methodology"**
    - Unnecessary throat-clearing
    - First paragraph already established this
    - Just start with the model development
2. **"carefully developed"**
    - Vague modifier; "systematic synthesis" is more precise
3. **"Additionally...Also..."**
    - Removed these weak transitional phrases
    - Integrated into numbered list format for clarity
4. **"This contributed to the generated iterative design that reflects..."**
    - Wordy and unclear
    - Simplified to "iterative refinement"
5. **"Being systematically descriptive of processes undertaken supports the argument of detail, articulation, and accurate presentation of how, when and why throughout the research."**
    - Extremely vague meta-commentary
    - Doesn't say anything concrete
    - Replaced with: "This systematic process demonstrates that the artefact emerged from methodologically grounded synthesis" (more direct, specific)
6. **Repetition of "practice"**
    - Original used "practice" 5 times in second paragraph
    - Reduced to 3 times, maintaining clarity
7. **"...new knowledge on provider practice about youth conceptualisation and engagement in health promotion, application of social media and similar technology-driven platforms as a resource and navigating institutional barriers and negotiating power dynamics emerged"**
    - Run-on, repetitive
    - Already covered in point (1)
    - Simplified to: "new knowledge emerged about how providers conceptualize youth engagement, navigate institutional barriers, and negotiate power dynamics"
8. **"The study, therefore, integrates..."**

- "Therefore" is unnecessary (relationship is already clear)
- Removed

9. **"...positions practice beyond a mere object of study but as an active site..."**
   - "Beyond a mere object" is awkward
   - Simplified to: "positions practice as an active site..."

Structural Improvements

Changed to numbered list (1-4) for artefact development process

Why:

- Clearer structure
- Easier to follow the systematic process
- Shows distinct stages

Combined two sentences about practice as site of research

Original: Two separate thoughts about what emerged and how it was integrated
Revised: One coherent sentence showing emergence → integration → artefact

Removed vague meta-commentary

Original: "Being systematically descriptive...supports the argument..."
This doesn't say anything meaningful.

Revised: "This systematic process demonstrates that the artefact emerged from methodologically grounded synthesis rather than ad hoc application of findings."
This directly addresses the Candy critique—showing your artefact wasn't just casually made from findings.

What the Revised Paragraph Does

✓ **Shows systematic artefact development** (numbered process)
✓ **Demonstrates methodological rigor** (addresses critique about PBR as label)
✓ **Uses Candy's language** ("site of research")
✓ **Connects practice → knowledge → artefact** (clear flow)
✓ **Eliminates repetition** (from first paragraph and within itself)
✓ **More concise** (~150 words vs. ~200 words original)
✓ **Clearer structure** (easier for examiner to follow)

Describe how the AI output was used, edited, or transformed.	
Post-AI Processing Methods:	All output and suggestions are read thoroughly and rewritten in my own words as a reflection of my understanding, and to maintain academic integrity.

AI Tool 3: NotebookLM

Specify the chapter number(s) in your research proposal/research component where AI was used.	
Chapter number(s):	**7**
Briefly explain why the AI tool was used (e.g., idea generation, summarisation, data analysis, image creation, etc.).	
Purpose of AI Use:	For the graphic design production of the practice-oriented artefact

Clearly state the AI tools used.	
AI Tool(s) Used:	**NotebookLM**
Exact prompts or queries entered into the AI tool. Include all relevant variations.	
Prompts Used:	Generate image of five petals lapping one into another to represent five non-linear but iterative phases. Phase 1 is Reach; Phase 2 is Engage; Phase 3 is Referral; Phase 4 is Uptake, and Phase 5 is Transformation. Youth and adults are at the centre as the core stakeholders to act upon and within the framework. Researchers, academia and government represent the tripartite governance model which are enabling stakeholders surrounding the five overlapping petals. Beneath the petals and the tripartite frames are two hands like the palms carrying the petals and the stakeholders, and representing the fundamental and indigenous principles that give the entire framework its roots, and reflected as typical root strands as under a tree.
A summary or description of the AI-generated output. (Optional: attach output in an appendix.)	
Output Received:	: The Youth-Adult co-design model for digital YSRH promotion
Describe how the AI output was used, edited, or transformed.	
Post-AI Processing Methods:	I used Adobe Photoshop to correct AI errors in the heading text and to expand on the notes about the Indigenous principles relevant to the framework.

STUDENT DECLARATION					
By signing, you are confirming that the AI use stated in the tables above is accurate and follows AUT's recommended guidelines detailed in the AI Hub and Postgraduate Handbook.					
Student Name:	**Adetoun Joan Nnabugwu**	**Signature:**	**A. J. N.**	**Date:**	**March 30, 2026**

Acknowledgments

My utmost gratitude to the Auckland University of Technology and the Faculty of Health and Environmental Sciences for the opportunity to study at this prestigious institution. I thank my academic supervisors, Dr Cath Conn and Associate Professor Radilaite Cammock, for holding my hands. Many times, I wanted to give up (COVID-19, pregnancies and childcare, balancing study, work and family commitments), but when I remember how you cheered me on, teaching and supporting my learning, I knew not to. Here we are today, and I am immensely grateful that you had my back. Dr Quentin Allan, we crossed paths during one of the most challenging points of writing my thesis – the advice you offered, alongside practical directions on how to improve my work, gave me the courage to push harder and better. Thank you. Shoba Nayar, I appreciate the quality of your editing services and turnaround time. Thank you, too.

To my dearest and the fairest of ten thousand to my soul, Obi'm, Charles Obinna Nnabugwu, THANK YOU. Na man you be, Odogwu. Leaving absolutely everything behind to start a new life in a land so far, none but the just the two of us, trusting and believing the sacrifice is worth it. Of course, it has now paid off! With two amazing children, Chiamanda and Chukwuanugom, joining us to make life more meaningful and beautiful, I cannot appreciate you all enough.

To my parents, Engr. J. A. and Elder (Mrs) R. O. Ogundare, and dad in-love, Chief Sabastine S. Nnabugwu, your prayers sustained me. To all other family members (my siblings, cousins, and in-laws), friends, my church family in New Zealand, RCCG Victory House – thank you for the prayers and encouragement. We made it!

Dear colleagues and associates, from AUT study rooms MH207 and MA203, to others from Oxford Policy Management in Nigeria and the United Kingdom, and Presbyterian Support Northern in Auckland, I am thankful that you gave me your shoulders to lean on. Sharing my challenges with some of you and how you stepped up to help can only be a privilege which I do not take for granted.

Above all mention, unto God, my Saviour and the giver of all wisdom and strength, be all praise and adoration for walking me through this journey. During the highs and the lows, you sustained me. Thank you, JESUS CHRIST.

Ethics Approval

This study was approved by the Auckland University of Technology Ethics Committee (AUTEC) on 1 June 2022 with the Ethics Application number 20/368.

Dedication

This work is dedicated to the providers whose practice and knowledge shape sexual and reproductive health promotion in New Zealand. To the youth who, through voice and resilience, keep challenging the need for a shift towards meaningful participation and authentic connection.

Chapter 1. Introduction

Sexual and reproductive health (SRH) is a fundamental component of a person's overall well-being, directly impacting physical, mental, and social outcomes, particularly for young people (World Health Organisation [WHO], 2006, 2017). In New Zealand, youth SRH (YSRH) promotion faces distinct challenges, from addressing specific public health issues to engaging effectively with a diverse, digitally native population (Garrett et al., 2020; Ministry of Health, 2019c, 2023b). As social media platforms increasingly shape how young people communicate and access information, their potential as a strategic tool for health promotion has become a critical area of inquiry. This research therefore explored New Zealand SRH providers' perspectives on using social media to promote YSRH, examining the opportunities, barriers, and systemic and structural factors that shape digital health promotion practices in the New Zealand context.

Generative Artificial Intelligence (GenAI), Big Data Analytics, the Internet of Things (IoT), and robotics have actively shaped information and communication technology in recent years (Cui, 2025; Mayer et al., 2016; Pang et al., 2023; WHO, 2016). As digital natives, young people are resident prosumers; that is, producers and consumers of content in this world space (Cahill, 2014; Conn et al., 2017; Toffler & Alvin, 1980). Therefore, the transition between the fourth and fifth Industrial Revolution must account for the global paradigm shift triggered by the COVID-19 pandemic (Pang et al., 2023; Rashid et al., 2025). Leveraging rapid technological advances to strengthen youth-adult partnerships in digital health promotion has become necessary (Wallace et al., 2025; Wang et al., 2022).

This chapter provides a brief overview of how digital technology is influencing SRH promotion, focusing on the landscape of YSRH in New Zealand. The chapter concludes by outlining the research objectives, questions, and the methodological and theoretical underpinnings that guide the study, providing a roadmap for the research.

1.1. Understanding Sexual Health and Reproductive Health and Their Relatedness

'Sexual health' and 'Reproductive health', commonly referred to as 'sexual and reproductive health (SRH)', are two distinct yet overlapping concepts. As far back as 1974–75, s*exual health* was defined as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love" (WHO, 2006). Clearer distinctions were established regarding terms such as sex, sexuality, and sexual rights during expert group meetings focused on SRH and rights in subsequent years (WHO, 2006, 2010). In 1994, at the International Conference on Population and Development (ICPD), *reproductive health* was collectively defined as "a state of complete physical, mental and social well-being and not merely

the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (WHO, 2017). This definition subtly captures sexual health as it also includes the ability to have safe and satisfying sexual relations.

YSRH promotion is critical to enjoying holistic SRH well-being, as it provides the knowledge and practice needed to navigate and improve YSRH outcomes, ultimately overriding negative social determinants (Dávila et al., 2025; Phillips et al., 2024; Sedgh et al., 2025). Current global reports suggest that meaningful progress in YSRH promotion requires urgent, pragmatic steps to meet the 2030 Sustainable Development Goals (SDGs). However, evidence from the literature (Achala et al., 2025; Chidwick, 2023; Noer et al., 2024; Starrs et al., 2018; United Nations, 2019, 2025) and the tracking update from the SDG website reveals a lag in attaining these goals, complicated by significant systemic barriers, including insufficient resources and infrastructure, a shortage in skilled professionals competent to deliver youth-centred services, and limitations imposed by traditional norms and lack of political commitments.

Young people's involvement in SRH promotion remains limited to programme beneficiaries, where they are positioned as recipients rather than co-designers of SRH ecosystems, which frustrates implementation efforts and equity-based outcomes (Sedgh et al., 2025; Singh et al., 2025). Global regions (e.g., Australasia, Europe, United States of America) and countries (e.g., Rwanda, Kenya, Ghana, South Africa) that are leading in positive YSRH outcomes are noted to prioritise effective implementation, integrated health information systems, and digital SRH to ensure a more inclusive gender- and sexual-diversity initiatives led by young people (Albury & Mannix, 2025; Saini et al., 2025; Singh et al., 2025; Tohit et al., 2025; Wallace et al., 2025).

1.2. Youth Sexual and Reproductive Health in New Zealand

In New Zealand, as in other Organisation for Economic Co-operation and Development (OECD) countries, SRH is a public health concern (King et al., 2024; Ministry of Health, 2024a; Sedgh et al., 2025; WHO, 2019, 2021). Adequate education and awareness about SRH are a concern for New Zealand youth (Phillips et al., 2024; Rose, Garrett, McKinlay, & Morgan, 2021; Rose et al., 2022). The WHO noted that having access to quality information and services on SRH is a basic human right (Starrs et al., 2018; WHO, 2017). Determinants of YSRH are many, including social, economic, environmental, legal, cultural, and genetic factors (Ministry of Health, 2023c, 2024b; Phillips et al., 2024). Additionally, family/individual values and belief systems make YSRH a more complicated topic today (Cammock et al., 2023; Henrickson et al., 2015; MacDonald, 2018).

Among young New Zealanders, sexually transmitted infections (STIs), such as gonorrhoea, syphilis, and chlamydia, are reaching epidemic proportions, with upward trends recorded in recent years, except during the COVID-19 pandemic, when there was a slight dip for obvious reasons, including limited social contact (New Zealand Institute for Public Health and Forensic Science [PHF

Science], 2024). Young New Zealanders between the ages of 20 and 29 years old are most at risk of contracting STIs, with those of the Māori and Pacific ethnicities most disadvantaged. This is evidence of deep-rooted structural inequities including, but not limited to, limited access to culturally safe and responsive services, inconsistent sexuality education, and socioeconomic disadvantage (Cammock et al., 2018; Phillips et al., 2024; Rose et al., 2024). Other studies (Albury & Mannix, 2025; Goodwin & Lyons, 2024; Rose et al., 2022; Rose, Garrett, McKinlay, Morgan, et al., 2021) have also reported significant barriers as a result of stigma, geographical and disability-related inaccessibility, as well as digital exclusion, which contribute to misinformation, no or untimely testing, particularly among Māori and Pacific youth. Sadly, while SRH outcomes for youth in New Zealand are a priority on paper, they do not translate into effective implementation and practice (Ministry of Health, 2024a, 2024b; Terry et al., 2012). One of the major reasons for this discordance is the lack of an authentic connection between policymakers, SRH providers, and the lived realities of young people, coupled with limited or no engagement with youth when conceptualising and implementing interventions (Cahill, 2014; Carroll et al., 2023; Goodwin & Boulton, 2024; Goodwin et al., 2025). Other reasons identified in the literature include limited resource allocation, low priority for health promotion, and inadequate cross-sectoral coordination (Rose et al., 2024; Sedgh et al., 2025). Empirical evidence also suggests that structural and institutional barriers, such as fragmented governance systems, inadequate monitoring mechanisms, and a lack of accountability frameworks, hinder the consistent delivery of youth-centred SRH promotion in New Zealand and similar economies (Achala et al., 2025; Sinha et al., 2025).

1.3. Youth Sexual and Reproductive Health Delivery in New Zealand

SRH promotion in New Zealand is part of the country's holistic health strategy. The government funds most of it, and it is delivered through general practice, hospitals, sexual health clinics, and community-oriented agencies such as non-governmental organisations (NGOs), laboratories, and health promotion SRH providers (Ministry of Health, 2023b; Rose et al., 2022). In practice, sexual health services are mostly distinct and offered separately from reproductive health services in New Zealand, despite their relatedness (Rose et al., 2024).

The New Zealand health system targets young people mainly through Youth One Stop Shops (YOSS), school-based health services, mobile clinics, and specific care services for mental health, oral health, and disability care, to name a few (Ministry of Health, 2024b). Private SRH providers and NGOs offer services that complement the public health system. Yet, access to healthcare varies across New Zealand for young people, with wider margins observed among ethnic minority groups, rural residents, persons living with disabilities, and gender- and sexually-diverse youth (Cammock et al., 2018; Fleming et al., 2022). Stigma and discrimination, fear of judgment from providers, and gender and sexual identity affirmation are some of the challenges facing young people in need of SRH

services in New Zealand and the Australian region (Phillips et al., 2024; Rose et al., 2022). Other challenges include travel costs and related transportation barriers, not knowing where to access care and treatment, and not knowing what medical and non-medical resources are available (Cashman et al., 2021; Rose et al., 2024). Terry et al. (2012) identified a structural and systemic deficit in New Zealand's SRH sector: limited dialogue and competing rationalities between policymakers and SRH providers, which often misalign agendas and, in turn, harm the health outcomes of the young people they serve.

YSRH care in New Zealand necessitates effective coordination and collaboration across multiple sectors and stakeholders. The increasing rates of STIs highlighted in the national surveillance dashboard indicate a disconnect between providers such as policymakers, healthcare professionals, and youth health SRH providers and the end-users, namely New Zealand's youth. This suggests that youth perspectives and positions may not have been fully incorporated into the delivery of holistic and inclusive programmes. Chapter 2 examines the contextual landscape shaping these outcomes through an ecosocial lens, critically examining how political, economic, social, technological, environmental, and legal determinants operate as pathways through which structural conditions become embodied as differential YSRH outcomes in New Zealand.

The overall well-being of young people is at significant risk if complications arise from sexually transmitted and blood-borne infections. Potential consequences include sepsis, neurological damage, fertility challenges, sexual and gender-based violence, unplanned pregnancies, and unsafe abortions, among others (Cashman et al., 2021; Saxton et al., 2022). To reverse this troubling trend, the nation must learn from past policy-making errors, improve programme implementation, and enhance youth engagement to achieve better SRH outcomes for young people (Gabarron & Wynn, 2016; Rose et al., 2024; Rose et al., 2022).

1.4. Why Use Social Media as a Tool for Health Promotion, and How is it Shaping Youth Engagement?

A healthy and mentally balanced youth, with the right support systems, family, peers, and infrastructural support, is better equipped to make informed and healthy choices. Living in the digital age has not made a balanced life with the right support systems any easier, particularly for youth; rather, it demands openness to new ideas and innovations, such as the application of disruptive and innovative technologies. Social media serves as a prominent platform where many young individuals spend time sharing, connecting, and gathering information, which they then apply in their daily lives (Condran et al., 2017; Cortés-Ramos et al., 2021). Leveraging social media as a tool for health promotion targeting youth sexual and reproductive well-being is, therefore, critical at this time and in this dispensation (Digital Inclusion Research Group, 2017; Gabarron & Wynn, 2016; Rose, Garrett, McKinlay, & Morgan, 2021).

The 1986 Ottawa Charter for Health Promotion defined 'health promotion' as the process of enabling people to increase control over, and to improve their health (WHO, 1986). It goes beyond the provision of services and is intricately woven into the implementation of policies and programmes, often specific, time-bound, and limited in scope and budget, to positively impact health outcomes and address health inequalities and inequities. For young people, promoting good health requires shared agency, ongoing advocacy, and mediation between divergent views and positions among young and adult stakeholders. This calls for coordination, collaboration, and complementary strategies in a multifaceted, multi-stakeholder environment (van Teijlingen et al., 2021).

The literature well establishes the use of social media platforms for youth health education. Empirical evidence (Abdul Hamid Alhassan et al., 2025; Engel, 2023; Hirvonen et al., 2021; Naseer et al., 2025; Pagoto et al., 2025; Sewak et al., 2023) demonstrates that digital health interventions can enhance SRH literacy and behavioural change among young people. Beyond their informational function, digital and technology-based interventions offer structural advantages (Hirvonen et al., 2021; Sewak et al., 2023; Taba et al., 2025; Wang et al., 2022) such as confidentiality, privacy protection and cost-efficiency in activities that were traditionally reliant on human input and resources, for example, training facilitation, printing and distribution of print media. Furthermore, digital tools like interactive websites, text messages, games, and multimedia are becoming more common and are seen to foster more engagement and immediate feedback (Naseer et al., 2025; Othman et al., 2025; Pagoto et al., 2025; Purcell et al., 2023). These channels and practices align with the contemporary models of youth-centred and peer-led health promotion. Putting young people at the forefront as co-designers and disseminators of health promotional messages would shift delivery from adult-led to youth-centred and youth-led, characterised by youth agency, ownership, and equity in health promotion processes. Such collaboration can also ease the disconnect and misfit with youth worldviews that adult providers currently experience (Carroll et al., 2023; Stubbing & Gibson, 2021).

Central to this study, therefore, is exploring how SRH providers have conceptualised and produced social media content, and the extent to which young people have informed or influenced this process. Examining this through a bi-directional lens, where both providers and youth can collaborate through shared agency to co-create social media content for YSRH promotion, presents the opportunity to evolve from the traditional, top-down communication strategy into a healthy and balanced space for positive youth engagement and empowerment (Cahill, 2014; Gonzalez et al., 2020; Lerner et al., 2021; Lipton, Dickinson, et al., 2025; Sewak et al., 2023).

1.5. Research Objectives and Questions

This research aimed to explore the perspectives and experiences of SRH providers in New Zealand and their use of social media as a health promotion tool among young people. Creating

opportunities for young people to access quality information and support their SRH is important in a rapidly evolving digital age (Palacios & Allen, 2019; Rose et al., 2022).

Gaining insights into SRH providers' ideas, experiences, and perspectives on social media as a tool could help address the challenges the health system and young people face in New Zealand (Decker et al., 2022; Palacios & Allen, 2019). The findings of the research aim to contribute to New Zealand society and its alignment towards the achievement of the 2030 SDGs, particularly 3.7, 3.3, 3.8, 5.6 and 5.b, discussed in Section 1.1. These goals advocate universal access to SRH services and rights for everyone, as well as the use of enabling technologies to promote information and communication technologies, particularly to empower young people, including girl-children and women (United Nations, 2020). This provides a strong rationale for this research.

The overall research question is 'How do SRH providers in New Zealand leverage social media to promote YSRH?' To obtain rich and contextual insights, this question was broken down into the following sub-questions:

1. How do SRH providers' perspectives, including the challenges and opportunities they identify, shape the use of social media as a tool for YSRH promotion?
2. What systemic and structural factors shape SRH providers' digital health promotion practices, and how do these align with or diverge from a youth-centred approach?
3. What approaches do providers employ to navigate these factors, and what transformations are needed to enable genuine youth-centred digital SRH promotion?

This study adopted a practice-oriented format as described in the 2026 AUT Postgraduate Handbook, yielding a practice-oriented artefact and a complementary exegesis. As a practice-oriented thesis, it falls under the format three category, showcasing "the relationship between the central concept, key contexts, focus and methodology of the practice-oriented work, thereby setting the thesis in its relevant critical context" (Auckland University of Technology [AUT], 2026, p. 52). In practical terms, the exegesis comprises literature reviews and critical commentaries on the themes developed from the data, and this informed the artefact, 'Youth-Adult co-design model for digital YSRH promotion'. The artefact can serve as a framework to guide collaborative and innovative partnerships among SRH providers and young people in SRH promotion in New Zealand and beyond.

1.6. Methodological and Theoretical Underpinnings for the Study

This study is grounded in a constructionist epistemology, which posits that knowledge is produced socially from people's interactions, associated meanings, and worldview, as well as the experiences that shape them (Crotty, 1998). It recognises that knowledge about YSRH is constructed through social interaction and power relations. From this position, it operates as a strength-based approach that views young people as capable agents of change whose knowledge, experiences, and cultural realities are central to understanding and addressing their SRH needs (Cahill, 2014; Collura et

al., 2019; Hirvonen et al., 2021). However, whether youth knowledge is legitimised within institutional contexts depends on power dynamics that determine whose voice is heard and whose knowledge counts in health promotion practice (Carter & Little, 2007; Chadha & Jha, 2025; Hémono et al., 2024; Purcell et al., 2023). Within a constructionist framework, the realities that inform YSRH promotion are understood as constructed through the interactions between adult providers and young people; yet, these interactions occur within contexts that privilege adult professional knowledge and experience over youth experiential expertise. Epistemologically, this calls for interrogating both the knowledge being constructed and whose knowledge is legitimised within institutional practice and systems.

Critical theory provides the framework for this research, informing how youth engagement, agency, and power are understood within the digital and health promotion context (Creswell, 2007; Crotty, 1998). It applies critical theory through the lens of Critical Positive Youth Development (CPYD), a framework that foregrounds issues of power and youth agency within the broader structural forces that influence how young people access, navigate, and utilise SRH resources (Ginwright & Cammarota, 2007; Gonzalez et al., 2024; Lerner et al., 2021). It ensures I can apply a critical lens to understand how structural and societal limitations, including adult-centric policy design, inequitable service delivery, and sociocultural norms, privilege adult authority over youth voice in SRH-related matters (Cahill, 2014; Goodwin & Lyons, 2024; San Cornelio & Gomez Cruz, 2014). More specifically, the CPYD framework harnesses youth agency as a strength-based approach, positioning youth as capable self-experts who can leverage their knowledge and experience to address these adult-driven limitations (Arnold & Silliman, 2017; Lerner et al., 2021; Tyler et al., 2020).

Guided by this theoretical stance and a practice-based research framework, I conducted qualitative interviews and group discussions with SRH providers to inform the development of the artefact, ‘Youth-Adult co-design model for digital YSRH promotion’. Underpinned by CPYD and critical theoretical principles, the data were analysed using reflexive thematic analysis (Braun & Clarke, 2021, 2022, 2024; Braun et al., 2019). This rigorous analytical process ensured the resulting practice-based artefact was rooted in providers' contextual knowledge and professional practice, and strengthened by established literature on youth autonomy and agency in digital health promotion. This analysis ensured that providers' perspectives could be examined within the broader context of systemic inequities and digital youth health promotion (Collura et al., 2019; Liebenberg et al., 2020). Furthermore, it framed their adult-based narratives not merely as professional insights, but as reflections of the wider health system that simultaneously supports and restricts participatory youth engagement (Henrickson et al., 2015; Kanengoni et al., 2020; Mansfield et al., 2025). Crucially, the analytical approach enabled examination of how providers position young people within their professional practice narratives and revealed assumptions about youth capabilities that may reproduce adult-centric systems despite engagement intentions. Thus, ensuring young people have a voice that

captures their needs and aspirations remains a critical necessity in the current digital era and for future health promotion efforts (Cahill, 2014; Collura et al., 2019; Ferretti et al., 2023).

In summary, this research adopted a practice-based qualitative approach and applied reflexive thematic analysis to examine how providers construct and communicate meanings around SRH, youth engagement, and social media. These methods are consistent with the constructionist epistemology and critical youth theoretical perspective underpinning the study. The methodology best suits this research as it adopts a critical and analytically rigorous approach to generating new knowledge. The research outcome informed the conceptualisation of the artefact, 'Youth-Adult co-design model for digital YSRH promotion', which promotes shared and balanced agency between adult providers and youth experts to enhance the delivery of digital YSRH promotion. Pertinent to SRH futures, it provides knowledge on the role of social media and how those delivering SRH initiatives can use different digital platforms more effectively.

1.7. My Worldview as a Youth and Researcher

As a young African girl, born and bred in the culture and practices of the Yoruba-speaking people of South-Western Nigeria, self-awareness is often considered an attribute of waywardness. Therefore, having a bold discussion about one's sexual identity, interests, and curiosity was rare, if at all found. The situation is more dire for the girl-child, one of whom I am, to ask questions about how she feels or express herself on topics about sex, relationships, and reproductive issues. The closest form of knowledge one would have was acquired in Biology and Physical Education classes. Other knowledge was picked up from the streets as stories or myths emanating from the neighbourhood and life lessons from the experiences of friends and acquaintances. For me, this resulted in fears, misinformation, and misconceptions about SRH issues.

Studying science-oriented courses in school helped a bit, as did the few times my mom would share her experience working with young girls and women as a practising midwife and nurse. By the time I started working, I knew I was interested in promoting youth health, and specifically in YSRH issues. This led to my work with several NGOs that facilitated community-level sensitisation campaigns on healthy sexual behaviours, advocating for abstinence, discouraging having multiple sexual partners, and promoting the use of condoms and other forms of contraceptives that can prevent the transmission of infections spread through the exchange of body fluids, particularly from sexual relations. As a programme/project officer back in Nigeria, I offered counselling services; performed HIV rapid testing using test kits at organised rallies and during community events; visited brothels to conduct educational sessions with sex workers; and contributed to the design of information, education, and communication resources that were distributed to different agencies nationwide. Subsequently, I transitioned into research and development, where I was exposed to using evidence to inform interventions and service delivery. This experience sparked my desire to learn more about

conceptualising projects and conducting research to support findings and contribute to the existing body of knowledge.

As an international student in New Zealand, I was initially shocked by how bold and engaged young people seemed in conversations that would normally be considered ‘sensitive’ where I come from. I realised young Kiwis better expressed themselves, their sexuality, and sexual preferences without much fear of being judged compared to my home country. Further, the way medical services are provided in New Zealand was very different. Registering with a general practitioner (GP) and booking appointments before visiting the doctor were alien to me. Then, I realised there are dedicated sexual health clinics, YOSS, that young people can visit to have comprehensive care, including primary healthcare, sexual health, mental health, reproductive health, and social services, to name a few.

The advancement in the use of technology in New Zealand was another significant difference in the two worlds to which I am now exposed. Back in Nigeria, access to information was mainly through traditional media—television, radio, and print—because they were more affordable. Although some Nigerian, and by extension African, youths beat the odds of expensive data, most still lack access to continuous and sustainable internet-based technology and resources compared to what is available in New Zealand.

Social media is everywhere nowadays (DataReportal, 2023), although platforms may differ by location and by the regulations that guide their operations in each region. How young people access these platforms, and why, also differs. Facebook, Instagram, and TikTok are widely used among youth today because of the social connections they build, lifestyle updates, and the influence of peers and other social elites (Martin, Cousin, et al., 2020; Pacheco & Melhuish, 2018). In addition, they share about themselves, search for answers, and form opinions based on their interactions on social media. To this end, as public health SRH providers, we must leverage platforms where young people feel comfortable, promote healthy choices and behaviours, and recognise youths as knowledge brokers and key stakeholders in their health outcomes.

1.8. Research Design and Field Experience

My research journey took a few turns, mainly because of COVID-19. Before the pandemic, I planned to return to Nigeria for data collection, but this changed because of travel restrictions and limitations on gatherings. This also required me to change my research location from Nigeria to New Zealand; however, I kept the target population as youth. Another change was the public health issue I initially chose. HIV/AIDS has been an epidemic in Nigeria for a long time, and so it was logical to research it; however, that is not the case here in New Zealand. Here, the incidence and prevalence rates of HIV/AIDS are almost negligible except among at-risk population groups like men who have

sex with men (MSM), and Black Africans, with higher statistics compared to other population groups in the country (Henrickson et al., 2015; Saxton et al., 2022).

To ensure my research remained relevant to the context, I investigated YSRH as the main public health issue, exploring it from the viewpoint of SRH providers who engage with these youth. I also needed to understand how both SRH providers and youth have used, and can use, social media as a tool for health promotion.

After receiving ethical approval for my study from the AUT ethics committee, I began recruitment and data collection. Over two phases, I held virtual interviews and focus group discussions with staff from different organisations that work with youth on SRH in New Zealand. After the first phase, the information gathered was reviewed, and preliminary findings were shared with participants so they could have a say and be part of the data analysis process. Their contribution at this stage informed the second phase of data collection. All data were then reviewed and categorised into themes, presented as findings through a critical youth lens. Applying a theoretical and thematic approach to data interpretation helps maintain rigour and credibility (Braun & Clarke, 2013, 2022) and supports reflexivity through the 'zoom-in and zoom-out' approach, helping me query the data as I worked with study participants to answer the research questions.

My experience as a researcher was further forged in this process. Working with SRH providers in a context different from what I had known before was both challenging and exciting. Gaining insights into how services are provided, especially the role that social media plays or can play within the SRH space, was eye-opening and a forward-thinking experience for me.

1.9. Research Contribution

This study addresses a critical gap in YSRH promotion. While digital technologies, particularly social media, have transformed how young people access and share health information, institutional health promotion practices have not adequately shifted their approach to recognise young people as knowledge producers and capable agents within these digital spaces. Despite rhetoric on youth participation, decisions about social media content creation, messaging priorities, and resource allocation in digital YSRH promotion have remained firmly within adult-dominated systems. This disconnect between young people's demonstrated digital capabilities and the hierarchical structures of institutional health promotion represents both a missed opportunity for effective YSRH outcomes and a continuation of adult-centric paradigms that marginalise youth voice.

This research makes several contributions. First, it provides empirical evidence of how SRH providers in New Zealand conceptualise and facilitate youth engagement in digital health promotion contexts, thereby revealing where current practice aligns with or contrasts with principles of meaningful youth voice and shared governance. Second, by analysing provider narratives through the CPYD lens, the study highlights the epistemic and structural barriers that constrain youth agency

within institutional practice, even when providers believe they are committed to delivering youth-centred services. Third, the research generated a practice-oriented framework, the 'Youth-Adult co-design model for digital YSRH promotion' that synthesises provider knowledge with critical perspectives and evidence on youth digital engagement. This framework foregrounds power-sharing, recognition of youth expertise, and the structural conditions that foster genuine collaboration and co-creation between adult providers and young people.

Several implications for practice abound in the contribution of this research. For SRH providers and health promotion professionals, the findings show how professional practice may unintentionally reproduce adult-centric frameworks despite aiming for participatory engagement; therefore, they should prioritise reflexive practice development. For policymakers and health institutions in New Zealand, the research demonstrates an evidence-based understanding of what meaningful youth engagement in digital health promotion requires, going beyond consultation toward shared governance of knowledge production and resource allocation. For youth advocacy organisations and young people, the study documents structural barriers to youth voice within health systems, providing an opportunity to inform advocacy efforts. For researchers and academia, this study offers methodological approaches for critically examining institutional discourse about youth and contributes to scholarship on CPYD, youth voice, and digital health promotion in New Zealand.

1.10. Structure of the Exegesis

This exegesis complements the artefact, a 'Youth-Adult co-design model for digital YSRH promotion', and explains how it was conceptualised. The introductory chapter summarises the public health issue and outlines how the research design aims to address it with innovative, contextually relevant solutions. Chapters 2 and 3 provide a more in-depth literature review. Chapter 2 first discusses a situational analysis of YSRH outcomes in New Zealand and the factors that influence them. It also identifies what has been done, gaps, and areas for future programming. The chapter also reviewed systems, policies, and strategies that shape the pace of interventions and how they affect uptake of youth SRH care.

Chapter 3 presents a critical literature review that examines the theoretical foundations of youth agency and how youth voices have been engaged or constrained within the SRH promotion space in New Zealand. Chapter 4 provides the theoretical and methodological foundation upon which the research is framed. It explores applying a critical youth lens to interpret findings, reflecting youth perspectives through the lens of SRH providers engaged in the study.

Chapters 5, 6, and 7 are the critical commentary chapters that "set the artefact in the relevant theoretical, historical and critical context" (AUT, 2026, p. 52). Chapter 5 situates the reflexive narrative of the research process. It details my reflections in practice as a researcher, a youth, and a youth-centred professional. It also reflexively describes the processes from research design through

artefact development, examining the power dynamics between me as the researcher and the researched adult providers, as well as between the adult providers and the young people targeted in health promotion practice.

Chapter 6 presents three interconnected themes, each corresponding to one research sub-question. This findings chapter illuminates youth-adult power dynamics in digital YSRH promotion, revealing how providers navigate tensions between control and collaboration, digital fluency and disconnect, and institutional constraints and partnership responsibilities. The chapter also examines opportunities and barriers providers identify in using social media for YSRH promotion, the systemic and structural factors shaping their practice, and identifies critical prospects for institutionalising authentic youth-adult partnerships, which inform the development of the research artefact presented in Chapter 7.

In line with AUT's format three thesis requirements, this thesis comprises an exegesis and a complementary artefact. The artefact, titled 'Youth-Adult co-design model for digital YSRH promotion', is presented in Chapter 7 and operationalises the study's findings into a strategic framework for practice. It gives SRH providers actionable steps to collaborate meaningfully with young people and build an authentic connection. Readers seeking the practical output of this research can refer directly to Chapter 7 for the full model, visual representation (

), and accompanying guidelines (**Error! Reference source not found.**).

The concluding chapter provides a final summary of analysis and methodology, recommendations and conclusions. The final chapter also covers study limitations and suggestions for future research on YSRH promotion.

Chapter 2. Overview of Youth Sexual and Reproductive Health

2.1. Introduction

Globally, SRH among young people is a public health concern (Barriuso-Ortega, 2025; Meherali et al., 2025; Sedgh et al., 2025), and this is no different in New Zealand, where it presents as complex interactions between individual behaviours, interpersonal relationships, community norms, institutional practices, and broader structural determinants (Ministry of Health, 2023a, 2024a; Public Health Advisory Committee, 2025; Rose et al., 2022). While significant progress has been made in recognising YSRH as a public health priority, persistent disparities remain, particularly among Māori, Pacific, LGBTQIA+, disabled, and care-dependent youth (Fleming et al., 2022; Ministry of Health, 2024b; Rose et al., 2024). Understanding these inequities requires moving beyond individualistic patterns to examining the multi-level systems and structures across political, economic, sociocultural, technological, environmental, and legal (PESTEL) domains that shape young people's experience and exposure to disease distribution, health risks, and access to preventive and protective measures.

Examining the structural and systemic determinants of YSRH outcomes in New Zealand serves as a critical lens through which the research is situated. While the main research questions focus on SRH providers' perspectives, challenges, and support needs in using social media for YSRH promotion, this chapter provides the broader structural and systemic context in which these experiences unfold. It enables a deeper analysis of how macro-level determinants, such as policy frameworks, funding, cultural norms, digital inequity, and institutional capacity, shape both the opportunities and constraints that SRH providers face. In doing so, this chapter bridges individual-level experiences with macro-level forces, allowing the research to describe SRH providers' perspectives, critique the systems within which they operate, and recommend pathways toward equity-driven, digitally enabled YSRH delivery.

Additionally, this chapter establishes the contextual foundation for understanding YSRH in New Zealand by examining both the health system landscape within which services are delivered and the structural determinants that produce patterns of SRH inequity. To ensure a robust review, the chapter is organised into two main parts. First, section 2.2 provides an overview of the SRH landscape, beginning with the global context before focusing specifically on the New Zealand health system, including its funding mechanisms, service delivery models and the role of key providers such as Te Whatu Ora, NGOs, and community-level SRH services. This situates YSRH within the broader architecture of health service provision in New Zealand. Second, Section 2.3 examines the patterns of SRH-related conditions among young people in New Zealand and analyses the macro-level determinants shaping them through an ecosocial lens organised across the six PESTEL domains.

Scope and Definition of Youth

In New Zealand, recent publications (Adams et al., 2022; Public Health Advisory Committee, 2025) mostly categorise a young person as someone aged 15-24, with approximately one in five (17%) New Zealanders in this age bracket (Ministry of Health, 2024b). Critical to note is that Māori and Pacific ethnic groups, relative to their share of the total national population, have a higher representation of young people who also fall within the reproductive age bracket (Stats NZ, 2023a), emphasising their significance in YSRH policy and service delivery (see**Error! Reference source not found.**).

The research focuses on New Zealand youth in general, with an emphasis on Indigenous and marginalised population groups where necessary. Based on the practice context, this study included two populations, each with different roles. First is the theoretical population, 'youth' as engaged through critical youth theory and CPYD, which follows the Ministry of Youth Development's definition of individuals aged 12 to 24 years. That is the population whose agency, and whose structural relationship to adult-controlled systems, this thesis theorised. Second, the SRH clientele population, that is, the 15-to-49 range, who are the population of clinical and service interest, reflecting how the SRH providers interviewed organise and deliver their services. Providers repeatedly described serving a broad reproductive-age clientele without age-differentiated service pathways: the same social media content, the same clinic access, and the same promotional messaging reach a 17-year-old and a 40-year-old attending the same service. This is an empirical finding about service delivery in New Zealand, and not a theoretical redefinition of who counts as 'youth.'

Table 1.

*Weighted percentage[1] of the youth population across major ethnic groups in New Zealand by age group**

Ethnic group	15–24 years		15–49 years	
	Weighted	**Unweighted**	**Weighted**	**Unweighted**
Māori	3.1%	17.6%	8.7%	48.7%
Pacific	1.7%	19.4%	4.6%	51.6%
European	8.3%	12.2%	28.3%	41.8%
Asian	2.1%	11.9%	10.1%	58.6%
Middle Eastern, Latin American African (MELAA)	0.2%	13.0%	1.1%	60.4%

*Weighted estimate by author. Data estimated from Stats NZ, 2023 website.

[1] Calculated by summing the percentages of the respective age ranges and multiplying them by the total national population to get the weighted ethnic population. "People can identify with more than one ethnic group and are counted for each ethnic group they identify with" (Stats NZ, 2023).

Theoretical and Analytical Framework

The theoretical lens applied in this first literature review is ecosocial theory, as described by Nancy Krieger (Breilh, 2021; Kelly-Irving & Delpierre, 2021; Krieger, 1994, 2001, 2005, 2021) and elaborated to cover wider scholarship on social determinants of health and embodiment (Breilh, 2021; Kelly-Irving & Delpierre, 2021). This approach examines how structural conditions determine health outcomes by establishing the pathways of embodiment, a process through which disease gets 'under our skin' (Krieger, 1994). This theory provides a framework for examining how social, political, economic, and cultural pathways operate to determine population health patterns. For YSRH, this implies an intricate review of the experiences of marginalisation, stigma and discrimination, income and poverty status, service access and uptake, or exclusion from the healthcare system, resulting in the biological manifestation of disease patterns such as STIs, unintended pregnancies, and related health outcomes among young people.

Four constructs guide the application of ecosocial theory in this chapter (Krieger, 2001, 2021). First is embodiment; that is, the biological incorporation of social experiences across a lifetime. Second, the pathways of embodiment are examined through multi-level routes of structural conditions that shape youth health, including material deprivation, psychological stress, toxic exposures, and differential access to health-promoting resources. Third, cumulative interactions of the multilevel of exposures and effects accumulated over time and across biological, individual, and societal levels. Fourth, crucial to the current study, is accountability and agency, which seeks to identify who is responsible for addressing health inequities, who the current system favours, and where opportunities abound for resistance and transformation.

Within adult-driven systems, the meaningful participation of young people is limited, resulting in designs and implementations far from youth realities (Rose et al., 2022; Sprague Martinez et al., 2020; Stubbing & Gibson, 2021). Additionally, institutional practices that position youth as passive recipients rather than active agents in their own health affairs represent forms of structural violence that become embodied as preventable SRH disparities (Fleming et al., 2022; Htong Kham & Ng, 2025; Rose, Garrett, McKinlay, Morgan, et al., 2021). By foregrounding youth-adult power relations as an analytical lens, Section 2.3 outlines how inequitable power dynamics within health promotion systems shape the experiences and outcomes of young people's SRH. This is achieved by using the PESTEL framework as the organisational outline for discussing the macro-level structural determinants that shape YSRH outcomes in New Zealand. While PESTEL has its roots in strategic and business management (Aguilar, 1967), its application in health and well-being discourse is not without precedent.

Cahill (2014) applied it as an analysis tool for organising young people to design the future and see themselves in it. Thakur (2021) applied the PESTEL framework as an analytical tool for identifying the dimensions of sustainable healthcare waste management during the COVID-19

pandemic, a measure towards reducing the risk of disease spread on a global scale. Similarly, it was applied by Vojinović and Stević (2022) and Vivek (2022) in the context of COVID-19, to examine macro-level factors influencing population health outcomes during the pandemic. In Australia, it was deployed by Tijani et al. (2022) to understand the macro-externalities that shape the mental health of architectural, engineering, and construction practitioners. More recently, Destrieux et al. (2025) combined PESTEL with SWOT analysis to identify the drivers and barriers of digital therapeutics' development and use. These applications demonstrate the capacity of the PESTEL framework as a tool to systematically map external structural forces that shape health outcomes across diverse contexts, making it well-suited for examining adult-controlled institutional environments within which youth navigate their SRH needs in New Zealand.

Each PESTEL domain in Section 2.3 was examined through the ecosocial theoretical lens that emphasises power relations, pathways to embodiment, cumulative effects across the life course, and accountability for producing and addressing health inequities. By combining the PESTEL framework and ecosocial theory, the hybrid approach enables the understanding of the interrelatedness of these domains and how they contribute to the biological incorporation of social conditions as health outcomes (Kelly-Irving & Delpierre, 2021; Tijani et al., 2022), while also highlighting crucial points that young people, including Indigenous youth, exercise agency and advocate for transformation despite operating within restrictive systems not designed by or with them.

Literature Search

Peer-reviewed articles, policy documents, and grey literature, as well as programme reports from local and international agencies produced within the last 10 years, were included in the literature review, with an exception given to older literature that was considered relevant to the research question. The geographical scope was the Australasia region, with a relative comparison to other OECD countries where relevant. The database search included Scopus, PubMed, ProQuest, Google Scholar; New Zealand-specific sources, such as the websites of the Ministry of Health, Ministry of Youth Development, Statistics New Zealand, and similar agencies; as well as reports from NGOs and longitudinal studies, including the Youth19 survey. Keywords and phrases searched are detailed in Table 2.

A brief description of the different categories of literature reviewed (including approximate number per category) is provided below. It summarises evidence on the epidemiological context, policies and strategic frameworks, population-based data, and service-based commentaries that informed this chapter. Many of the publications contributed to more than one analytical category (e.g., policy documents drawing on epidemiological data or digital interventions embedded in service delivery). Therefore, they were counted across all relevant categories to reflect the interconnectedness of SRH determinants.

1. **Policy documents and strategies (~20)**: This category includes official policies and strategic publications from government ministries like the Ministry of Health, Ministry of Social Development, and Oranga Tamariki, as well as other relevant local and international sources like the Sexual Wellbeing Aotearoa (formerly Family Planning New Zealand), WHO, and OECD. They outline the political and legal commitments and Te Tiriti obligations that set the stage for youth SRH in New Zealand. While they emphasise young people's right to equitable access to quality health services, the effectiveness of these policies ultimately depends on how they are implemented, resourced, and monitored.
2. **Population data and epidemiological reports (~12)**: From the sources included in this category, population-based and statistical evidence about young New Zealanders was obtained. Data were gathered from census information available on Stats New Zealand and PHF Science[2], websites, peer-reviewed publications and grey literature. Longitudinal studies carried out by independent researchers and surveillance reports that monitor the trends of STIs among youth were reviewed. Additionally, the review covered evidence on the social determinants of YSRH outcomes in New Zealand. Where possible, distinctions were made by residence type (e.g., rural/urban) and ethnicity (e.g., Māori and Pasifika youth), as well as similar marginalisation issues faced by LGBTQ+ and disabled youth. Evidence on the lived experiences or digital health-specific outcomes of young New Zealanders, particularly from marginalised communities, remains limited. Additionally, more evidence-based studies and reports are needed to better understand the link between YSRH outcomes and the effects of structural and systemic factors.
3. **Programme and intervention-related studies and commentaries (~18)**: Under this category, youth and provider perspectives are explored, complementing findings from epidemiological reports by highlighting systemic drivers such as limited funding, stigma, and uneven service distribution across regions, cultural responsiveness, and inclusivity issues. YSRH literacy studies and the Relationships and Sexuality Education curriculum-based interventions, and their impact on youth knowledge and practice, are also considered. Findings here draw more from grey literature sources than from peer-reviewed articles.
4. **Digital and technology-based studies and reports (~14)**: This group of literature provided evidence on the developing landscape of digital health on a global scale, focusing on young people. Compared with the global context, knowledge and practice on using social media and similar technologies for health-related interventions in New Zealand are emerging; however, there is a dearth of knowledge on their impact on YSRH outcomes. Sources are mainly from peer-

[2] The New Zealand Institute for Public Health and Forensic Science (PHF Science) was formerly known as the Institute of Environmental Science and Research (ESR).

reviewed and grey literature, with fewer available on New Zealand than in other OECD countries such as Australia, Canada, the United Kingdom, and the United States.

Table 2.

Indicative phrases and keywords applied in the literature search strategy.

Category	**General keywords/phrases for searches**	**Specific to young people**	**Specific to the New Zealand context**
Policy documents and strategies	OECD SRH policy SRH service delivery WHO Health Promotion Framework	Youth engagement in SRH delivery Youth participation in SRH policy framing OECD YSRH outcomes Frameworks guiding youth health	New Zealand Child and Youth Health Strategy New Zealand Health Strategy New Zealand Health Budget 2025 New Zealand abortion law National health promotion strategy Digital health framework in New Zealand
Population data and epidemiological reports	Global landscape on YSRH Social determinants of health SRH service utilisation rates	Youth health promotion YSRH outcomes in the Australasia region Youth STIs prevalence rates Access and affordability of reproductive health	Young people in New Zealand Social determinants of health in Aotearoa YSRH outcomes in New Zealand Reproductive health services in New Zealand Teenage pregnancy rates in New Zealand
Programme and intervention-related studies and commentaries	Adult providers' perception of social media for health promotion SRH service access and utilisation Sociocultural factors affecting YSRH Structural determinants of SRH	Youth health practitioners Youth voice in SRH programme design and implementation Youth-adult partnerships in health Youth-led co-design in health Critical youth theory Best practices from youth-led programmes Youth agency in public health	SRH services in New Zealand Youth-led co-design in New Zealand School-based health services SRH education in New Zealand SRH outcomes for rural youth Family Planning New Zealand SRH in New Zealand Youth sexual health in New Zealand Māori youth health outcomes Youth reproductive health in New Zealand
Digital and technology-based studies and reports	Digital health promotion Social media health promotion	Young people's use of social media YSRH and social media Youth-centred digital SRH promotion	Digital literacy in New Zealand Social media health promotion in New Zealand

Category	General keywords/phrases for searches	Specific to young people	Specific to the New Zealand context
	Social media use for health promotion Digital determinants of SRH The future of digital health and social media promotion Challenges of SRH promotion on social media		YSRH promotion in New Zealand

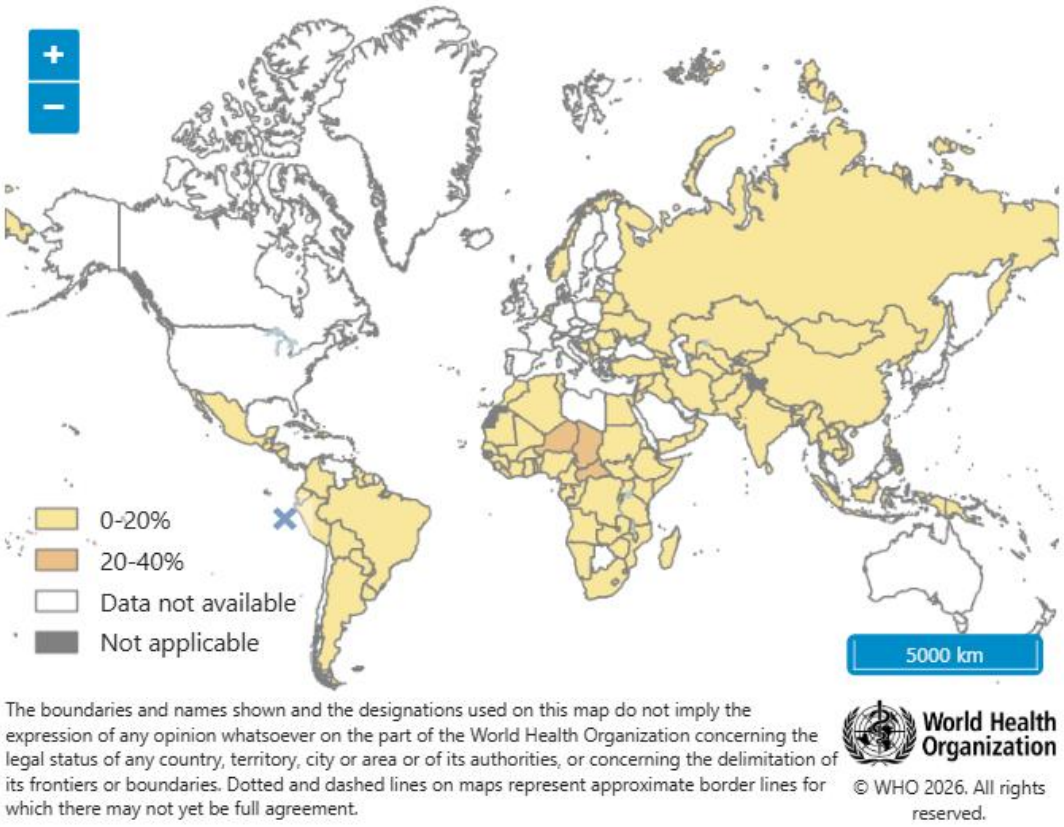
2.2. State of Youth Sexual and Reproductive Health

Throughout the world, young people between 10 and 24 years old make up one-quarter of the population (Bukenya et al., 2025; Lohan et al., 2025) and maintaining their physical, mental, and psychosocial health and well-being is critical to global development. The recognition of adolescent girls and young women as a priority population is highest in the African and Americas regions (over 60%) but lowest in the Eastern Mediterranean Region (11%) (WHO, 2024b). Despite these regional commitments to SDG 5.3 targets to eliminate child marriage, global data reveal that substantial proportions of young women aged 20 to 24 years, particularly in parts of Africa, the Middle East, and South Asia, were married before age 15 (see

), highlighting persistent structural barriers to YSRH and rights (WHO, 2026b). These structural failures translate into major SRH outcomes observed among these adolescents and young people. They include early sexual debut, unintended teenage pregnancies and high abortion rate; STIs, sexual coercion and intimate partner violence; gender inequalities and harmful traditional practices (Liang et al., 2019; Soeiro et al., 2023). Additionally, achieving equitable access to youth-friendly information and services, encompassing the effective uptake and utilisation of STI diagnostics and treatment, contraceptives, safe abortion, maternal and newborn care, remains a significant global challenge for this demographic (WHO, 2026a). The challenge is worse among girls and women, more so among those in low- to middle-income countries (LMICs) and conflict settings (Soeiro et al., 2023; Zampas & Nihlén, 2025).

Figure 1.

Proportion of women aged 20–24 years who were married or in a union before age 15 (SDG 5.3.1 – Global level) (WHO, 2026b)



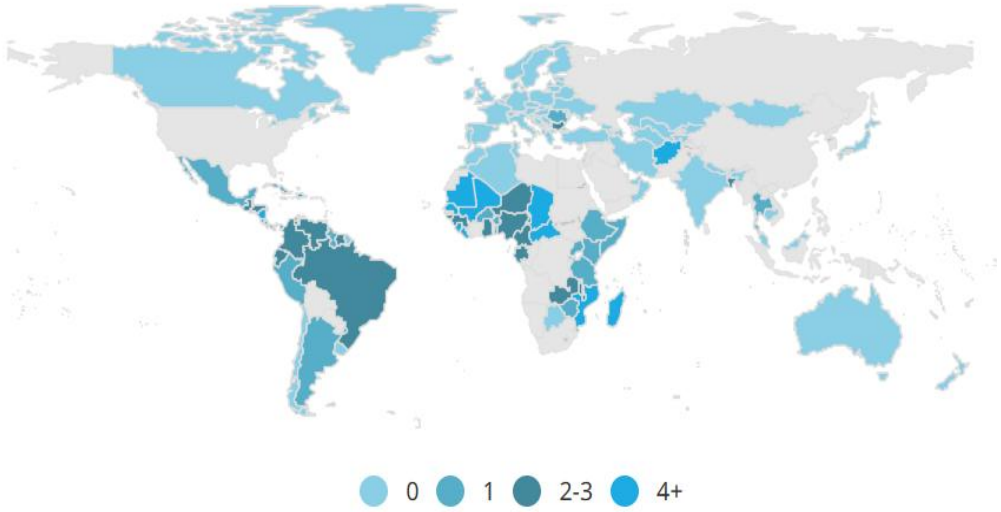
Note: A global overview of young women (20-24 years) who married before 15 years by the WHO (2026b). Copyright 2026 by World Health Organization. Reprinted with permission.

Young people, mostly girls, also experience serious complications during pregnancy and childbirth (WHO, 2024a, 2026c). In 2019, the WHO reported that approximately 21 million pregnancies among adolescents in LMICs, of which half were unintended, resulted in 12 million births; and a significant proportion (55%) of the remaining non-live births were aborted, mostly under unsafe conditions. As of 2023, the United Nations Children's Fund (2024a) report indicated that the global adolescent birth rate stood at 1 in 1000 births for girls aged 10–14 years, and up to 39 births per 1000 for adolescent girls and young women aged 15–19 years. Across regions, the sub-Saharan African regions recorded the highest of 3 per 1000 births among the younger adolescents (see Figure 2) and 93 per 1000 births among the older adolescents (see Figure 3). Under-age marriage, adolescent pregnancies, and related complications (threatened abortion, pre-eclampsia, low-birth weight, vesicovaginal fistula) remain leading causes of death for this demographic, particularly in LMICs (Askew, 2017; Cagli et al., 2025), with unsafe abortion contributing significantly to adolescent maternal mortality in settings with restrictive laws or inadequate public health systems (United Nations Children's Fund, 2025b). The projected estimates of adolescent deaths between 2023 and

2030 are 6.3 million deaths (WHO, 2024b), if adequate measures are not in place to prevent child marriages, early sexual encounters, and childbirths; manage STIs; and improve access to contraceptive use, without relenting on advocating for and ensuring youth autonomy. Additionally, beyond the prevention of pregnancies, there is a need for improved adolescent maternal care during and after childbirth (Askew, 2017; United Nations Children's Fund, 2024a; WHO, 2024a). These reports indicate adolescent mothers have significantly less contact with skilled health professionals throughout pregnancy and the postpartum period compared to older women, creating a critical deterrent to the realisation of their SRH rights.

Figure 2.

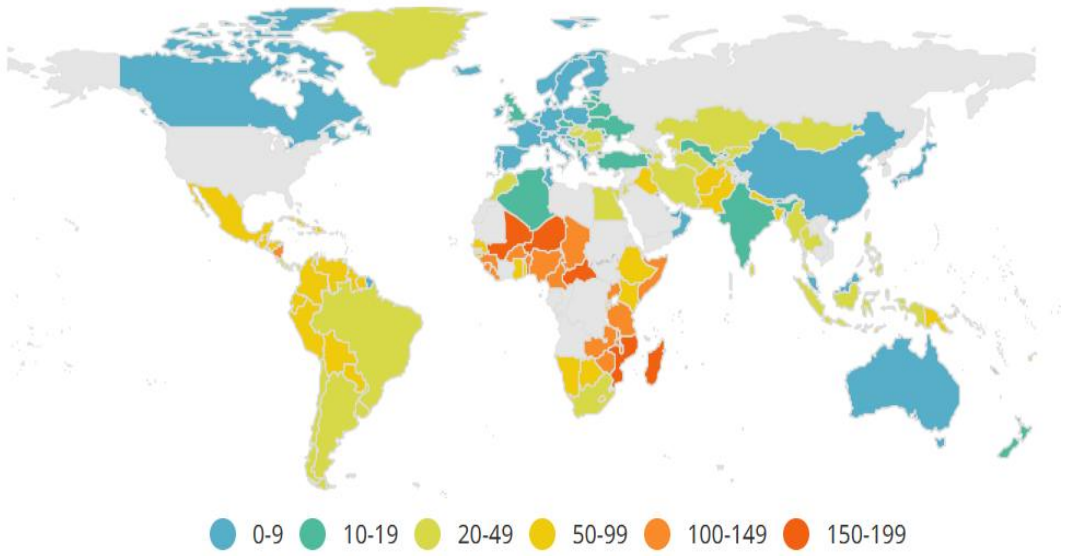
Adolescents aged 10 - 14 birth rate by country 2017–2023 (United Nations Children's Fund, 2024a)



Note: Global distribution of teenage pregnancies (10-14-year-olds) per 1000 births. Adapted from Early childbearing. Copyright 2024 by United Nations Children's Fund. CC-BY 3.0 IGO license.

Figure 3.

Adolescents aged 15 - 19 birth rate by country 2017–2023 (United Nations Children's Fund, 2024a)

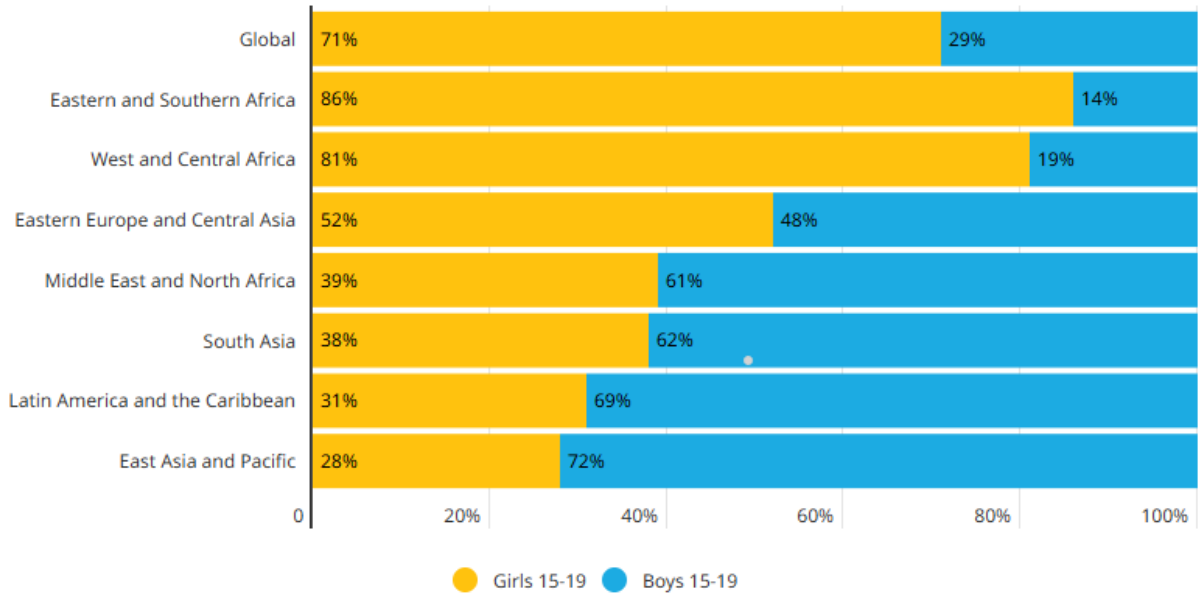


Note: Global distribution of teenage pregnancies (15-19-year-olds) per 1000 births. Adapted from Early childbearing. Copyright 2024 by United Nations Children's Fund. CC-BY 3.0 IGO license.

Young people have remained disproportionately affected by STIs globally, with adolescent girls bearing the greatest burden (Zhang et al., 2022). Beyond the approximately 370,000 young people aged 15–24 years who were newly affected with Human Immunodeficiency Virus (HIV) in 2023, rates of chlamydia, gonorrhoea, and syphilis are rising among youth, with antimicrobial-resistant gonorrhoea strains posing growing threats (United Nations Children's Fund, 2024b; 2025a). HIV burden is particularly acute in sub-Saharan Africa, where 9 out of 10 new adolescent infections occur among girls, reflecting intersecting biological, social, and economic vulnerabilities. Globally, 7 out of 10 new HIV infections among 15– 19-year-olds are among adolescent girls, a gender disparity rooted in cultural norms, sexual violence, and limited access to prevention and treatment services. Current trends project 183,000 annual new adolescent HIV infections by 2030 without accelerated intervention (United Nations Children's Fund, 2024b).

Figure 4.

Estimated distribution of new HIV infections among adolescents 15–19 years, by gender and region, 2024[3] *(United Nations Children's Fund, 2024b)*



Note: An overview of HIV incidence rate by gender and global regions. Adapted from FAST FACTS: Critical gains in HIV response, but adolescent – especially girls – remain disproportionately affected, UNICEF warns on World AIDS Day. Copyright 2024 by United Nations Children's Fund. CC-BY 3.0 IGO license.

A 2023 global policy survey by the WHO (2024b) revealed that 77% of countries have a strategic plan on adolescent and SRH, respectively. The same report noted that 42% of countries have SRH policies on self-care and 57% on infertility management. Further, up to 81% of countries have developed multisectoral policies for violence against women, and 79% explicitly include first-line support for survivors in their mandates. However, a critical gap in the educational systems targeted at training youth-specific professionals was also shared (see

[3] No data available for North America and Western Europe

). This implies that while high-level strategic planning is prevalent, the educational infrastructure and cross-sectoral integration that are required to empower youth-specific professions and protect young victims of gender-based violence are underdeveloped.

Table 3.

Global regions with selected policies/guidelines/laws on adolescent health as reported in the 2023 WHO Sexual Reproductive, Maternal, Newborn, Child and Adolescent Health policy survey (WHO, 2024b, p. 64)

	Global (%)	AFR (%)	AMR (%)	EMR (%)	SEAR (%)	WPR (%)	LIC (%)	LMC (%)	UMC (%)	HIC (%)
Strategic plan for adolescent health/well-being (n=151)[a]	76.8	86.4	80.8	64.3	81.8	71.4	87.5	78.7	69.8	77.8
National standards for delivery of health services to adolescents (n=115)	79.1	81.8	84.6	64.3	90.9	71.4	79.2	80.4	81.3	75
National standards for health-promoting schools (n=115)	72.2	77.3	57.7	92.9	81.8	71.4	87.5	71.7	65.6	66.7
At least one designated full-time person for the national adolescent health/well-being programme (n=115)	85.2	93.2	84.6	71.4	100	78.6	100	82.6	81.3	83.3
Regular government budget allocation to support the national adolescent health/ well-being programme (n=115)	54.8	45.5	53.8	35.7	100	71.4	41.7	52.2	68.8	58.3
Continuous professional education system for primary health workers to receive adolescent-specific training (n=115)	67.8	77.3	61.5	35.7	90.9	64.3	62.5	73.9	68.8	50
Laws/policies that provide graduated licensing for novice drivers (n=115)	47	40.9	42.3	57.1	63.6	42.9	45.8	41.3	53.1	58.3
Laws/policies that regulate marketing of alcohol to minors (n=115)	77.4	68.2	88.5	64.3	81.8	85.7	54.2	80.4	87.5	83.3
Laws/policies that designate an appropriate minimum age of a customer for the sale alcoholic beverages (n=115)	76.5	63.6	92.3	64.3	81.8	85.7	58.3	71.7	90.6	91.7

HIC: high-income country, LIC: low-income country, LMC: lower-middle-income country, UMC: upper-middle-income country.

[a] Includes data from 2021 European action plan for sexual and reproductive health survey.

See also Annex 2.

Indicates lowest proportion of Member States reporting existence of policy/guideline/law or highest proportion reporting absence of restrictive aspects of a policy/guideline/law. Indicates low proportion of Member States reporting existence of policy/guideline/law or high proportion reporting absence of restrictive aspects of a policy/guideline/law Indicates intermediate proportion of Member States reporting either existence of policy/guideline/law or absence of restrictive aspects of a policy/guideline/law Indicates high proportion of Member States reporting existence of policy/guideline/law or low proportion reporting absence of prohibitive aspects of a policy/guideline/law Indicates highest proportion of Member States reporting existence of policy/guideline or lowest proportion reporting the absence of restrictive aspects of a policy/guideline/law

Note: This table gives an insight into the availability of policies/guidelines/laws across global regions. From "Sexual, reproductive, maternal, newborn, child and adolescent health: Report on the 2023 policy survey," by the United Nations Children's Fund (2025b) and licensed for re-use under a CC BY-NC-SA 3.0 IGO.

and

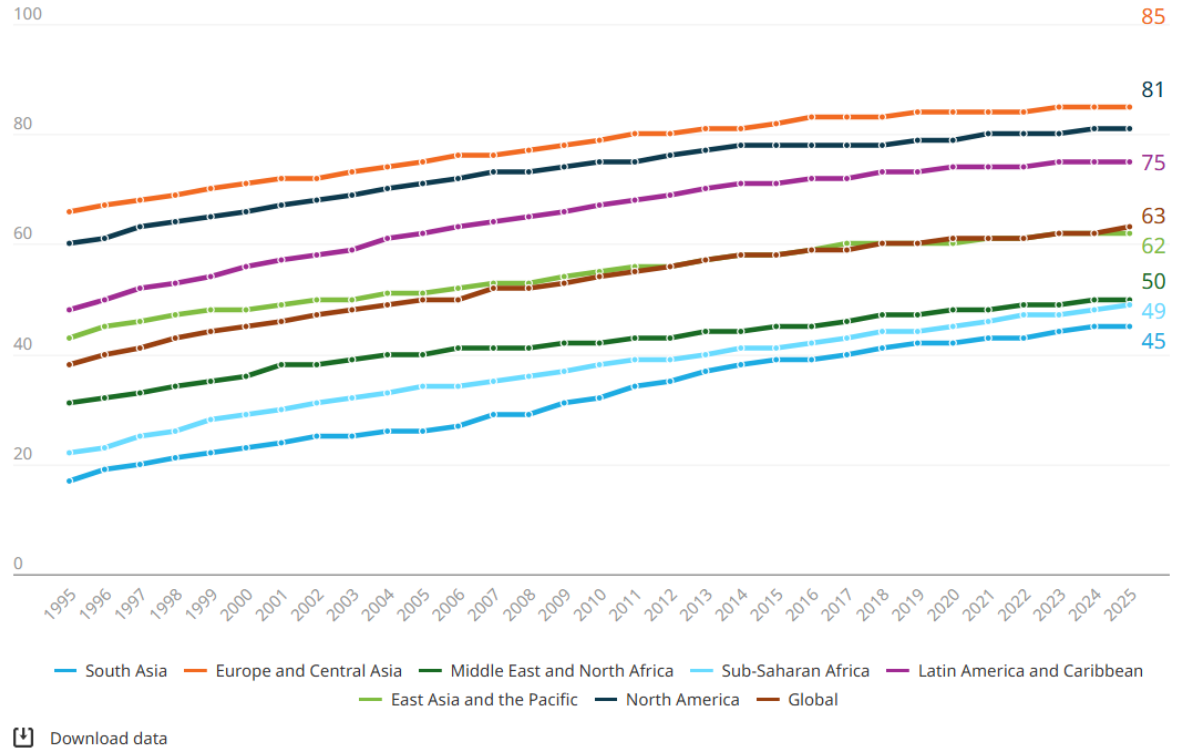
also show an obvious gap of missing data across global regions. Yet, the absence of data does not mean there is no child marriage happening in Western Europe, North America, parts of East Asia and the Australia/New Zealand region. Therefore, it may mean rates are too low to capture, or that reporting priorities differ and alternative indicators are monitored (captured at a different age, i.e., 18 instead of 15 years) (WHO, 2024b). Nevertheless, missing data may mask practices entrenched in traditional or religious norms, especially among migrant and refugee communities, in rural settings, and where parental approvals override national child-rights policies (Calac & Mackey, 2025; Weber et al., 2021). The lack of data may also reveal systemic and structural deficits in monitoring and surveillance bias (Drewe et al., 2012; Rajaofera et al., 2025), which can lead to inadequate planning and capacity to address the problem.

Despite the dearth of data, about 85% of 155 countries are reported to have policies or laws relating to comprehensive sexuality education in schools (UNESCO, 2021); and out-of-school youth, including youth not-in-employment-or-education (NEET) populations, are largely excluded from formal SRH education programmes (Huang, 2021; Rose et al., 2022; Tanton et al., 2021). Undeniably, digital access and engagement have expanded youth's access to information and opportunities unprecedented in the pre-digital age (Liang et al., 2019). However, it has also exposed them to online harm and misinformation, creating a dual reality of empowerment and risk.

The global report has recorded an increase in the proportion of adolescents and young adults accessing reproductive health care from 38% to 63% between 1995 and 2025; see Figure 5 below (United Nations Children's Fund, 2025b). However, their access remains predominantly adult-controlled, with restrictive policies limiting youth autonomy (United Nations Children's Fund, 2024a; WHO, 2024a, 2024b). In the Middle East and North Africa, South Asia and sub-Saharan Africa, only one in two or fewer girls aged 15–19 years had their contraceptive needs met during this period, compared to three out of four girls in Latin America and the Caribbean, and over 80% in North America, Europe, and Central Asia (United Nations Children's Fund, 2025b). The 2023 WHO policy survey reported that about 35% of countries allow unmarried adolescents to access contraceptive services without parental/legal guardian consent, while fewer than 50% permit independent access to HIV counselling, testing, and treatment (WHO, 2024b). This persistent adult gate-keeping operates alongside another critical barrier: young people are significantly under-researched, partly because the same ethical and legal issues that restrict service access and utilisation also limit their participation in research, making it challenging to develop evidence-based and inclusive interventions that respond to their actual needs and experiences (Lohan et al., 2025).

Figure 5.

Proportion of adolescent girls aged 15–19 years with contraceptive needs met between 1995 and 2025 (culled from United Nations Children's Fund, 2025b).



Note: Modern methods of contraception include female and male sterilization, the intra-uterine device (IUD), the implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), lactational amenorrhea method (LAM), emergency contraception and other modern methods not reported separately (e.g., the contraceptive patch or vaginal ring).

Source: Aggregates calculated by United Nations, Department of Economic and Social Affairs, Population Division from surey data compiled in World Contraceptive Use 2024.

Note: The chart was produced by the United Nations Children's Fund (2025b) and licensed for re-use under a Creative Commons Attribution-Non-commercial 3.0 IGO license.

Beyond research exclusion, youth remain marginalised from the policy development processes. While 77% of countries have adolescent SRH strategic plans, meaningful youth engagement in designing these frameworks is minimal, with tokenistic consultation often practised over genuine relationship building and youth leadership in health systems and governance (Lohan et al., 2025; WHO, 2024b). This systematic exclusion from both knowledge production and policy-making perpetuates adult-controlled systems that fail to reflect youth realities and priorities.

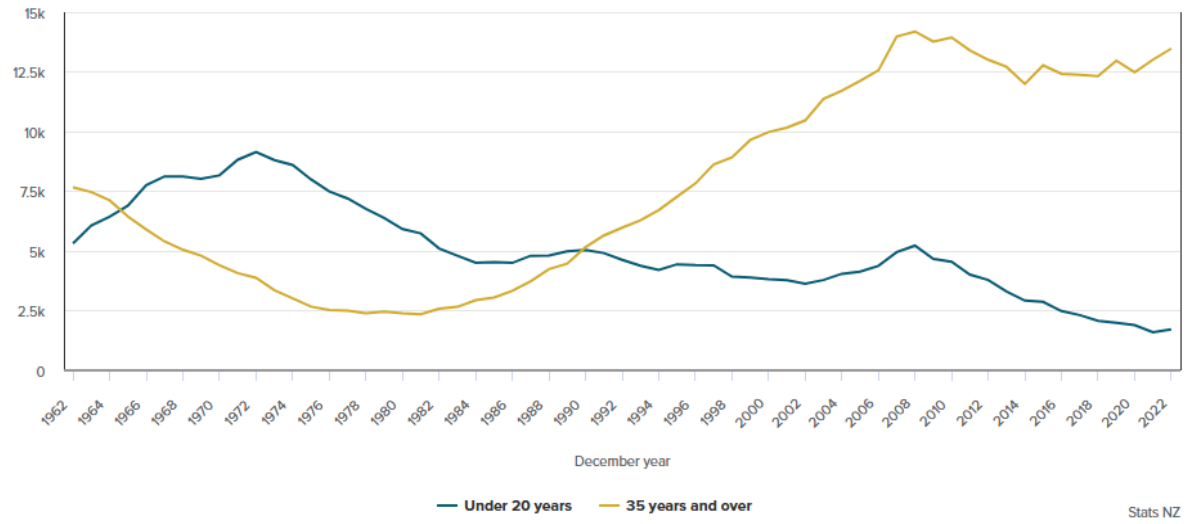
2.2.1. Youth Sexual and Reproductive Health in New Zealand: Examining the Public Health Issues

SRH services are offered through primary care providers, school-based health services, and youth-friendly clinics (Ministry of Health, 2024a, 2024b); however, significant disparities persist for youth, particularly for Māori, Pacific, LGBTQIA+, and rural youth (Messenger et al., 2021; Phillips et al., 2024; Rose et al., 2022). These disparities are underpinned by both individual behaviours and broader structural determinants that require comprehensive and systemic analysis (Brennand & Santinele Martino, 2022; Cammock et al., 2024; Denison et al., 2018).

New Zealand youth are considered to have a poor understanding of their SRH (Phillips et al., 2024; Rose et al., 2024), fuelling misinformation, misconceptions, and behavioural anomalies that threaten a healthy and balanced lifestyle (Rose et al., 2022). Although the rates of teenage pregnancies have dropped by more than half over 40 years, see Figure 6 below (Stats NZ, 2023b), there are higher rates of teenage pregnancies among Indigenous youth compared to non-Indigenous peers (King et al., 2024). Age, education level, and place of residence (high-, middle-, and low-income countries) are among the factors that influence awareness of reproductive health services (Cammock et al., 2018). Rose et al.'s (2024) study found that young people in New Zealand do not know where to go for care and treatment or what medical and non-medical resources are available to them.

Figure 6.

Number of births to women aged under 20 and 35 or more, between 1962 and 2022



Note: The chart was produced by Stats NZ (2023b) and licensed for re-use under a Creative Commons 4.0 International.

The challenge of poor understanding of YSRH among youth is not limited to New Zealand. Studies in Australia have found that young people are often unable to access SRH services because they simply do not know what is available (Aibangbee et al., 2023); for example, key services such as

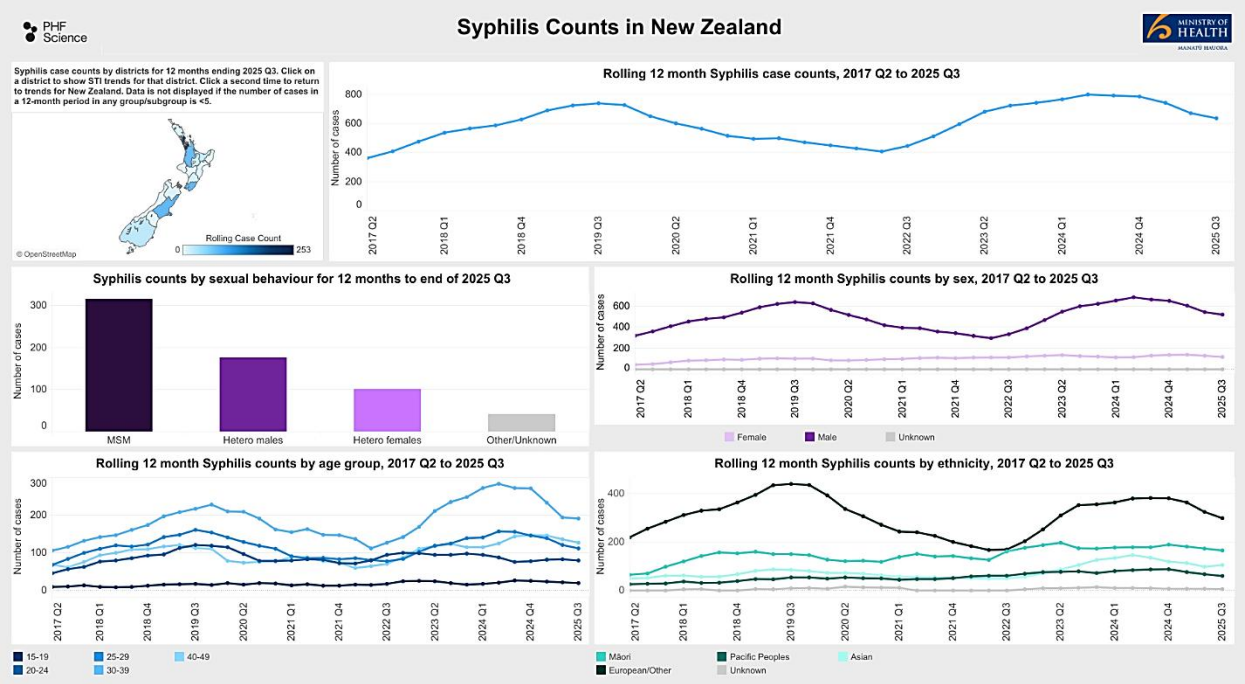
medications for the termination of pregnancies (Cashman et al., 2021). The problem is particularly pronounced for marginalised groups in both countries, with Indigenous people, rural residents, refugees, and migrant men facing a greater disadvantage due to poor knowledge and access to SRH care (Aibangbee et al., 2023; Phillips et al., 2024; Rose et al., 2024).

Recent national publications suggest that the prevalence rate of STIs, mainly syphilis, gonorrhoea, and chlamydia, among young people in New Zealand is high (PHF Science, 2024, 2025; Saxton et al., 2022). Further, marginalised youths who are bisexual, gay, or persons living with disabilities were found to be at greater risk (Aibangbee et al., 2023; Brennand & Santinele Martino, 2022; González & Veale, 2025; Rose et al., 2025), reflecting intersecting social and structural inequities. While national surveillance data underreport youth-specific indices beyond age-group analysis, consistently high STI prevalence among young people suggests they mirror overall national trends. This justifies a focused exploration of YSRH within the wider epidemiological context.

Evidence from the national surveillance reports (PHF Science, 2025) puts syphilis as the topmost STI affecting young and older adults, particularly those aged between 25 and 39 years (see Figure 7 below). This evidence reflects a heightened vulnerability during the peak of sexual activity and reproductive health engagement (Ministry of Health, 2023a; Rose et al., 2024). In alignment with global and local evidence, men who have sex with men (MSM) are more at risk of contracting the infection, while the rates among heterosexual males and females are slowly and steadily increasing, suggesting the diffusion of risk beyond traditional high-exposure networks (Mansfield et al., 2025; Phillips et al., 2024). Similarly, by gender, the disparities remain high, with men accounting for the majority of reported cases, while women's infections show gradual increases after 2021, underscoring the need for inclusive prevention and partner-notification strategies (Lipton, Dickinson, et al., 2025; Ministry of Health, 2023a). Across ethnic groups, New Zealand European/Other populations represent the largest number of reported cases; yet Māori and Pacific youth experience disproportionate impact relative to population size, reflecting inequities in access, stigma, and continuity of care (Goodwin & Lyons, 2024; Rose et al., 2024; Rose et al., 2022).

Figure 7.

Syphilis Rates in New Zealand (2017 Q1 – 2025 Q2) (PHF Science, 2025)

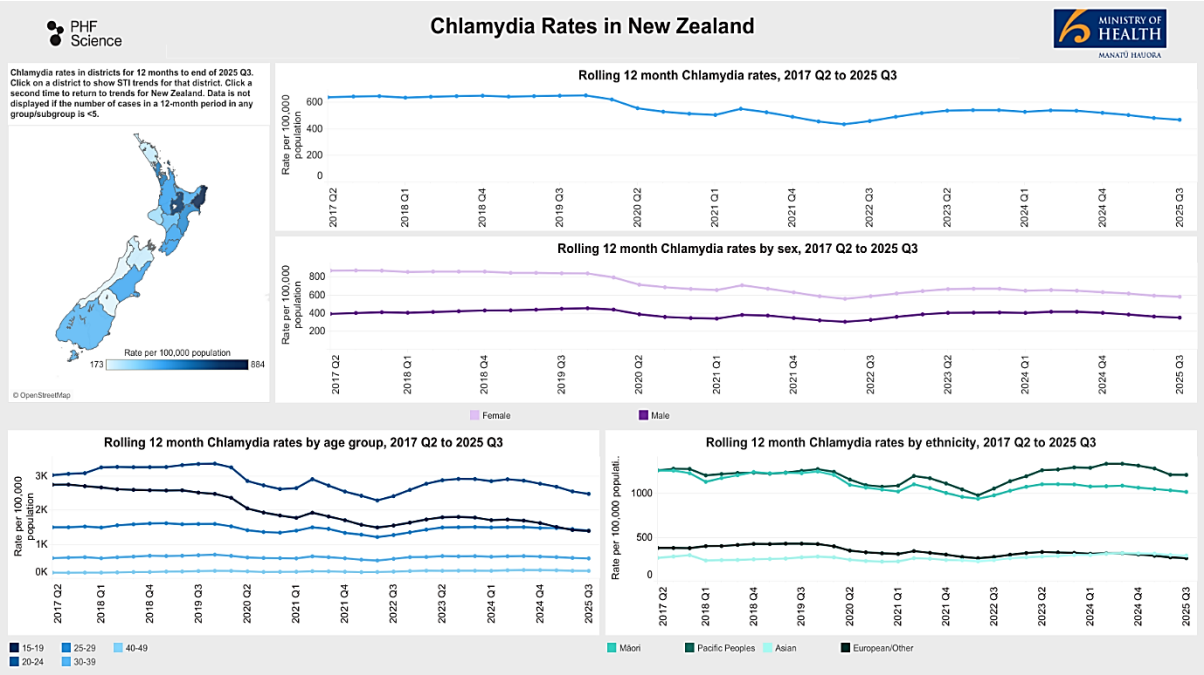


Note: The prevalence rate of syphilis among youth within reproductive age over 12 months in New Zealand. The chart above is disaggregated by selected age (15 – 49 years), gender and ethnicity. Adapted from "New Zealand Sexually transmitted Infections (STI) Quarterly Dashboard" by the New Zealand Institute of Public Health and Forensic Science. Last updated on November 24, 2025. (https://public.tableau.com/app/profile/esr.nz.surveillance/viz/STI_Quarterly_esrwebsite/Overview) In the public domain.

The review of the chlamydia surveillance data from the STI dashboard (PHF Science, 2025) shows that infection rates remain disproportionately high among young people aged 15 to 29 years (Figure 8), confirming persistent age-linked vulnerability despite an overall decline through 2025 Quarter 2. The sharpest decline was recorded among those aged 15 to 19 years; yet this group, alongside 20- to 24-year-olds, continues to experience the highest rolling rates nationally, reflecting their heightened sexual activity, limited routine testing, and variable access to youth-friendly SRH services (Phillips et al., 2024; Rose et al., 2024). Gender patterns also indicate that females consistently account for the majority of reported cases, a disparity partly attributed to more frequent screening compared with males, whose lower rates likely reflect under-testing rather than reduced exposure (Lipton, Dickinson, et al., 2025; Mansfield et al., 2025). Ethnic disparities persist, with Māori and Pacific peoples carrying the heaviest burden relative to population size, underscoring the intersection of cultural, socio-economic, and access-related inequities (Cammock et al., 2023; Ministry of Health, 2024a, 2024b; Rose et al., 2022).

Figure 8.

Chlamydia rates in New Zealand (2017 Q1 – 2025 Q2) (PHF Science, 2025)

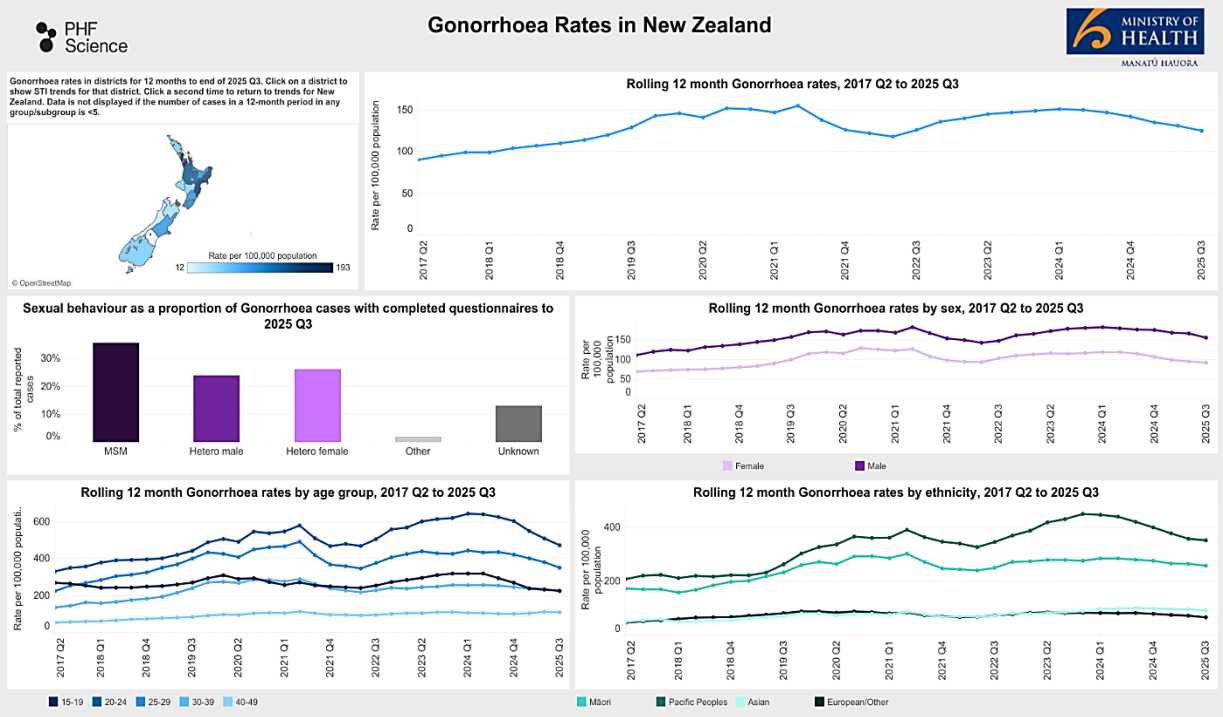


Note: The prevalence rate of chlamydia among youth within reproductive age over 12 months in New Zealand. The chart above is disaggregated by selected age (15 – 49 years), gender and ethnicity. Adapted from "New Zealand Sexually transmitted Infections (STI) Quarterly Dashboard" by the New Zealand Institute of Public Health and Forensic Science. Last updated on November 24, 2025. (https://public.tableau.com/app/profile/esr.nz.surveillance/viz/STI_Quarterly_esrwebsite/Overview) In the public domain.

Furthermore, the gonorrhoea surveillance dashboard (Figure 9) reveals a persistent high infection rate among young adults aged 20–29 years, who represent the largest share of reported cases nationwide (PHF Science, 2025). Rates among 15- to 19-year-olds have declined gradually since 2023 Quarter 4, but this cohort continues to experience elevated transmission risk due to limited testing and inconsistent condom use (Phillips et al., 2024; Rose et al., 2024). By gender, males record consistently higher rates than females, a trend linked to behavioural risk factors and testing practices within male-dominated networks such as MSM, accounting for approximately 37% of cases in 2025 Quarter 2. Again, ethnic trends mirror broader STI inequities, with Māori and Pacific peoples experiencing higher rates relative to other groups, reinforcing the intersection of structural disadvantage, cultural stigma, and access barriers (Goodwin & Lyons, 2024; Mansfield et al., 2025).

Figure 9.

Gonorrhoea Rates in New Zealand (2017 Q1 – 2025 Q2) (PHF Science, 2025)



Note: The prevalence rate of gonorrhoea among youth within reproductive age over 12 months in New Zealand. The chart above is disaggregated by selected age (15 – 49 years), gender and ethnicity. Adapted from "New Zealand Sexually transmitted Infections (STI) Quarterly Dashboard" by the New Zealand Institute of Public Health and Forensic Science. Last updated on November 24, 2025. (https://public.tableau.com/app/profile/esr.nz.surveillance/viz/STI_Quarterly_esrwebsite/Overview) In the public domain.

In summary, there are critical differences in the scope of general SRH compared to youth-specific SRH. Table 4 summarises additional considerations on autonomy, confidentiality, and developmental approaches, such that extend beyond standard SRH frameworks, justifying the need for youth-specific approaches.

Table 4.

Key differences between general SRH and youth-specific SRH

Feature	General SRH	YSRH
Target population	All persons within the reproductive age, typically 15–49 years. Includes adolescents, young and older adults	Young people aged 10–24 years; in New Zealand, aged 12–24 years. Covers adolescents and young adults
Primary focus	Family planning, maternal health, STI/HIV prevention and treatment, sexual dysfunction, infertility management, menopause care	Prevention-focused: STI/HIV prevention, contraception access and uptake, puberty and sexuality education, consent and healthy relationships, privacy and confidentiality, mental health

Feature	General SRH	YSRH
Major health outcomes	Maternal mortality, contraceptive use, STI/HIV incidence, safe abortion care, infertility treatment, cancer screening and management	Adolescent pregnancy rates, STI/HIV incidence – chlamydia, syphilis, gonorrhoea, early sexual debut, child marriage, comprehensive sexuality education, youth-friendly service access and utilisation, gender inequalities and sexual violence, mental health comorbidities
Service delivery strategy	Integrated into primary health care, specialist clinics, hospital-based, often family-oriented	Youth-friendly service centres, school-based health services, peer education, digital/social media outreach
Core principles	Universal health coverage, informed choice, equity, and rights-based	Confidentiality and privacy (autonomy from parent/legal guardians), youth participation and voice, developmentally appropriate messaging, peer support, non-judgmental care
Barriers to access and utilisation	Cost, geographic distance, stigma and discrimination, cultural and religious norms, gender identity and sexual orientation, disability	Parental/legal guardian consent, concerns about privacy and confidentiality, fear of judgment from adult providers, non-availability of youth-friendly services, lack of information on available services, age-based restrictions
Information and education approach	Clinical counselling, public health campaigns, community outreach, partner/family education	Comprehensive sexuality education, peer-to-peer education, digital/social media information and education, youth-led campaigns, interactive and participatory engagement
Rights Framework	SRH rights, bodily autonomy, freedom from violence, right to information and services, informed consent	UN Convention on the Rights of the Child, right to development, National Framework on Child Rights, protection from exploitation balanced with youth autonomy

2.2.2. Global Overview of Youth Sexual and Reproductive Health Promotion

The SDGs (Hassan & Golub, 2025; United Nations, 2025), specifically, Targets 3.3, 3.7, and 3.8, serve as an international framework for health-related strategies and developments globally. Target 3.7 aims for a future where there is universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes (SDG, Target 3.7). Additionally, SDG 3.3 mandate that, “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and

combat hepatitis, water-borne diseases and other communicable diseases", is directly related to the prevention of STIs, including HIV infections, which disproportionately affect young people globally. The third relevant goal, SDG 3.8, "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" also emphasises the importance of young people having equitable access to SRH services, such that it is affordable and high-quality. Evidence from the literature (Achala et al., 2025; Chidwick, 2023; Noer et al., 2024; Starrs et al., 2018; United Nations, 2019, 2025) suggests there is a lag in delivering the outcomes set 10 years ago, thus placing a call on government, providers, and other key state actors, including the young people, to enter into 'overdrive', quoting the United Nations Secretary-General, Antonio Guterres, if these goals are to be met.

At the global level, YSRH promotion faces significant systemic barriers, including insufficient resources and infrastructure for widespread implementation, a critical shortage of qualified and culturally competent health promotion professionals to deliver youth-centred services, and the persistent limitations imposed by cultural opposition and political resistance (Noer et al., 2024). All these have profound restrictions on the youth's SRH rights and access to quality SRH information and services.

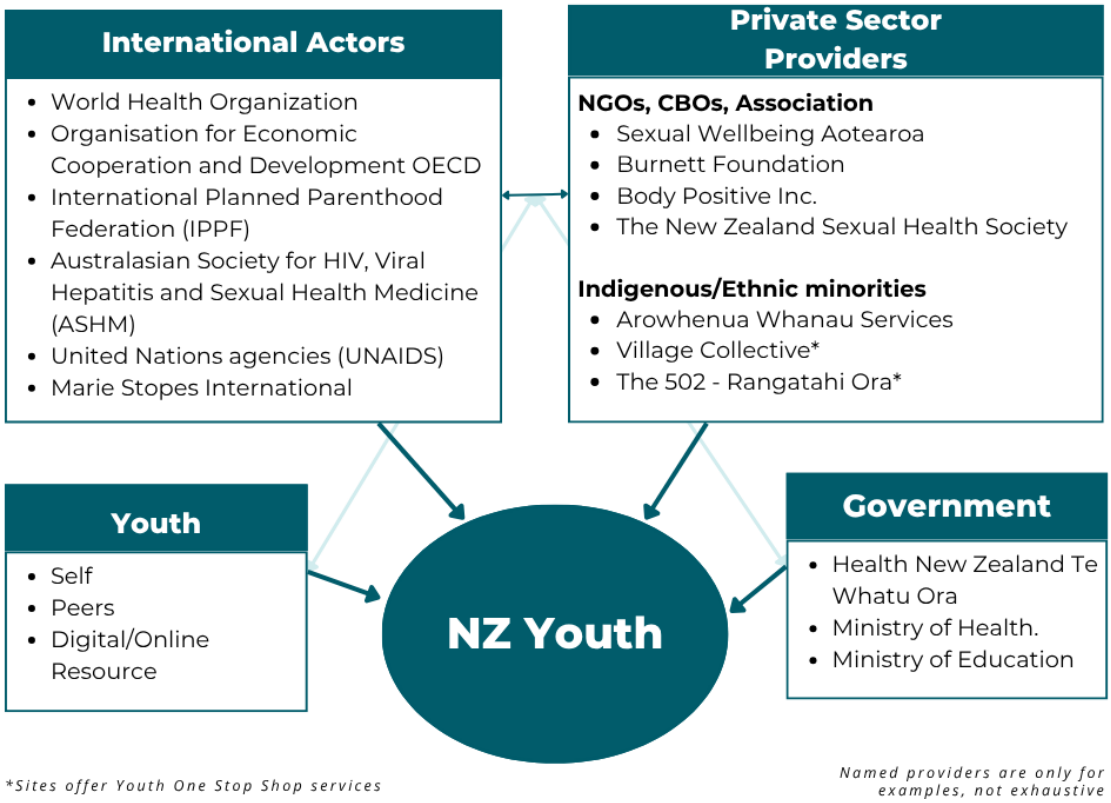
Across Africa and Asia, scoping reviews of SRH education policies reveal that the challenge is implementation rather than the lack of adoption. Beginning from policy design to curriculum scope, issues of stigma and discrimination, unskilled and untrained educators, poor resourcing and infrastructure are ridden with inefficiencies and underrepresentation of young people with shared agency alongside other stakeholders (Khosla & Tzortziou Brown, 2025). With a promising digital present and future, YSRH promotion is presented with an unparalleled opportunity for scale as well as complexities around governance, ethical, and equity challenges.

2.2.3. New Zealand's Approach to Youth Sexual and Reproductive Health Promotion

To address YSRH as a public health issue, the government and its stakeholders implement policies and programmes targeting young people through youth-centred SRH clinics often known as YOSS spread across the country, run by School-Based Health Services and NGOs, such as Sexual Wellbeing Aotearoa, Burnett Foundation, as well as through mobile and outreach clinics that move from one community to another, see Figure 10 below (Ministry of Health, 2009, 2023b; Sexual Wellbeing Aotearoa, 2017). The next paragraphs detail the SRH service offered by these services to young people in New Zealand.

Figure 10.

Overview of SRH providers in New Zealand



Note: Author-generated. The image illustrates the different stakeholders in the YSRH ecosystem in New Zealand and how they are interdependent in their operations. Key to this is identifying young people as a part of the stakeholder framework. Power relations are not examined here.

New Zealand Youth One-Stop Shops

The New Zealand Youth One Stop Shops are committed to enhancing the health, development, and well-being of young people in New Zealand by offering them free and confidential services, suited to the needs of each community in which they are situated (Vibe, 2024). Regionally, 2 out of the 10 locations are in the South Island, while the remaining 8 are up north. They are designed to cater to the health needs of rangatahi aged 10–24 years (Healthify, 2025). They are mostly managed by community-based organisations across the country to provide holistic services on youth health and well-being (Ministry of Health, 2024b). Publicly available update on the programme funding suggests that up to NZ$19 million was released by the government in the 2021/22 budget cycle (Office of the Auditor-General, 2024), while there is a current and growing demand for additional funding based on unmet needs and system transformation (Mental Health Foundation, 2025).

Unlike other SRH providers, YOSS are considered to be more affordable, assure confidentiality, and are convenient in terms of access to care and consumables (Garrett et al., 2020; Ministry of Health, 2009). The care providers are perceived as non-judgmental and youth-friendly.

Noteworthy is that adolescents and young adults between 12 and 24 years, a population group characterised by high-risk behaviour and lifestyle, such as unprotected sexual activity, alcoholism and substance use and abuse, tend to make up the majority of service users at the YOSS, compared to the rest of the population (Ministry of Health, 2009, 2019c). While the perception about staff and the environment of YOSS is deemed commendable, the persistent high rates of STIs among young adults, their risky lifestyle choices, and peer pressure, suggest room for improvement in the design and delivery of the programme as well as the engagement of these young people (Ministry of Health, 2023b, 2024a).

School-based Health Services (SBHS)

SBHS are free and confidential health and well-being services implemented in secondary schools across New Zealand, and mostly run by nurse practitioners (Health New Zealand Te Whatu Ora, n.d.) The programme supports up to 115,000 students in 300 secondary schools to navigate their physical, mental, and social well-being needs, including SRH, injury management, and referral to specialist services when needed (Health New Zealand Te Whatu Ora, 2025). The most recent series of SBHS programme evaluations revealed the need for a strengths-based, culturally safe, and equitable approach that prioritises relationship building, consent, and continuity of care (Health New Zealand Te Whatu Ora, 2023). Engaging with school stakeholders, including the students, ensures smooth uptake (Dixon et al., 2022). The funding for SBHS is from multiple sources, including Health New Zealand, the Ministry of Education through the School High Health Needs Fund, and programmes like Mana Ake under Health New Zealand, as well as from some school annual operating grants (Health New Zealand Te Whatu Ora, 2023; Office of the Auditor-General, 2024).

Mobile and Outreach Clinics

One of these is campervan clinics operated by Counties Manukau and funded by Te Whatu Ora Health New Zealand to travel across the Auckland region in New Zealand, providing medical services on the go (Department of Corrections, 2023). Another one is the HBU Mobile Youth Health Clinic operating as a walk-in clinic in the Bay of Plenty region (Healthpoint Limited, 2025), funded under the 15% budgetary allocation of the Western Bay of Plenty Primary Health Organisation (2025). Some of the high-needs areas visited include schools, correctional facilities, and remote areas, offering free primary healthcare services, including SRH to service users, which may include young people. The mobile clinics are mostly staffed with a GP, nurse, or healthcare assistant who are supported on-site by facility staff, where available. Per site, campervan clinics are present for approximately 90 minutes, but also offer home visits (different from ambulatory services), when necessary (Department of Corrections, 2023).

Private Providers of Sexual and Reproductive Health Services in New Zealand

Several community-based organisations (CBOs) and NGOs make up the landscape of private providers of SRH services in New Zealand. While these entities may often secure government contracts in the form of grants or international aid, they maintain operational independence, exercising

full oversight on their governance structure, service protocol, target demographics, and geographic areas of service (Office of the Auditor-General, 2006). The demand for a specific type of service may dictate their establishment and delivery, but they still maintain the autonomy of addressing a wide range of health and well-being issues, including physical and mental health, educational outreach, and psychosocial support.

As local health service providers, these organisations are inherently positioned to be closer to the people being served, often leading the way in culturally responsive and identity-specific services (Healthify, 2025; Vibe, 2024). This is evident in the prevalence of Kaupapa Māori services, which prioritise Indigenous health models, and other specialised NGOs like Sexual Wellbeing Aotearoa, Burnett Foundation, and Body Positive Incorporated. They provide a range of specialised care, ranging from peer counselling to STI testing services, contraception and peer support for persons living with HIV, a critical gap that public health services often struggle with or are considered unwelcoming by youth. Some of the YOSS centres also fall within this scope of practice of private providers with youth-trained professionals tailored to meet the health needs of young New Zealanders, and are good examples of private providers funded by the government (Healthify, 2026; Vibe, 2024). Other sources of funding for private providers include the organisation board, fundraising and similar social enterprises managed by the organisation, and philanthropic donations.

An umbrella body, the New Zealand Sexual Health Society Incorporated (NZSHS, 2026), brings together "a group of professionals working in the field of sexual health". The multidisciplinary body is made up of doctors, nurses, researchers, academia, educators, health promoters, and other similar practitioners in public health to complement the government's efforts to manage the health and well-being of its people. The NZSHS and specialised service providers, like the Sexual Wellbeing Aotearoa, are also recognised as educational providers and accreditation providers for other practitioners in the country.

It is important to note that national policies and direction have a direct impact on the private providers' service design and implementation (Came et al., 2018). Therefore, they may run the risk of being siloed or silenced if their agenda is against the government or the adults who steer the wheels of governance against youth autonomy and agency.

In New Zealand, YSRH issues transcend those of STIs and unwanted pregnancies. It encompasses ethnic identity, sexual orientation, self-esteem, mental health, and diversity (Ministry of Health, 2024a, 2024b). Despite several national strategies aimed at improving youth well-being, a gap remains in synthesised evidence that links structural determinants with service delivery mechanisms and communication strategies. The hybrid PESTEL-Ecosocial theory approach described in the following section applies a holistic framework that addresses the structural and behavioural determinants of SRH and identifies how the health outcomes that young people continue to experience in their sexual and reproductive well-being are biologically incorporated and cumulatively interact over the course of life (Destrieux et al., 2025; Krieger, 2021; Vojinović & Stević, 2022).

2.3. Patterns Shaping Youth Sexual and Reproductive Health Outcome: A Hybrid PESTEL and Ecosocial Analysis

Addressing issues of power and accountability is particularly salient for YSRH, where health systems, policies and services are predominantly designed and controlled by adults, often with limited meaningful youth participation in co-design (Cammock et al., 2024; Rose et al., 2022). Adult-dominated governance structures, funding priorities determined without youth input, services that fail to reflect young people's cultural identities and lived realities, and institutional practices that position youth as passive recipients rather than active agents in their health, all operate as forms of structural violence that become embodied as preventable SRH disparities (Fleming et al., 2022; Rose, Garrett, McKinlay, & Morgan, 2021). By foregrounding youth-adult power relations as a central analytical thread, this section of the literature review examines how inequitable power dynamics within health promotion systems shape the conditions under which young people navigate their SRH.

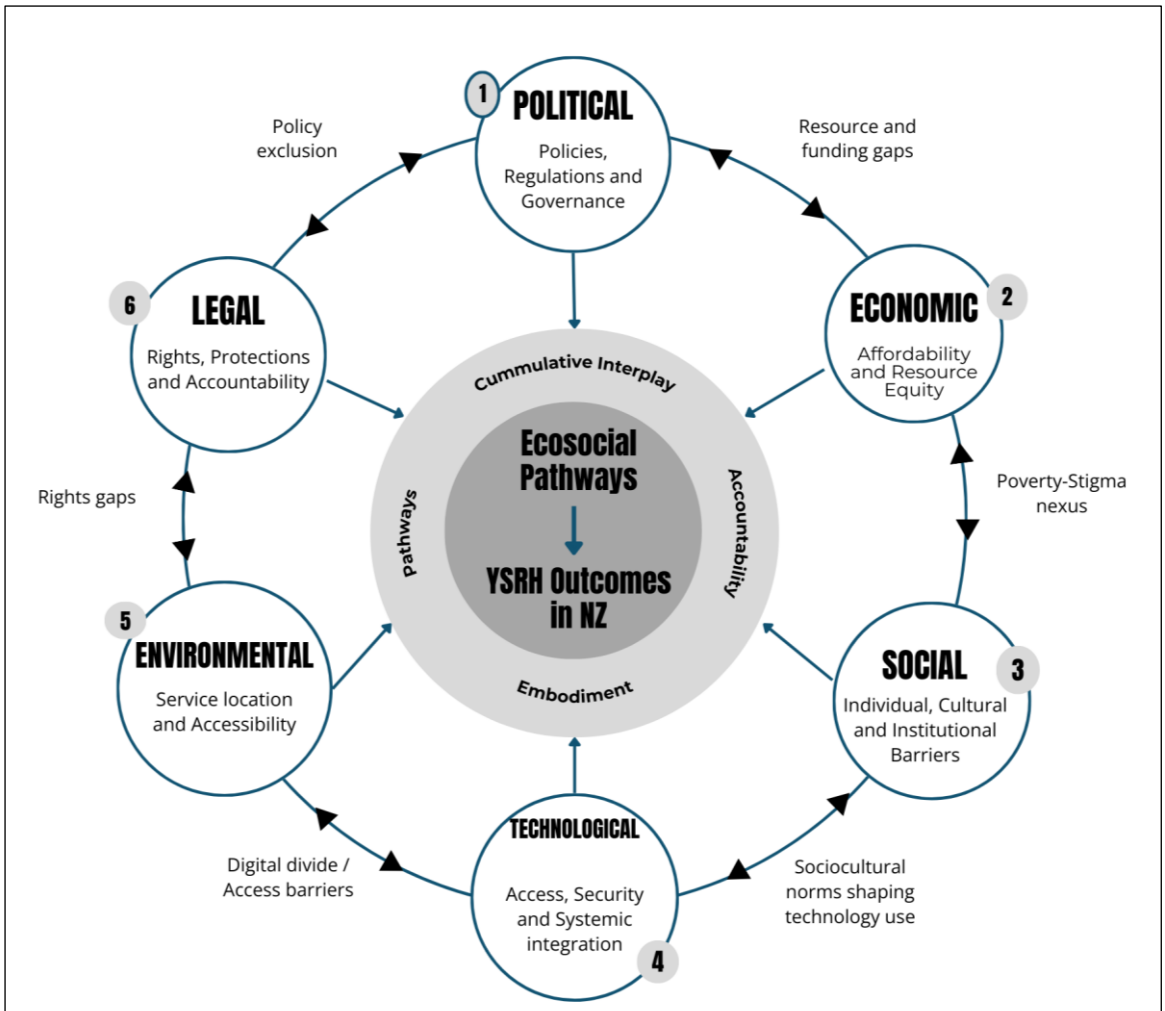
To carefully examine the macro-level structural forces challenging youth autonomy and agency over their SRH in New Zealand, the PESTEL framework is employed as an organisational framework for constructing the evidence of factors interacting with YSRH outcomes from literature (refer to Figure 11). While PESTEL originated from business management contexts to assess external organisational environments (Aguilar, 1967), its systematic categorisation of macro-environmental factors provides a comprehensive structure for mapping the adult-controlled institutional landscape within which young people must navigate their SRH needs. Cahill (2014, p. 487) applied the same framework[4] during group exercises with young people to design the future with themselves in it.

In addition, ecosocial theory is applied as the analytical lens that shows the pathways of embodiment and accountability. Ecosocial theory (Krieger, 2001, 2009, 2021), enables analysis of how adult-dominated structures become biologically incorporated as differential YSRH outcomes among young people. Critically, ecosocial theory's attention to agency and resistance allows examination of how youth and Indigenous communities challenge and reshape these structures, despite operating within systems not designed by or for them.

Figure 11.

PESTEL-Ecosocial framework for YSRH outcomes in New Zealand

[4] Cahill referred to the framework as STEEPL, but referenced the same domains illustrated in PESTEL.



Ecosocial Theory Key Concepts	Sites of resistance against structural factors
• **Embodiment**: How social conditions become biologically incorporated • **Pathways**: Multiple routes through which inequities operate • **Cumulative Interplay**: Effects accumulate across life course • **Accountability**: Who is responsible for creating and addressing inequity	• Youth movements • Indigenous health frameworks • Community-led initiatives

Note: Author-generated. This figure illustrates the macro-level interaction of the PESTEL domains, showing how political, economic, social, technological, environmental and legal structures cumulatively interact to co-produce the broader ecosocial architecture that shapes YSRH outcomes.

It is important to clarify the relationship between the two frameworks; PESTEL provides the organisational structure for categorising and reviewing the literature across the key domains of macro-determinants, while ecosocial theory provides the analytical lens through which these factors are interpreted, theorised, and understood as pathways to embodied health inequities. Each PESTEL domain in this section is, therefore, not merely a description of contextual factors but also an emphasis on how power relations influence pathways to embodiment and its cumulative effects across the life course, and then, through accountability, identifies who is creating and responsible for producing and addressing health inequities.

2.3.1. Political Factors

In New Zealand, SRH is positioned within a holistic national health strategy and delivered through a publicly funded, mixed-provider system that includes general practices, hospitals, school-based services, specialist or population-specific sexual health clinics, and community-based agencies (Ministry of Health, 2023). This system reflects the country's political will to promote population health through universal and equitable access to healthcare. However, through an ecosocial lens, the design, implementation, and outcomes of SRH policies reveal how political structures and governance operate as pathways through which power inequities become embodied as differential health outcomes (Krieger, 2009; Logie et al., 2024). Young New Zealanders, particularly Māori and Pacific youth, and other marginalised populations, continue to experience disproportionate rates of STIs, unintended pregnancies, and delayed care-seeking as consequences of adult-controlled policy processes that systematically exclude youth voice (Kenyon et al., 2022).

The 2001 SRH Strategy, and its successors, sought to provide coordinated policy guidance for SRH providers and institutions, with explicit goals to reduce rates of STIs and unplanned pregnancies among high-risk groups, especially young people (Ministry of Health, 2001, 2023). While these commitments marked a significant political recognition of health disparities, structural determinants such as institutional racism, fragmented implementation, and limited youth co-design have constrained their transformative impact, operating as mechanisms through which governance failures become biologically incorporated. Phase Two of the strategy (Ministry of Health, 2003) focused on integrating best practices into clinical and community care settings; however, successive updates have not consistently maintained a youth-centred focus. The most recent 2023 update to the New Zealand Health Strategy, which sets a 10-year vision for equity across population groups, including Pacific peoples, women, persons with disabilities, and rural communities, demonstrates youth marginalisation because young people are still not prioritised in standalone terms (Minister of Health, 2023). Instead, their needs are expected to be addressed indirectly through the 2024 Child and Youth Wellbeing Strategy (Ministry of Social Development, 2024), which itself lacks specific operational guidance for SRH interventions. This policy architecture reflects cumulative exclusion across the life course: youth positioned as recipients rather than co-designers of policies shaping their health futures creates conditions for disengagement, stigma, and, ultimately, preventable health risks.

Additionally, despite having formal commitments to Te Tiriti o Waitangi and inclusive policy development, policy-practice gaps persist, revealing how political structures reproduce rather than address inequities. For example, Māori and Pacific leadership have continually shaped culturally grounded frameworks, such as the Māori Sexual Health Framework and the Best Practice Framework for Pacific SRH Promotion (Australasian Society for HIV Viral Hepatitis and Sexual Health Medicine (ASHM) & New Zealand Sexual Health Society, n.d.; Veukiso-Ulugia, 2013a). Unfortunately, these are not always translated into consistent, resourced, or youth-accessible practice. This disconnection

between Indigenous and Pacific youth communities and service providers reflects underlying structural inequities in knowledge translation, policy accountability, and cultural responsiveness (Cammock et al., 2024; Rose et al., 2022). This presents a pathway through which institutional racism and colonial power structures become embodied. When policies developed by and for Māori and Pacific communities are under-resourced or ignored, the resulting service gaps, cultural disconnection, and lack of trust accumulate as chronic stress, delayed care, and disproportionate disease burden among these populations.

New Zealand's obligations under international human rights agreements, including the UN Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), as well as its commitment to the SDGs, position it as a country with strong normative frameworks for SRH equity. However, comparative evidence suggests a lag in youth SRH outcomes and in the implementation fidelity of youth-specific policies relative to other OECD nations (Rose, Garrett, McKinlay, & Morgan, 2021; Terry et al., 2012). These reports identify New Zealand youths as being more vulnerable to mental health issues, suicide, SRH risks, including STIs, unintended pregnancies, and risky behavioural lifestyles (Ministry of Health, 2009). These disparities are not merely statistical patterns but embodied consequences of political accountability failures; the gap between policy commitments and lived realities operates as a determinant of health, shaping who has access to timely care, who experiences stigma in seeking services, and whose bodies bear the burden of governance neglect (Dávila et al., 2025). The ecosocial principle of accountability asks, 'Who is responsible for these outcomes, and who holds power to change them?' This question points to the need for strengthened policy continuity, sustainable funding, youth-led governance, and embedded accountability mechanisms that centre youth and Indigenous communities as agents in their own health futures rather than passive subjects of adult-driven interventions.

While the political will to improve YSRH is evident in national strategies and international alignments, frequent policy shifts, siloed interventions, and limited youth participation in decision-making processes undermine the systemic transformation needed. These governance-level gaps represent structural barriers that operate across multiple levels, from macro-policy exclusion to institutional implementation failures to interpersonal provider-youth disconnection, creating cumulative pathways through which political marginalisation becomes embodied as health inequity. Yet sites of resistance abound through Indigenous frameworks, youth advocacy movements, and community-driven initiatives to demonstrate agency despite operating within constraining political structures, revealing possibilities for transforming governance toward genuine partnership and equitable health outcomes.

2.3.2. Economic Factors

The review of national policies like the Abortion Legislation Act (2020), which decriminalised abortion, demonstrates how legal reforms intersect with economic pathways to shape health access. While improved accessibility through self-referral and a wider range of SRH providers represents a laudable step toward equity, the reform's potential remains constrained by economic barriers that operate as pathways through which resource inequity becomes embodied as differential health outcomes (Black & Paterson, 2019; Sexual Wellbeing Aotearoa, 2017). Theorising this shows that issues of costs associated with referrals, transportation to specialised centres, and licensed SRH providers, as well as time taken off work or school, could become material determinants that accumulate differently across social strata. Low-income and rural-resident youth, especially Māori and Pacific peoples and migrant populations, are faced with compounding barriers where economic disadvantage intersects with geographic isolation and systemic racism. Evidenced by Rose, Garrett, McKinlay and Morgan (2021); Rose et al. (2022), and Wimsett et al. (2022), the cost and distance travelled to SRH clinics are a critical driver of contraception uptake, affecting more Māori and Pacific Peoples compared to other ethnicities in New Zealand. This disproportionate impact on Māori and Pacific youth reflects a pattern of how economic structures reproduce colonial inequities across generations (Cammock et al., 2018; Krieger, 2009).

Service utilisation patterns also illustrate how economic factors shape youth agency and health-seeking behaviour (Krieger, 2021; Logie et al., 2024). While young New Zealanders with no notable difference observed across ethnicities would often visit their general practice clinics, marginalised population groups like the LGBTQI+ youth indicated a preference for any other provider (Carroll et al., 2023; González & Veale, 2025; Rose, Garrett, McKinlay, Morgan, et al., 2021). Research has informed that young people's choice of sexual health clinic is determined by ease of access, client privacy and confidentiality, fee-free services, availability of telehealth services and non-judgmental staff (Goodyear-Smith & Ashton, 2019; Rose, Garrett, McKinlay, & Morgan, 2021; Wimsett et al., 2022), an indication of how economic accessibility intersects with psychosocial safety. This pattern showcases an ecosocial pathway; that is, when economic determinants (e.g., cost of service, transportation expense, and proximity of sexual health clinics) combine with social barriers (e.g., stigma, discrimination), marginalised youth face cumulative disadvantage that shapes their health-seeking behaviour, embodied as chronic stress, delayed care, untreated STIs, unintended pregnancies and complications arising (Krieger, 2021; Rose et al., 2022).

The economic exclusion of youth NEET exemplifies how labour market position operates as a structural determinant of health. With New Zealand's youth NEET rate at 12.8% in 2025 (Ministry of Business Innovation and Employment, 2025), almost a 2% increase from the 2023 record, economic marginalisation heightens the risk of poor SRH outcomes and deepens inequities, more so among the indigenous population (Huang, 2021). NEET status marks deeper socioeconomic exclusion that

features through multiple pathways: lack of healthcare support through employment-linked insurance or medical coverage, disconnection from health education initiatives and promotional campaigns delivered through workplaces or educational institutions, and exclusion from digital health interventions access via platforms that youth mostly engage with, like social media (Fleming et al., 2022; Garrett et al., 2020; Huang, 2021). As a result, NEET youth are further entrenched in health and socioeconomic inequities through cumulative interactions whereby economic exclusion compounds lack of information, reinforcing risky behaviours that further limit economic opportunities, creating cycles of disadvantage that become biologically incorporated across the life course.

Research by Tanton et al. (2021) showed that NEET youth are more likely to engage in harmful health behaviours and report poorer SRH outcomes, with younger women facing elevated risks of unwanted pregnancies and experiences of non-voluntary sex. Fear about the side effects of contraceptives, misinformation and lack of knowledge become a double disadvantage for youth NEET, operating as pathways through which economic marginalisation becomes embodied (Wimsett et al., 2022). These authors articulate that the lack of economic resources limits service users, such as young people's access to accurate information and quality services. Their experiences of poverty and economic exclusion create chronic stress that affects decision-making, risk assessment, and the capacity to prioritise long-term health. These outcomes not only increase pressure on the healthcare system and compromise physical, sexual, and mental well-being, but also result in long-term economic consequences, including dependence on social benefits and constrained labour market participation (Public Health Advisory Committee, 2025; Sedgh et al., 2025; Tanton et al., 2021). Altogether, such marginalisation reflects how health and economic inequities reproduce each other across the life course, with bodies bearing the cumulative burden of structural neglect.

Structural and systemic economic barriers operate as determinants that shape who can access timely and appropriate care, creating differential exposures to knowledge deficits, delayed treatment, and inadequate prevention measures that proliferate health inequities across socioeconomic lines (Engel, 2023; McGinn & Wise, 2024). A lack of culturally responsive, safe, free, or low-cost services can further deter the marginalised youth population from accessing critical, life-shaping SRH services, functioning as institutional violence against these youth (Cammock et al., 2023; Rose et al., 2022). An ecosocial analysis from an accountability perspective asks, 'Who holds the power for resource allocation and the decisions that determine which youth populations can afford health, and who is responsible for addressing these inequities?' The immediate need for intersectoral investment in accessible, cost-effective or no-cost youth-responsive SRH services targeted at economically vulnerable and systemically marginalised populations represents not merely a policy recommendation but an ethical imperative to disrupt pathways through which economic structures become embodied as preventable suffering. Nonetheless, resistance against imbalanced power relations exists, whereby CBOs are providing free or sliding-scale services, peer support networks sharing resources and information, and youth advocacy demanding economic justice demonstrate agency despite operating

within constraining economic structures, revealing possibilities for transforming resource distribution toward meaningful engagement and authentic connection.

2.3.3. Social and Cultural Factors

Social and cultural factors significantly shape YSRH outcomes in New Zealand (MacDonald & Dixon, 2022; Phillips et al., 2024; Public Health Advisory Committee, 2025). The 2014/2015 New Zealand Health Survey (Ministry of Health, 2019b) revealed that the median age of first sexual intercourse among youth is 17 years, with over one-third reporting sexual activity before that age. Notably, early sexual debut was significantly higher among youth who had been involved with Oranga Tamariki, the statutory child protection agency (Fleming et al., 2022; Ministry of Health, 2019b), resulting in a form of institutionalised marginalisation that operates through multiple intersecting pathways. Studies have shown that involvement with child welfare services represents cumulative exposure to adverse social conditions such as trauma, unstable housing, and systemic marginalisation, which interact and accumulate over the course of life to amplify SRH risks (Engel, 2023; Fleming et al., 2022; Garrett et al., 2020; Krieger, 2021). Lower rates of condom use and concerning gaps in engagement with safe sex practices, STI screening, contraceptive use, and routine health-seeking behaviour highlight how early institutional contact becomes biologically incorporated as heightened vulnerability to adverse SRH outcomes (Fleming et al., 2022; Krieger, 2009, 2021; Phillips et al., 2024).

Cultural identity and provider responsiveness also play pivotal roles in whether and how young people can access SRH promotional resources (Palm & Gaum, 2021; Perumal, 2011; Te Morenga et al., 2018). Rose et al. (2022) found that Māori and Pacific youth were more likely to engage with SRH services when they were delivered by culturally matched staff. This underscores the importance of cultural safety, not just as a desirable service attribute, but as a necessary condition for service uptake and trust-building in diverse youth communities. The findings reveal an ecosocial process that when health systems fail to reflect and respect the cultural identities of those they serve, they reproduce structural exclusion that becomes embodied through multiple mechanisms—delayed care seeking due to anticipated discrimination, chronic stress from navigating culturally unsafe spaces, and, ultimately, worse health outcomes (Cammock et al., 2023; Carlson et al., 2022; Garrett et al., 2020; Ministry of Health, 2001). It also reflects patterns of broader social inequalities and institutional disconnection experienced by care-experienced youth and Indigenous youth who face systemic barriers erected through colonial legacies that continue to shape contemporary health systems (Breilh, 2021; Nairn et al., 2021; Public Health Advisory Committee, 2025). Mainstream health systems often fail to provide culturally relevant or youth-centred health education, effectively excluding these populations from health-promoting knowledge and reinforcing inequities across generations (Rose, Garrett, McKinlay, & Morgan, 2021; Young et al., 2024).

Another critical concern is the widespread lack of youth-appropriate and culturally relevant SRH education (Mukoro et al., 2025). This operates as a structural pathway through which knowledge inequities become embodied as preventable health risks. According to Cammock et al. (2018) and DeLacy et al. (2019), many New Zealand youth report limited awareness and inadequate knowledge to make informed decisions about SRH, family planning, and consent. These knowledge gaps present as material determinants. Without accurate information, young people cannot assess risks, recognise symptoms, negotiate consent, or access appropriate services, leaving them susceptible to preventable conditions such as STIs and unplanned pregnancies, which carry long-term physical and psychosocial consequences (Fleming et al., 2022; Ministry of Health, 2019c). Therefore, from an accountability perspective, the question emerges: 'Who is responsible for ensuring youth receive comprehensive, culturally responsive SRH education, and whose interests are served by maintaining knowledge deficits?' (Krieger, 2006, 2021; von dem Knesebeck, 2015). Education-based models of SRH are reported to have a higher positive impact on knowledge and behavioural change compared to other forms of interventions (Desrosiers et al., 2020; Robertson, 2024); yet, the failure to deliver such education in culturally responsive ways targeted at the most at-risk and disadvantaged youths represents a political choice that perpetuates inequities (Dávila et al., 2025; Mohyeddin, 2024).

Disability status is another social factor compounding youth vulnerability through pathways of ableist exclusion that intersect with other forms of marginalisation, creating acute risks especially for young women (Brennand & Santinele Martino, 2022; Phillips et al., 2024). Young people living with disabilities often encounter significant barriers to accessing SRH services, including the absence of accessible communication tools like braille, sign language interpreters, and screen-readable digital platforms (Lipton, Dickinson, et al., 2025; Ministry of Health, 2001; United Nations, 2014). These structural deficits reflect ableist service design and function as institutional violence that reinforces health inequities by limiting access to critical SRH information and care (Iezzoni, 2024; Lundberg & Chen, 2024). When SRH information is not presented in formats accessible to all youth, those with disabilities are further marginalised in ways that are both preventable and unjust (Aibangbee et al., 2023; Fleming et al., 2022; Ministry of Health, 2003). This exclusion can become biologically incorporated when lack of information limits informed decision-making, inaccessible services deter care-seeking, and chronic experiences of exclusion result in psychosocial stress that affects overall well-being (Lundberg & Chen, 2024; Obeng-Gyasi, 2023).

Peer pressures, stigma, and discrimination operate as social-relational pathways that often shape youth behaviours and outcomes. When reinforced by stigma and discrimination, they can lead to harmful outcomes such as sexual promiscuity and the spread of misconceptions and misinformation among youth (Farrugia et al., 2021; Melendez-Torres et al., 2024; Young et al., 2024). As a result, young people may make uninformed and risky decisions, delay seeking proper healthcare, or avoid services altogether. In New Zealand, Māori, Pacific, disabled, migrant, and LGBTQIA+ youth frequently encounter stigma and discrimination within SRH settings, where feelings of judgment

undermine trust and deter timely care (Rose, Garrett, McKinlay, & Morgan, 2021). These experiences operate as pathways of embodiment where anticipated or encountered judgement, stigma, and discrimination lead to chronic psychosocial stress, shape health-seeking behaviours, and become embodied as delayed diagnoses, untreated infections, and mental health impacts (Rose et al., 2024; Rose, Garrett, McKinlay, Morgan, et al., 2021; von dem Knesebeck, 2015). These experiences of exclusion intersect with systemic inequities such as racism, ableism, and socioeconomic marginalisation, demonstrating cumulative interplay where multiple forms of oppression compound across the life course to produce persistent disparities in SRH outcomes (Aibangbee et al., 2023; Kelly-Irving & Delpierre, 2021).

Historical evidence demonstrates how stigma and discrimination function as a structural determinant that reproduces inequities across generations. Past national strategies have also shown how stigma surrounding HIV/AIDS and adolescent sexuality entrenched barriers, particularly when services lacked cultural safety or failed to involve communities in their design (Deane et al., 2023; Goodwin & Boulton, 2024; Ministry of Health, 2003). From an ecosocial lens, stigma and discrimination act as structural determinants, extending beyond individual attitudes to operate as a social structure that shapes institutional practices, resource allocation, and power relations, perpetuating inequities across generations, thereby intensifying preventable SRH risks among already marginalised youth populations (Cammock et al., 2024; Deane et al., 2025; Krieger, 2006; Rose et al., 2024). These intergenerational patterns reveal how social conditions are embodied across populations and time, as youth inherit both the material conditions and psychosocial burdens created by past structural inequities (Goodyear-Smith & Ashton, 2019; Krieger, 2021; Lerner et al., 2023).

Lastly, it is important to emphasise that YSRH outcomes in New Zealand are not an absolute individual choice, but are deeply embedded in social structures, cultural norms, and relational trust (Aibangbee et al., 2023; Cammock et al., 2024; Conti, 2025). Addressing these social and cultural determinants requires inclusive education and community engagement, and sustained investment in culturally competent, youth-led, and disability-inclusive SRH services. There must be continuous efforts to institutionalise Indigenous frameworks that centre cultural values and community self-determination, youth-led advocacy challenging stigma and discrimination, demanding inclusive services and peer support networks creating safe spaces for marginalised youth, demonstrating how youth communities resist and reshape structures that constrain their health and revealing possibilities for transformation within systems not designed by or for them (Lipton, Dickinson, et al., 2025; Mark & Hagen, 2020; Meherali et al., 2025).

2.3.4. Technological Factors

The technological landscape reveals how adult-controlled digital infrastructure operates as a pathway through which inequities become embodied as differential SRH outcomes among New Zealand youth. While 88% of 18–29-year-olds access the internet daily from home, 72% from work

(Figure.NZ, 2022), and 81% use social media (DataReportal, 2023), disabled youth face disproportionate online harm and access constraints (InternetNZ, 2024) demonstrating how platforms designed without inclusive input create exclusionary pathways. This aligns with Cammock et al. (2018) and Aibangbee et al.'s (2023) findings that in New Zealand, vulnerable youth are more at risk in digital environments. Low-income youth in high-income countries face barriers to telehealth due to affordability and digital literacy, while in LMICs infrastructural gaps further entrench exclusion (Sewak et al., 2023; Uleanya & Gamede, 2018), demonstrating that digital platforms reproduce existing inequalities when equity is not centred (Petretto et al., 2024).

Young people use social media for content creation, peer support, and information sharing (Martin, Cousin, et al., 2020; Pacheco & Melhuish, 2018), yet these platforms expose them to misinformation alongside accurate health content (Farrugia et al., 2021; Martin, Cousin, et al., 2020). This dual reality particularly affects marginalised youth who already distrust mainstream services (Martin, Alberti, et al., 2020; Rose et al., 2024). Privacy concerns and worry about parental visibility of app usage deter sustained engagement (Rose, Garrett, McKinlay, Morgan, et al., 2021; Rose et al., 2022). Similar observations were made in the United States (Martin, Alberti, et al., 2020; Wang et al., 2022). As a result, the risk of misinformation and concerns over privacy cumulatively function as structural barriers where adult-controlled design becomes embodied as delayed care-seeking patterns.

No doubt, digital platforms have fundamentally reshaped the landscape of SRH information dissemination and service delivery, offering both substantial advantages and complex challenges in New Zealand and other countries (Fleming et al., 2022; PHF Science, 2024; Rose, Garrett, McKinlay, & Morgan, 2021). However, gaps remain in integrating data across telehealth, social media, and app-based interventions. This fragmentation prioritises institutional surveillance over youth-centred integration, creating missed opportunities (Albury & Mannix, 2025; Albury et al., 2025). Youth-created health content and peer networks demonstrate resistance, revealing possibilities for transforming technology from reproducing inequities and enabling health justice (Kang et al., 2023; Ludin et al., 2022; Pagoto et al., 2025).

2.3.5. Environmental Factors

The physical and systemic accessibility of SRH services remains a challenge for many young people in New Zealand. It operates as an environmental pathway through which spatial inequities become embodied in differential health outcomes. Garrett et al. (2020) noted that youth often disengage from follow-up appointments and referral services due to limited-service proximity, transportation barriers, or unwelcoming clinic environments. Theorising this from an ecosocial perspective, the distribution of YOSS, availability of after-hour clinic appointments, and the location of services relative to where youth live and study all contribute to young people's access to care and subsequent behaviour (Ministry of Health, 2009; Rose, Garrett, McKinlay, & Morgan, 2021). For youth living in rural areas, or those with disabilities, environmental barriers are compounded by the

absence of inclusive design features and reliable transport (Brennand & Santinele Martino, 2022; Ministry of Health, 2003), creating a cumulative exclusion that is embodied as delayed care and unmet health needs (Kenyon et al., 2022; Krieger, 2005, 2021).

Additionally, while youth-friendly clinics are available across the country (McGinn & Wise, 2024; Ministry of Health, 2009), uneven distribution, overburdening, poor staff-to-client ratios, and physical layout of clinics that discourage youth engagement reflect how adult-controlled resource allocation prioritises institutional efficiency over youth accessibility (Gardner, 2011; Garrett et al., 2020; Rose, Garrett, McKinlay, & Morgan, 2021). These infrastructural limitations, when paired with staff fatigue and inconsistent youth-centred practices, operate as environmental factors that shape youth perception of SRH services and uptake (Rose et al., 2022; Rose, Garrett, McKinlay, Morgan, et al., 2021). This raises the questions 'Who is responsible for deciding clinic location and operating hours? Who is responsible for needs prioritisation in spatial planning, and who bears the burden when environmental design excludes youth?' (Krieger, 2006, 2009; MacDonald & Dixon, 2022).

For youth living with disabilities, environmental exclusion is both a physical and systemic reality (Lundberg & Chen, 2024; Obeng-Gyasi, 2023). Mainstream healthcare settings frequently lack accessible features such as braille signage, wheelchair ramps, visual or auditory aids, and user-friendly websites or booking systems (Ministry of Health, 2001, 2003). Absence of inclusive design creates spatial and communicative barriers that prevent disabled youth from fully accessing SRH services, reflecting a systemic neglect where ableism is embodied as disproportionately high levels of unmet health needs (Fleming et al., 2022). These inequities show the failure to apply universal and inclusive design principles across schools, clinics, and digital spaces operates as a pathway for environmental inaccessibility to be biologically incorporated as preventable health outcomes (Barriuso-Ortega, 2025; Iezzoni, 2024; Logie et al., 2024).

Global environmental disruptions expose how service environments shape youth health. COVID-19 lockdowns, reduced clinic hours, and public transport restrictions disproportionately affected marginalised youth, particularly NEET youth (Sultan et al., 2025; Te Hiranga Mahara - The Mental Health and Wellbeing Commission, 2022), limiting their access to contraception, STI testing, and counselling services (Huang, 2021; Tanton et al., 2021). These disruptions highlighted geographic and infrastructural vulnerabilities within the SRH service system, and reinforced the importance of flexible, resilient, and decentralised models of care, such as mobile clinics, school-based health services, and digital outreach, capable of withstanding future environmental shocks (Denison et al., 2018; Rose et al., 2024). The constraints presented by such disruption operate as both a geographic and infrastructural vulnerability while demonstrating cumulative pathways of environmental barriers and compounded exclusion during crises (MacDonald & Dixon, 2022; Obeng-Gyasi, 2023). Lastly, it also reflects the power relations between youth and adults, where the latter determines service geographies without much of the youth's input (Kang et al., 2023; Krieger, 2006).

2.3.6. Legal and Regulatory Factors

As a signatory to international policies and mandates like the CEDAW, SDGs, UN Convention on the Rights of the Child (UN Committee on the Rights of the Child (CRC), 2009; United Nations, 2014; WHO, 2021), New Zealand has a legal and ethical obligation to ensure that all women and girls, including young people and those from marginalised communities, have access to comprehensive, affordable, and non-discriminatory SRH services. In essence, legal frameworks operate as pathways that can either protect health rights or reproduce inequities through implementation gaps (Dávila et al., 2025). Persistent SRH disparities, particularly among Māori, Pacific, and LGBTQIA+ youth, signal gaps in the implementation of these commitments and raise questions about the effectiveness of current health governance structures in meeting their obligations. Who is responsible for ensuring laws translate into equitable outcomes, and whose interests are served when rights remain unrealised? (Ghebreyesus & Kanem, 2018; Guglielmi et al., 2024).

Several frameworks are in place, establishing fundamental human rights for everyone in New Zealand, including anti-discrimination protections. The Human Rights Act 1993 explicitly prohibits discrimination based on sexual orientation, sex, disability, and race, and it underpins health service obligations for equity and inclusion. The Bill of Rights Act 1990 further enshrines rights to freedom from discrimination and equal treatment before the law. Additionally, the Marriage (Definition of Marriage) Amendment Act 2013 extended marriage equality to same-sex couples, while amendments to the Births, Deaths, Marriages, and Relationships Registration Act 2021 enhanced gender self-identification rights. Within SRH policy frameworks, the Sexually Transmitted and Blood Borne Infections (STBBI) Strategy (Ministry of Health, 2023a) and Women's Health Strategy (Ministry of Health, 2023c) explicitly acknowledge equity gaps and prioritise marginalised populations, reinforcing New Zealand's anti-discrimination commitments in health service delivery.

However, legal protections do not automatically translate into equitable access; they operate through institutional implementation achieving or undermining health rights. Youth from Indigenous and ethnic minorities persistently face racism and systemic bias (Rose et al., 2024; Rose, Garrett, McKinlay, Morgan, et al., 2021). Similarly, LGBTQIA+ youth experience stigma and discrimination within clinical environments (Mehringer & Dowshen, 2019; Rose, Garrett, McKinlay, Morgan, et al., 2021), and migrants experience cultural and language barriers (Aibangbee et al., 2023). Disabled youths experience compounded by layers of disproportional provisions from mainstream healthcare (Brennand & Santinele Martino, 2022), resulting in feelings and experiences of exclusion and a lack of cultural safety. It is patterns such as these that Dávila et al. (2025) and Krieger (2021) described as cumulative pathways where legal protections intersect with economic, environmental and social determinants, which become embodied as unmet contraceptive needs, unintended pregnancies, and preventable STIs, among youth.

The disconnect between legal frameworks and lived realities reflects broader power dynamics in health governance. While youth rights are established internationally and in New Zealand (age of consent in the New Zealand Crimes Act 1961; access to contraceptive care and abortion services Abortion Legislation Act 2020); implementation remains controlled by adult-dominated institutions that often prioritise institutional convenience, parental authority, or provider discretion over youth autonomy (Cammock et al., 2018; Cashman et al., 2021; Phillips et al., 2024; Rose, Garrett, McKinlay, & Morgan, 2021). From an accountability perspective, questions arise of who holds power to enforce these rights, who gains from selective implementation, and how do youth from marginalised communities claim rights when structural barriers prevent access? Legal protections must be understood as operating pathways that either disrupt or reproduce inequities and the structural transformation that determines whose right is realised in practice (Dávila et al., 2025; Zampas & Nihlén, 2025)

2.3.7. How PESTEL domains interact to produce embodied YSRH inequity

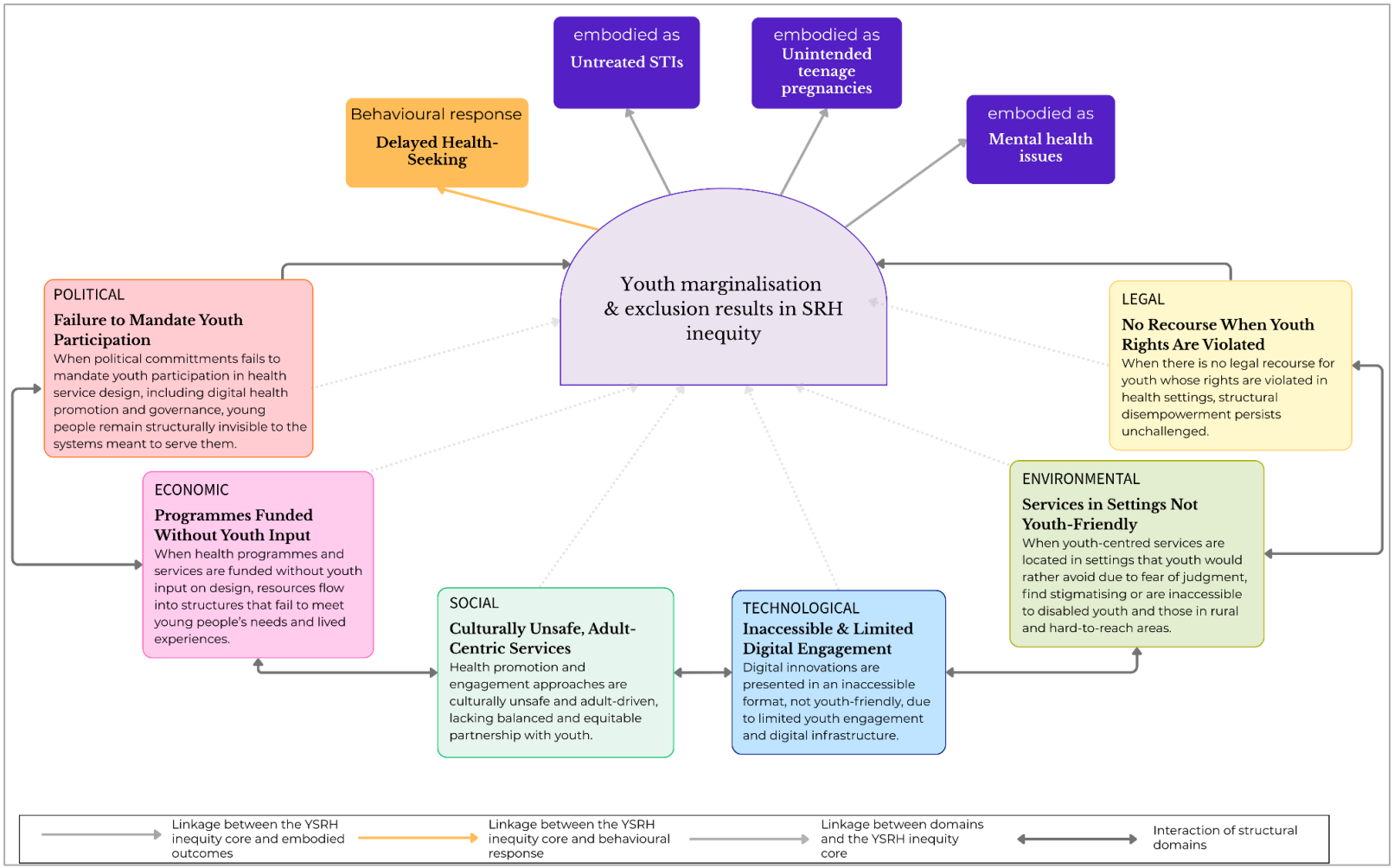
Taken together, the six PESTEL domains do not operate as isolated failures. They interact and compound one another to produce a cumulative structural environment in which young people are systematically excluded from health systems designed with them. Political neglect creates conditions for youth marginalisation and exclusion, while economic misalignment and deprioritisation entrench these conditions. Social, technological, and environmental barriers materialise at the point of care, and the absence of legal responsibility and accountability reinforces these forms of marginalisation, leaving them unchallenged. The result is not simply poor service delivery or health communication deficits; it manifests as youth marginalisation embedded across every level of the health system, driving delayed care-seeking, which is embodied in preventable SRH outcomes such as untreated STIs, unintended teenage pregnancies and mental health issues presenting as psychosocial stress, feelings of stigma and being discriminated against. See Figure 12.

An illustration of how PESTEL domains may interact to produce embodied YSRH inequity

below.

Figure 12.

An illustration of how PESTEL domains may interact to produce embodied YSRH inequity



Note: Author-generated. This conceptual map illustrates how interactions across the PESTEL domains may produce youth marginalisation and exclusion, resulting in delayed health-seeking and embodiment of SRH inequities. Adapted from Krieger's (2001) ecosocial theory of disease distribution.

2.4. Gaps in the Literature and Future Research

While policy documents like the Children's Act 2014, the Child and Youth Strategy 2024 - 2027, and the New Zealand STBBI Strategy (2023–2030) recognise young people as priority groups, the data in the public domain does not consistently reflect their commitment. Reports from the Ministries, surveillance trends, and well-being insights about young people persistently showcase the inequities faced by marginalised youth—rangatahi Māori, refugee youth, NEET youth (Aibangbee et al., 2023; Huang, 2021; PHF Science, 2024), suggesting missed connections between policymakers, providers, and the young people. Stigma and discrimination continually shape the lived experiences of these youth as gloomy and unsupported (Rose et al., 2024; Rose, Garrett, McKinlay, Morgan, et al., 2021); an outcome rooted in cultural mismatch and pervasive systemic challenges (Aibangbee et al., 2023; Cammock et al., 2018). Furthermore, the limited evidence on Indigenous knowledge health promotion contributes to young people often feeling misunderstood by providers and underrepresented across the domains of influence (Camino, 2005; Cammock et al., 2024; Rose et al., 2022).

A fundamental gap exists in understanding the mechanisms through which structural determinants become embodied as differential health outcomes among New Zealand youth. While research documents disparities across political, economic, social, technological, environmental, and legal domains, limited work examines how these factors operate as pathways individually and cumulatively to produce the biological incorporation of inequities as STIs, unintended pregnancies, and mental health impact. Particularly absent is research tracing how youth-adult dynamics across these domains compound to create conditions for preventable health risks, and how marginalised youth navigate intersecting structural barriers that accumulate across the life course. This gap in mechanistic understanding limits the capacity to design interventions that disrupt pathways of embodiment rather than merely addressing the symptoms.

Evidence also suggests gaps in longitudinal studies focused on adolescent and young people's knowledge, attitude, and perception of SRH-related topics, including STIs, information and care access (Fleming et al., 2022; Saxton et al., 2022; Stats NZ, 2023b). For instance, the 50% decline reported in the prevalence rate of teenage pregnancies in New Zealand (Stats NZ, 2023b) does not translate to improved knowledge and uptake of contraceptives among youth and adults within reproductive age (Cammock et al., 2018; Messenger Beth et al., 2021; Rose et al., 2022). Moreover, limited research examines how policy changes, as the 2020 Abortion Legislation review interacts with economic, geographic, and social barriers to shape actual access patterns, especially for rural, low-income and marginalised youth populations.

Additionally, there is a scarcity of research on youth-led and youth-centred practice in New Zealand. Several studies (Cammock et al., 2024; DeLacy et al., 2019; Goodyear-Smith & Ashton,

2019; Mehringer & Dowshen, 2019; Rose et al., 2022) revealed young people feel intimidated and judged when accessing healthcare provided by adult SRH providers, exposing a lack of genuine connection, sense of community and trust between them.

Noteworthy is research examining how adult control over health system design, from policy development to service delivery and digital platform creation and control, systematically excludes youth voice and expertise, and what models of genuine youth-adult partnerships might transform these power dynamics. Digital and technological innovations such as mobile and web-based apps, chatbots, and AI-driven social media content have proven to be useful in bridging this disconnect elsewhere (Lim et al., 2022; Serpagli & Mensah, 2021; Sewak et al., 2023; Wang et al., 2022); however, New Zealand appears to be lagging. Furthermore, limited evidence abounds on how digital platforms designed without youth co-creation may reproduce rather than remediate existing inequities, particularly for disabled youth requiring accessible technologies and marginalised youth concerned about privacy and surveillance.

2.5. Summary

This chapter has examined the state of YSRH in New Zealand, revealing both progress and ongoing gaps in implementation. While political commitment is evident through a range of legislations and strategies, challenges remain in translating these frameworks into practice that genuinely reflects young people's lived realities and support for youth agency. Health inequities are strongly shaped by systemic and structural barriers, particularly for Māori, Pacific, disabled, LGBTQIA+, and migrant youth, with factors such as gender, ethnicity, disability, and refugee status interacting with socioeconomic disadvantage to amplify young people's vulnerability to poor SRH outcomes and care not situated within a safe and culturally responsive context. Digital technologies and social media platforms provide new opportunities to overcome some of these barriers, particularly those associated with cost, geography, and stigma, though their impact depends on equitable access, digital literacy, and trust in providers. Ultimately, advancing YSRH requires embedding youth-led and youth-centred practices within service delivery and policy, supported by structural reform and innovative, culturally responsive approaches.

Chapter 3. Youth Voice in Sexual and Reproductive Health Promotion Using Social Media: A Critical Review

"Youth Futures work can create a more empowered youth and validate the youth voice". (Cahill, 2014, p. 488)

3.1. Introduction

Rapid global digital advancements have made it necessary for SRH information and services to adopt creative, adaptive, and engaging channels to reach young people (Abou Chawareb et al., 2025). One such channel is social media, which is continuously evolving and integral to how young people currently socialise. Leveraging these platforms to support and engage with young people so they can lead a healthy sexual and reproductive life is, therefore, critical and timely.

Discussing creative and innovative ways to engage young people foregrounds youth autonomy and youth agency (Cahill, 2014; Collura et al., 2019; Lipton, Dickinson, et al., 2025). While these concepts may be used interchangeably in health promotion, they differ analytically. The dialectical meaning of youth autonomy refers to their capacity to make self-directed choices, while youth agency denotes their ability to act individually and collectively within, against, and upon social and institutional structures (Freire, 1970; Gonzalez et al., 2020; Gonzalez et al., 2024; Tyler et al., 2020). Contemporary health promotion theories variously privilege these dimensions, with autonomy-focused models (e.g., Self-Determination Theory) insufficient to account for youth agency in structurally constrained contexts (Lipton, Dickinson, et al., 2025; Raingruber, 2014; Sharma, 2021; Tyler et al., 2020). Nonetheless, both concepts are underpinned by critical youth voice, which this second literature review chapter focuses on.

This chapter elaborates on the theories and terms associated with health promotion and YSRH promotion in the light of youth autonomy and youth agency. It explores how the concept of critical youth voice challenges traditional YSRH promotion strategies within global and New Zealand landscapes, identifying how policies and perspectives shape youth engagement. Balancing this shift within the rapidly evolving digital age, the review also explores the intersection of critical youth voice and social media, and how these digital platforms serve both as a space and a tool for facilitating youth agency in New Zealand's YSRH environment.

Relevant literature that explores power dynamics, participation, voice, and identity of young and marginalised groups such as Māori, Pasifika, LGBTQI+, and youth in poverty, and how these contribute to YSRH outcomes in New Zealand, were identified and reviewed. It included peer-reviewed articles, grey literature from global organisations like the WHO, and briefs and reports from government and non-governmental agencies. This helped capture information from news articles, blogs, government and institutional websites, conference papers, and policy documents. Online databases searched included Scopus, CINAHL, Web of Science, Medline via EBSCO, and Google

Scholar. For policy documents, the Overton database proved a valuable resource. While preference was given to publications after 2020, a few notable and critical publications that preceded this timeline were included in the review. The search strategy adopted keywords such as ‘sexual health’, ‘reproductive health’, ‘social media’, ‘health promotion’, ‘youth’, ‘youth sexual and reproductive’, health outcomes, ‘service providers’, ‘New Zealand’, ‘Aotearoa’, ‘Australasia’, ‘OECD’. A critical youth lens shaped data interpretation, highlighting how adult-centric led systems and practices either promote or constrain YSRH and well-being in a digitally active world.

3.2. Health Promotion and Youth Sexual and Reproductive Health Promotion

As a key concept in public health, health promotion gained its collective defining framework from the 1986 Ottawa Charter for Health Promotion, ‘as the process of enabling people to increase control over, and to improve their health’ (Nutbeam & Kickbusch, 1998; WHO, 1986). Different timelines and definitions have shaped health promotion practice, with commonalities in improving health through a systematic and multifaceted approach, as documented by various authors (Liu et al., 2024; Raingruber, 2014; Sharma, 2021). Figure 13 outlines the timeline of major achievements that have shaped the definition and practice of health promotion.

Figure 13.

Timelines defining health promotion concepts and practices globally

Note: Author-generated. The figure summarises major timelines that have shaped health promotion concepts and practices globally

Further to the Ottawa Charter was the Jakarta Declaration, which set the precedent for health promotion in the 21st century and posited that effective health promotion strategies have the potential to initiate the development and change in lifestyle, which directly impacts the social determinants of health (Nutbeam & Kickbusch, 1998; WHO, 1997). While the Ottawa Charter articulated the foundational principles and action areas of health promotion, the Jakarta Declaration reframed these priorities for a globalised and increasingly market-driven, people-centred health landscape, emphasising the importance of investment and action (see Figure 14). As a result, health promotion extends beyond an exclusive focus on individual-level determinants of health such as age, gender, genetics, individual health behaviour and lifestyle—diet, smoking habit—to encompass actions that address social (e.g., local networks and support systems), environmental (e.g., air quality, climate change), and economic (e.g., income status, poverty index) determinants of health, which is broader and applies to context and community level factors (Nutbeam & Kickbusch, 1998; Nutbeam & Muscat, 2021; Smith et al., 2006).

Figure 14.

Aligning priority areas identified in the 1986 Ottawa Charter (inner ring) and the 1997 Jakarta Declaration (outer ring)

Note: Author-generated. Aligning the foundational principles from the Ottawa Charter with the Jakarta Declaration, globalised health promotion efforts are a collective investment and action that expands beyond individual-level determinants to address contextual determinants.

From advocating for an enabling environment to improving the resourcing and financing of health promotion programmes, these priorities strengthen the need for sustained investment in youth-centred interventions, which often suffer from short-term, project-based funding despite long-term outcomes. In principle, the priority focus areas mark a positional shift, from perceiving the community as a fixed location to recognising it as a network of people, coalitions, and multi-sectoral partnerships. This reframing positions digital platforms, schools, community settings, and youth-focused organisations not as separate spaces but as an interconnected ecosystem that centres youth voice and supports youth agency. This kind of ecosystem is what was described in the UK study that involved young people and adults to co-create a peer-led digital space for young people to share and learn about their sexual health (Hirvonen et al., 2021; Purcell et al., 2023)

Following the 1986 Ottawa Charter, the definition of health promotion suggests that personal skills affect one's ultimate health outcome: 'control over, and improve their health'. The Jakarta Declaration extended this definition to include systems and structures, including legal, political, and environmental institutions, as well as infrastructure, to empower individuals and communities. This shift moves from deficit-based risk education models to one that enables meaningful youth participation. Furthermore, beyond treating illness through health services, the Jakarta Declaration calls for a system-wide architectural framework that integrates digital health systems, youth-friendly services, school health linkages, and policy frameworks, creating an enabling environment for young people to thrive.

Nonetheless, in applying these priorities to youth health promotion, specifically in relation to their autonomy and agentic positions, the Ottawa Charter priority areas emphasise government responsibilities and regulations over shared governance with young people regarding their SRH. Further, while the Jakarta Declaration attempted to address this limitation by including corporations, media, NGOs, and international actors in the critical role they play in health outcomes, these structures and actors are mostly adult-led and under-scrutinised in terms of their power balance with youth. These are some of the critical issues raised by Cahill (2014); Gonzalez et al. (2020); Lerner et al. (2005); Lerner et al. (2021); and Lipton, Dickinson, et al. (2025), to name a few, on the challenges of structural actors to meaningfully engage with young people as partners and equal decision-makers on matters affecting them.

While the 1986 Ottawa Charter and the 1997 Jakarta Declaration have set the standard for how health promotion should be designed and targeted, this has not necessarily translated into practice in the current era. Neither has holistically addressed how youth participation should work in health promotion. Important to note also is that while the Ottawa Charter creates the foundational principles that guide health promotion, the Jakarta Declaration's emphasis on partnerships and investments can create room for more power imbalance because the youth voice is still being instrumentalised rather than genuinely empowered and supported to thrive in its own way (youth autonomy and youth agency).

In considering YSRH promotion, the literature search did not yield a universal definitive statement on what this phrase means; however, drawing on the literature consulted in this review (Nutbeam & Kickbusch, 1998; Nutbeam & Muscat, 2021; Raingruber, 2014; Sharma, 2021; Smith et al., 2006; WHO, 1997), YSRH promotion can be summarised as,

> *carefully designed, youth-centred and participatory processes that enable young people to collectively and individually increase control over the social, structural, and systemic determinants of their sexual and reproductive health outcomes within contexts shaped by adult-youth power relations through coordinated educational, policy, organisational, regulatory and environmental actions, with the explicit aim of advancing equity, rights and well-being.*

In principle, such health promotion activities are conceived as co-constructed with young people, whose participation extends beyond consultation to engagement as knowledge producers, self-experts, co-designers, and co-researchers, as well as decision-makers in the design, implementation, and evaluation of the SRH intervention. This framing deliberately resists narrowly defining YSRH as simply 'informing or educating young people about sex and reproductive health'. Instead, it positions YSRH as a socially produced phenomenon shaped by gendered norms, stigma, and culture. It is also a politically governed agenda that determines the age of consent, frames and regulates policies and laws, and is heavily involved in funding decisions. Further, it situates it as an institutionally mediated activity through schools, digital platforms, youth-led and youth-centred organisations, and SRH services.

In summary, Table 5 outlines the key differences between health promotion and YSRH.

Table 5.

Key differences between health promotion and YSRH promotion

Feature	**Health promotion**	**YSRH promotion**
Target	General population, framed within the population or community level	Adolescents, young adults under 25 years and sometimes older, to include youth within reproductive age
Focus area	Broad determinants of health, including social, economic, environmental, political, legal, as well as health equity and overall well-being	Sexual and reproductive needs, relationship and sexuality education, contraception, STDs and STIs, gender and sexual identity, informed consent
Strategy	Multisectoral and intersectoral, policy legislation and regulation, environmental sustainability, equity	Peer engagement, including peer influencing, awareness and educational campaigns, service access and uptake, mostly within adult-led systems and structures
Principles	Equity, empowerment, collaboration, and community development	*The ideal* - Youth autonomy and agency, confidentiality, participation through co-creation, cultural reciprocity

Feature	Health promotion	YSRH promotion
		In practice, participation via consultation, professional authority (conflicts with youth autonomy and agency), and cultural awareness
Implementation	Government-led health systems, private organisations and CBOs	Adult-led institutions, involving youth in a tokenistic manner rather than enabling shared governance
Indicators	Population-level indices, service utilisation trends, risk factor mitigation and reduction, alignment with international rights and frameworks, and equity measures	STI incidence and prevalence rates, teenage pregnancy rates, service access and uptake trends, knowledge and behavioural outcomes

These differences establish the need to reimagine YSRH promotion in contemporary contexts, by making the deliberate shift from adult-designed to youth-led and youth-centred, from instructional and authoritative to meaningful and balanced participation, from clinic-based and face-to-face to hybrid and digitally mediated, and from fear-based risk reduction to approaches that support youth empowerment, autonomy, and agency.

3.2.1. Health Promotion Models and Theories – An Overview

Having established what health promotion and YSRH are, it is important to understand how health promotion is conceptualised and translates into practice. This section provides a brief, selective review of key health promotion models and theories relevant to youth empowerment, youth autonomy, and youth agency that scholars and practitioners have developed over time. Such models and theories provide a structured way to understand where, how, and for whom health promotion interventions are designed and delivered (Sharma, 2021).

Importantly, health promotion theories differ in how they conceptualise agency, assign responsibility for health, and engage (or not) participation and power. These differences foreground the need for critical considerations when addressing youth-related health topics. Commonly cited models and theories cover behavioural theories, intervention-based models, environmental and ecological frameworks, and communication theories, which cut across several disciplines and fields of practice (Raingruber, 2014; Sharma, 2021). Within this landscape, an increasingly influential model of practice is youth-centred frameworks such as the Positive Youth Development (PYD) framework, and its critical extension, the CPYD framework, as articulated by Richard Lerner and Maru Gonzalez in their respective works with colleagues (Gonzalez et al., 2020; Gonzalez et al., 2024; Lerner et al., 2023; Lerner et al., 2005; Lerner et al., 2021). Other scholars who have made significant contributions to youth voice are Janine Cahill and Caitlin Cahill, who established the importance of enabling youth voice, participation, and power dynamics within adult-dominated systems (C. Cahill, 2016; J. Cahill, 2014). While PYD is grounded in strengths-based developmental traditions, its critical extension

draws on Paulo Freire's (1970) theory of critical consciousness, a pedagogical paradigm focused on dialogue, power, and collective action. However, because this review is limited to foundational health promotion models, Table 6 prioritises a comparative, high-level overview over in-depth discussion, examining their alignment with youth autonomy and youth agency.

Because health promotion models have proven insufficient to fully theorise youth autonomy and agency, it is necessary to engage further with literature that explicitly interrogates power, voice, and agency in youth-related contexts. This is examined next (after Table 6), beginning with the conceptualisation of the youth empowerment movement and further exploring how issues of power and participation have shaped health promotion practices and youth-adult relationships.

Table 6.

A selective and comparative overview of models and theories of health promotion and their alignment with youth autonomy and agency (Haugan & Eriksson, 2021; Raingruber, 2014; Sharma, 2021)

Model / Theory	Alignment*	Rationale explaining the alignment	Notable scholars
Behavioural Change Models			
Health Belief Model	Low	While popular and often referenced in health promotion interventions, this model positions youth as passive recipients of expert knowledge. It lacks a participatory or co-creative inclination in its construct, as it individualises responsibility for health. It does not account for the structural, relational (power), and developmental contexts that these young people navigate in their SRH.	Irwin Rosenstock (1966). Becker and colleagues, 1970s–1980s
Theory of Planned Behaviour, an extended version of the Theory of Reasoned Action	Low	Widely used to predict health-related behavioural change, it conceptualises behaviour as an outcome of individual intention shaped by attitudes, subjective norms, and perceived behavioural control. It frames social factors as the perceived expectation of others (e.g., family members, peers, etc.), privileging individual intention while ignoring other factors that limit young people's capacity to act. Evidence from youth-centred and health promotion studies (Aibangbee et al., 2023; Cammock et al., 2023; Dávila et al., 2025; Dryjanska et al., 2025; Engel, 2023) shows that health behaviours are shaped by structural, social, economic, and environmental determinants of health, which could be beyond an individual's control.	Fishbein and Ajzen (1975); Ajzen (1985).
Social Cognitive Theory	Low	Theorises that individuals learn through observation, imitation, and role-modelling. While this may hold for individual youth and supports human agency and self-efficacy, it falls short of capturing the collective activism of young people who initiate, challenge, and sustain behavioural change within and against structural and institutional constraints.	Bandura 1989, Whitehead 2001 (Nursing practice)
Self-Determination Theory	Moderate	While it addresses the need for competence and capacity to interact, and for an individual to have the autonomy to initiate action and manage one's behaviour, the power of interpretation lies with an authority figure, often an adult, who is considered above the client and holds the professional lead. Therefore, it is weak on the collective, political and structural support for youth agency.	Deci and Ryan, 1985
Intervention-based Models			

Model / Theory	Alignment*	Rationale explaining the alignment	Notable scholars
Tannahill's Model (original 1980 and revised in 2009)	Moderate	With later refinements, this health promotion model remains highly relevant to action research and community-based participatory research, incorporating social determinants, equity, and participation (Raingruber, 2014; Sharma, 2021). It moves beyond educational or service-based interventions to facilitate a conceptual space for community engagement; yet it still lacks in conditioning youth agency to adult-led designs and implementation (Arnold & Silliman, 2017; Collura et al., 2019), thereby having limited recognition of young people as capable of shaping structures and their meaningful participation in decision-making processes in ways that reflect their autonomous and agentic positions (Burkhard et al.; Cahill, 2016; Cahill, 2014).	Tannahill 1980; 2009
The Behaviour Change Wheel (BCW) (2005 and 2011)	Moderate	Conceptualises behaviour change as the primary and intended outcome of interventions designed and implemented by adult professionals (D'Lima et al., 2020; Michie et al., 2011). Even when interventions are directed at young people, decision-making, starting from problem framing, the intervention logic, and policy outcomes, is primarily adult-led (Carney et al., 2016). As with the previously discussed models, it weakly recognises young people as knowledge custodians and self-experts. Consequently, youth agency becomes a tool within the predetermined intervention design, rather than engaging young people as co-stakeholders with shared governance in problem framing, collective action, or structurally transformative participation.	Susan Michie and co-authors across series of publications, 2005, 2011
Information-Motivation-Behavioural Skills Model	Low	The model supports competence building by emphasising access to information, motivation and behavioural skills as pre-determinants of the behavioural change. However, it is mainly intervention-driven, with adults conceptualising the problem, determining behavioural change pathways, and defining success criteria. Youth agency is considered a condition and an instrument for acquiring skills and the motivation for behaviour change, rather than as a tool for initiating collective, political, and structurally situated action.	Fisher and Fisher, 1992
Communication Theories			
The Diffusion of Innovations Theory	Low	Relevant to health promotion in its use of electronic media and informatics, making it more relevant in this age of rapid proliferation of digital technology. Its limitations lie in categorising innovation adoption on an individualised basis, rather than as co-creators or agenda setters. These categorisations are not viewed through the critical lens of power dynamics, participation or structural constraint; therefore, they are limited in theorising youth voice or collective agency.	Rogers, 1962; Glanz, Rimer and Lewis, 2002

Model / Theory	Alignment*	Rationale explaining the alignment	Notable scholars
Information-Motivation-Behavioural (IMB) Skills	Moderate	As a theoretical concept, it emphasises developing competence and behavioural skills through personal motivation and access to information. While it favours individual capacity building, youth agency largely remains conditional and instrumental, framed around compliance with externally defined behavioural goals rather than transformative, collective, or youth-led action.	Fisher and Fisher, 1992
Freirean Model of Critical Pedagogy	Strong	Positions learners, youth in this case, as political subjects capable of dialogue, resistance, and collective action. Fosters youth agency by facilitating communication in a dialogic, not transmissive, manner. Knowledge production is actualised as a political and collective action.	Freire, 1970
Environmental and Ecological Models			
The Social Ecological Model	Strong	It focuses on the interdependence of individuals and the context in which they function. The theory functions as a multi-level system with strong structural framing around youth agency, especially when combined with participatory or critical approaches or youth-centred theories, such as Zimmermann's. It does not account for the influence of growing up in the digital age (Ranatunga & Priyanath, 2025). The recent revision by Jessica and Jonathan (2023) incorporates a techno-subsystem, or virtual microsystem, that may, to some extent, address this limitation, but it remains under-tested, particularly in the context of YSRH promotion.	Bronfenbrenner (1977). McLeroy et al., 1988
The Salutogenic Theory 1996	Moderate	As a theory, it positions individuals as active agents who can navigate stressors and orient themselves toward good health, rather than as passive recipients of risk-reduction strategies. It deprioritises disease risks and enhances comprehension, manageability and meaning-making as central to health and well-being. While it shifted decisively from a deficit-based approach, it has limited consideration of power relations, adultism, and collective youth voice, especially in how it influences health promotion practice. Thus, while it favours youth autonomy, it limits youth agency.	Antonovsky, 1979, 1996
Youth-centred Frameworks			
Youth Empowerment Framework	Moderate	Serves as a fundamental concept in the theorising of youth-centred frameworks like the PYD and CPYD. Emphasises leadership, participation, and capacity building, and has significantly contributed to the shift from deficit-based framing of young people to their agentic capability, competence, and empowerment as citizens who can influence social change in their lives and communities through interpersonal	Rappaport, 1987; Whitmore, 1988; Zimmerman, 1995; Holden et al., 2004

Model / Theory	Alignment*	Rationale explaining the alignment	Notable scholars
		and political relations. Despite this development, youth agency may remain adult-led, state-controlled and outcome-driven unless it is embedded in critical theory.	
Positive Youth Development	Moderate	As a youth-centred framework, it recognises that individual assets such as competence, confidence, connection, character, caring, and contribution are crucial to positive development. However, it is considered less critical of power relations, adultism, and structural injustice (Arahanga-Doyle et al., 2019). Youth agency is evident at the interpersonal level, and not through collective action.	Richard Lerner and fellow scholars, 2005, 2021, 2023, 2025
Participatory Action Research (PAR) / Youth Participatory Action Research (YPAR)	Strong	Fundamental to co-design and co-creation because young people are positioned as knowledge producers and decision-makers. Youth agency is enacted through praxis, dialogue, and shared governance rather than consultation or tokenistic engagement.	Freire, 1970; Cornwall, 1995; Cahill C., 2016; Cahill J., 2014; Cahill H. and Dadvand, 2018
Critical Positive Youth Development (CPYD)	Strong**	CPYD explicitly critiques power, inequality, adultism, and structural constraints shaping youth-oriented relationships, whether youth-led and/or youth-centred (Akom et al., 2008; Gonzalez et al., 2024). As a justice-oriented framework, it provides a critical lens for examining adult-youth interactions, emphasising shared governance, reflexivity and enabling the conditions for young people to thrive in their autonomous and agentic realities through meaningful participation, and not mere symbolic characterisation. This study adopts CPYD as the preferred theoretical framework because it aligns with the methodological approach employed: analysing adult-provider narratives through a critical youth lens to interrogate and understand how youth autonomy and agency are constructed, enabled, or constrained within social-media-based YSRH promotion. The application of the CPYD framework was applied in the development of the artefact, 'the Youth-Adult co-design model for digital YSRH promotion' (see Chapter 7).	Ginwright, 2011; Ginwright and Cammarota, 2013; Gonzalez et al., 2020; Gonzalez et al., 2024

Author synthesis. **Preferred framework for this study. *Alignment categorisation with youth autonomy and youth agency: Low = no attribution to youth autonomy and youth agency; Moderate = some attribution to either youth autonomy or youth agency; Strong = High attribution to youth autonomy and youth agency)

3.2.2. Overview of Youth Empowerment

Early scholarship by Rappaport (1987) and Whitmore (1988a, 1988b) articulated empowerment as a concept that enables individuals and communities to have control over themselves and the contextual factors that shape their lives. It is widely conceptualised as a process rather than an outcome across the literature, with emphasis on shifts in the dynamics associated with power, capacity, and control (Htong Kham & Ng, 2025; Kabeer, 1999; Perkins & Zimmerman, 1995; Planas-Lladó & Úcar, 2024; Postmus et al., 2013; Ranatunga & Priyanath, 2025; Whitmore, 1988b; Zimmerman, 2000). Historically, as a concept, it was commonly applied in adult-oriented research and policy contexts (Planas-Lladó & Úcar, 2024; Ranatunga & Priyanath, 2025); however, more recent literature has increasingly legitimised and refined its application in youth studies, recognising young people as active social actors rather than passive recipients of intervention (Htong Kham & Ng, 2025; Planas-Lladó & Úcar, 2024). The shifts in definition and application more closely aligned it with Paulo Freire's (1970) critical pedagogical discourse on dialogue, power, and collective action for social change.

Foundational work by Zimmerman (1995, 2000, 2018) and later scholarship by Cahill (2016), Cahill and Dadvand (2018), Cahill (2014), Perkins and Zimmerman (1995) have been instrumental in conceptualising 'youth empowerment' as a theoretical construct, thereby establishing young people's agency, engagement, and participation in efforts to improve their own circumstances and those of their communities. Notably, Zimmerman's theoretical stance takes root in Bronfenbrenner's (1979, 1994) ecological systems theory, which situates young people's development within their interconnected systems, including family, peers, schools, institutions, and broader sociopolitical contexts (Htong Kham & Ng, 2025; Raingruber, 2014; Sharma, 2021), highlighting the importance of context in shaping young people's opportunities to exercise power and agency. Given its conceptual strengths, empowerment has been applied across multiple disciplines and fields of practice, contributing to its persistent ambiguity and varied interpretations (Nussbaum, 2009; Postmus et al., 2013; Ranatunga & Priyanath, 2025; Úcar Martínez et al., 2017).

Empowerment and youth empowerment are consistently discussed through a shared set of conceptual keywords that reflect both analytical and applied dimensions. Commonly searched and used terms include 'types of empowerment', determinants and dimensions of youth empowerment', and 'theoretical models and constructs of empowerment', all of which reflect how scholars refine, conceptualise, operationalise, and address the term across contexts (Perkins & Zimmerman, 1995; Planas-Lladó & Úcar, 2024; Ranatunga & Priyanath, 2025; Zimmerman, 2000). Within youth-focused scholarship, empowerment is frequently associated with positive youth development, youth power, youth voice, youth participation, youth engagement, youth agency, youth governance, youth activism, and youth organising, signalling a shift from individual capacity building towards relational, collective, and political understandings of young people's roles in social change (Cahill & Dadvand,

2018; Cahill, 2014; Ginwright & Cammarota, 2007; Gonzalez et al., 2020; Russell et al., 2009; Úcar Martínez et al., 2017).

While youth empowerment has advanced the cause of young people towards increased participation, capacity building, and engagement, Planas-Lladó and Úcar (2024) and Htong Kham and Ng (2025) have demonstrated that these changes are not automatic, especially within adult-led, state-controlled or top-down systems that challenge youth autonomy and agency. Consequently, such constraints further widen the gap between meaningful participation and genuine empowerment (Arnold & Silliman, 2017; Cahill, 2016; Cahill, 2014).

In New Zealand

Youth empowerment in New Zealand dates back to the early 20th century, shaped by colonial history, faith-based social action, Indigenous youth development traditions and, much later, by state-led youth policies (Arahanga-Doyle et al., 2019; Nairn et al., 2021; Society of St Vincent de Paul in New Zealand). Like other trajectories of empowerment, early youth involvement in social change in New Zealand was largely adult-organised and welfare-oriented, mostly through church activities and volunteering initiatives. These approaches often presented young people as disadvantaged, marginalised, or at-risk, requiring guidance and protection, rather than as individuals or collective social actors capable of shaping social change (Appleton, 2003; Society of St Vincent de Paul in New Zealand; Watt, 2003). The impact of colonisation, land dispossession, and imposed education and justice systems on the Indigenous people of New Zealand further heightened the systems and structural inequalities, shaping contemporary youth experiences and opportunities for empowerment (Goodyear-Smith & Ashton, 2019; Phillips et al., 2024; Sheridan et al., 2011)

By the late 20th century, youth empowerment discourse in New Zealand gradually shifted toward participation, rights and strength-based development, resulting in the establishment of the Ministry of Youth Affairs in 1989 and the Youth Development Strategy Aotearoa in 2002 (Appleton, 2003; Watt, 2003). During this period, youth activism and organising became more prominent, with young people engaging in political movements that challenged the dominant social and institutional order, often operating within and against formal structures of participation (Baxter et al., 2015; Nairn et al., 2021). Regardless, authors like Garrett et al. (2020); Goodyear-Smith and Ashton (2019); and Rose et al. (2024) have documented that in practice, youth empowerment remains uneven, with adult-defined agendas, institutional constraints, and policy timeframes that limit the depth of youth influence over decision-making and social change.

To address these limitations and ambiguity, conceptual analyses by some authors have sought to unpack empowerment as a multidimensional construct (Cavalieri & Almeida, 2018; Kabeer, 1999; Planas-Lladó & Úcar, 2024; Ranatunga & Priyanath, 2025). However, even within these frameworks, young people are still characterised as marginalised or at-risk populations and remain frequently framed through adult-defined priorities and outcomes (Russell et al., 2009; Úcar Martínez et al.,

2017). These critiques have prompted a move towards youth voice, which is beyond tokenistic participation or symbolic expression, to a form of power that thrives in its own agency, is recognised as a knowledge expert, and can influence and make decisions within youth-adult relationships despite prevailing contextual constraints (Ardizzone, 2007; Cahill, 2014; Fassett et al., 2025; Liebenberg et al., 2020; Palacios & Allen, 2019). Such a shift lays the groundwork for youth voice and other critical youth frameworks.

3.3. From Youth Empowerment to Youth Voice

Building on these critiques, this section moves beyond empowerment frameworks to examine youth voice as a distinct analytical construct, focusing on how power, legitimacy, and decision-making authority are negotiated within youth-adult relationships, particularly in health promotion contexts. Unlike empowerment, youth voice signals the legitimacy of young people's perspectives; their authority to name problems; and their ability to shape decisions within social, political, and institutional structures (Cahill, 2014; Ginwright & Cammarota, 2007; Palacios & Allen, 2019). Youth voice, therefore, moves beyond participation as inclusion toward an understanding of voice as relational, political, and structurally mediated. It draws attention to how young people's contributions are enabled, filtered, or silenced through adult-controlled processes, timelines, and norms, and whether opportunities for expression translate into influence and change. Following this reasoning, youth voice is not merely speaking or being heard, but concerns power, recognition, and the redistribution of decision-making authority within youth-adult relationships.

This conceptualisation builds on critical theory, particularly the scholarly foundation established by Paulo Freire (1970), which situates youth voice within broader struggles over power, domination, and social transformation. Freire's concept of critical consciousness emphasises dialogue, power sharing, and collective action as necessary conditions for oppressed groups to recognise and challenge the structural forces shaping their lives. This extends into the construct of the CPYD framework by Gonzalez et al. (2020) as a theoretical and analytical concept, which rejects the deficit and protectionist position over young people, presenting them as capable political subjects whose knowledge and experiences are central to processes of change. Therefore, critical youth scholarship reframes youth voice not as consultation or expression alone, but as a relational and political practice through which young people interrogate power, resist adultism, and participate in transforming the social and institutional conditions that apply to them (Ardizzone, 2007; Cahill & Dadvand, 2018; Fassett et al., 2025)

With the understanding of critical consciousness and the conceptualisation of youth voice as relational, political and power-laden, CPYD emerges as a framework that operationalises these principles within youth development and health promotion contexts. It arises from the convergence of critical pedagogy, social justice traditions, youth empowerment theory, and strengths-based youth

development (Arnold & Silliman, 2017; Ginwright & Cammarota, 2002; Gonzalez et al., 2020; Perkins & Zimmerman, 1995). Extending earlier PYD approaches (Lerner et al., 2005; Lerner et al., 2021; Tyler et al., 2020), CPYD explicitly centres youth voice, collective agency, and equitable youth-adult power sharing, while foregrounding the structural conditions that shape young people's opportunities to act. In this way, CPYD reframes young people not as passive recipients of services or ordinary participants in adult-designed interventions, but as co-creators of knowledge and agents of change whose experiences and critical perspectives are essential to shaping meaningful and just outcomes (Cahill, 2016; Cahill, 2014; Gonzalez et al., 2024). By embedding Freire's emphasis on dialogue, power dynamics, and collective action within a youth-centred developmental framework, CPYD provides a theoretically coherent lens for examining how youth voice is enabled, negotiated, and regulated within adult-dominated systems, including YSRH promotion.

Within the CPYD framework, youth voice and agency are operationalised through an expanded articulation of individualised assets captured in the revised 7 Cs: competence, character, connection, confidence, caring, contribution through critical action, and critical consciousness (Arnold & Silliman, 2017; Gonzalez et al., 2020; Gonzalez et al., 2024). The 7 Cs is a modification of the 5 Cs previously outlined by Lerner et al. (2005). This expanded model deliberately foregrounds the political and collective dimensions of youth development by centring critical consciousness and contribution through action. These additions reflect a shift from viewing youth development primarily as individual capacity-building toward understanding it as a process embedded in social relations, power structure, and opportunities for collective engagement. Based on the arguments of Arnold and Silliman (2017), Cahill and Dadvand (2018), and Gonzalez et al. (2020), and situating the shift within the YSRH promotion context, the 7Cs provide a lens for examining how young people's knowledge, experiences, and critical perspectives are recognised and mobilised or marginalised within adult-led interventions, particularly in digital spaces where youth participation is often visible, but influence over content, narratives, and decision-making remains uneven.

Based on the CPYD framework, shifting from empowerment to youth voice reflects a deeper recognition that participation and capacity building are not enough, and more attention needs to be given to power, legitimacy, and influence within youth-adult relationships. Examining CPYD through the Freirean lens provides the platform for interrogating how youth voice is constructed and negotiated in practice. It also establishes the theoretical lens for subsequent analysis, which explores youth voice within New Zealand's adult-dominated health promotion systems.

3.4. Critical Youth Voice and Youth Sexual and Reproductive Health Promotion in New Zealand

Increasingly, youth empowerment in New Zealand has intersected with health promotion and well-being discourse, particularly through relational and holistic approaches grounded in mātauranga

Māori and rangatahi voice (Carlson et al., 2022; Stubbing & Gibson, 2021; Te Hiranga Mahara - The Mental Health and Wellbeing Commission, 2022). Drawing on the work of Arnold and Silliman (2017), Cahill (2014), Chadha and Jha (2025), and Decker et al. (2022), it is evident that youth empowerment in health promotion practice, including YSRH initiatives, is often uneven, shaped by adult-dominated systems that constrain youth influence by maintaining professional control over agendas, processes, and intervention design. This gap underscores the need for critical youth-centred frameworks that move beyond participation toward analysing how youth voice is enabled, constrained, or mediated within adult-led health promotion context, an imperative that directly informs the analytical orientation of this study.

3.4.1. Adult-led Health Systems and Their Limits on Youth Agency

Despite the increasing recognition of youth-specific needs in SRH, many SRH institutions in New Zealand remain predominantly adult-led both in structure and in practice. These organisations, often driven by professional expertise and biomedical authority, tend to adopt top-down models of care and decision-making that can inadvertently exclude or marginalise the voices of the very youth they aim to serve (Garrett et al., 2020; Rose, Garrett, McKinlay, Morgan, et al., 2021).

Viewed through a CPYD lens, this adult-centric system contrasts with partnership and co-leadership between adults and youth (Lerner et al., 2021; Tyler et al., 2020). CPYD underscores the importance of critical consciousness and power-sharing, calling for adult SRH providers to actively engage with youth in shaping those services (Gonzalez et al., 2020; Lerner et al., 2005). However, in practice, opportunities for such collaboration remain limited, especially in New Zealand. While organisations such as YOSS offer a more holistic, youth-friendly approach, their structures are still embedded in adult decision-making hierarchies and resource limitations (Garrett et al., 2020).

The implications of this are evident in how youth perceive and engage with health systems and structures. Studies have shown that young people often report fear of judgment, lack of trust, and a sense of being patronised by adult service providers (Rose, Dunlop, et al., 2024; Rose, Garrett, McKinlay, Morgan, et al., 2021)). These perceptions reduce their willingness to seek care, especially for sensitive issues like contraception or STI testing. Māori and Pacific youth, in particular, have highlighted how mainstream services often fail to reflect their cultural values and ways of knowing, reinforcing their alienation and reducing service uptake (Rose, Dunlop, et al., 2024). Moreover, the structure of most health organisations does not provide sustained platforms for youth to participate meaningfully in design, implementation, or evaluation (Lipton, Dickinson, et al., 2025; Ministry of Health, 2009).

Similarly, examining the 2023 New Zealand Health Strategy and other government frameworks from a critical perspective, they often lack explicit direction for incorporating youth-led digital health approaches. This gap highlights a significant disconnect between traditional, top-down healthcare models and the cultural shift required to meet the lived realities of young people. Thus,

while adult SRH providers play an essential role in ensuring health promotion interventions are targeted and inclusive, their dominant position within SRH systems must be critically interrogated.

3.4.2. Beyond Reach: Systemic Barriers to Youth-centred Healthcare in New Zealand

Barriers do not emerge in isolation but are produced through the organisational, professional, and policy logics of adult-led health promotion systems which risk management, efficiency, and accountability in ways that often marginalise youth voice and realities. Several studies (Garrett et al., 2020; Phillips et al., 2024; Rose et al., 2022) have established that providing accessible and equitable sexual health care is challenging for all stakeholders, including New Zealand youths. The inequity is much more pronounced among priority population groups; that is, Māori and Pacific youths and gender-diverse youths. Further, the cost (financial and non-financial) of care and treatment is also a barrier for this group, increasing their vulnerability and worsening health outcomes. Additionally, fear of judgment and negative perceptions from service providers, family, and peers has also challenged healthcare access among youths in New Zealand. Sociocultural values, confidentiality concerns, sexual diversity, self-stigmatisation, and cost and transportation challenges are other noted barriers (Rose et al., 2024; Rose et al., 2022).

Youth care can be multidimensional, requiring integrated, multifaceted approaches that run concurrently (Ministry of Health, 2024b; Ministry of Social Development, 2024). SRH services provision in New Zealand and elsewhere, by health care specialists, youth workers, and advocates, is characterised by high needs and a large volume of administrative, non-contact work (Garrett et al., 2020). Understanding this critical balance is why YOSS in New Zealand were established. Community-based, youth-focused, and designed to encompass a wide range of in-demand services including but not limited to sexual health, reproductive health, and mental health matters, YOSS operate as independent entities yet still rely on government funding (Ministry of Health, 2009), which directly affects the amount of work these facilities can undertake.

As a ‘wraparound’ facility, YOSS work well for young people with complex needs, as they offer holistic care (Healthify, 2026); however, this can be time-intensive and requires specialist or professional care for high-needs individuals (Garrett et al., 2020; Sheridan et al., 2011; Stubbing & Gibson, 2021). This level of care drives costs and can be laborious, influencing service uptake by potential and new clients. Garrett et al. (2020) noted in their observational study that the uneven distribution of YOSS facilities in New Zealand and the high demand for their services make it challenging for young people to access the services, even in urban and metropolitan areas where they are more likely to be set up. Studies by Sentís et al. (2019) and Goodyear-Smith and Ashton (2019) support these findings.

From a CPYD perspective, these barriers indicate inequitable power-sharing and the continued dominance of adult-led models that restrict youth autonomy and voice (Arnold & Silliman, 2017; Gonzalez et al., 2024). CPYD calls for systems that promote critical consciousness, enabling

young people to recognise and challenge the structures that shape their health outcomes (Cahill, 2014; Gonzalez et al., 2020). However, the current design of health promotion within existing YSRH practice often positions youth as passive recipients of care rather than active agents in shaping service delivery (McGinn & Wise, 2024; Minister of Health, 2023). This dynamic undermines trust and diminishes opportunities for meaningful engagement, particularly where cultural safety is absent (Cammock et al., 2023; Rose et al., 2022).

In response, the literature increasingly examines participatory and digitally mediated approaches as points of analytical contrast within YSRH promotion (Goodwin & Boulton, 2024; Lim et al., 2022; Lipton, Dickinson, et al., 2025). Together, the structural constraints identified above both limit service accessibility and shape the conditions under which youth voice is recognised, prioritised, or excluded within SRH promotion systems.

3.5. Policy and Practice Response to Sexual and Reproductive Health in New Zealand

This section critically examines how policies and practices in New Zealand address the determinants of SRH outcomes among young New Zealanders. This understanding is crucial to responses aimed at addressing health inequities and inequalities in YSRH. The review also considers how policies and practices influence, or can influence, the use of social media for YSRH promotion in the country.

The established history of SRH globally and locally situates it as a widely recognised, persistent public health issue (Minister of Health, 2023; Ministry of Health, 2023a, 2023c; WHO, 2021). In New Zealand, successive strategies since the mid-1990s have articulated objectives focused on reducing STIs among young people, particularly Māori and Pacific populations and addressing unintended adolescent pregnancies (Ministry of Health, 2001, 2003, 2023a, 2023c; Ministry of Social Development, 2024). However, a growing body of literature suggests that translating these policy intentions into youth-centred and contextually responsive practice remains uneven, especially in relation to young people's cultural and digital realities (Goodwin & Lyons, 2024; Lerner et al., 2021; Liebenberg et al., 2020).

The New Zealand Health Strategy, updated in 2023, continues to set the tone for the country's health system in the following decade (Minister of Health, 2023). Its main objectives are to achieve health equity for diverse and marginalised populations and improve health outcomes for all New Zealanders. Priority is given to strategies targeting Pacific people, women, persons living with disabilities, and rural residents. While it is understandable that each of these groups includes young people, the strategy overall has not provided a focused approach to youth; instead, it suggests it complements the 2019 New Zealand Child and Youth Wellbeing Strategy. This gap reflects a broader pattern in health policy in which young people are subsumed under other population categories rather

than recognised as a distinct group with specific cultural, digital, and developmental realities (Castleton et al., 2025; González & Veale, 2025; Lipton, Dickinson, et al., 2025; Wijamuni et al., 2025)

The 2024–2027 New Zealand Child and Youth Wellbeing Strategy (Ministry of Social Development, 2024) policy document is described as the government's resource for capturing its vision and strategy for children and young people in New Zealand. It emphasises a social investment approach with targeted interventions that address the drivers of health disparities at individual, whānau, and systemic levels. Priorities include improving household income, housing stability and security, and preventing harm through cross-government efforts. Furthermore, one of its six high-level outcomes promises that young people will be "involved and empowered" in matters related to them. However, the strategy defines youth primarily as those aged 24 years old and below, excluding young adults aged 25 and over, many of whom remain sexually active and within the reproductive age bracket. This is more concerning given the high incidence rate of STIs among 20–29-year-olds in New Zealand, alongside reports of fertility complications, low uptake of family planning services and contraceptive use (Cammock et al., 2018; Mehringer & Dowshen, 2019; Ministry of Health, 2023a, 2024b; Phillips et al., 2024). Moreover, for younger youths covered by the strategy, rather than providing measures specific to their SRH, a more generalised approach to health and well-being is prescribed. This reinforces earlier critiques that youth-specific SRH concerns are frequently marginalised within broader well-being policy frameworks (Ministry of Health, 2024a, 2024b; Rose et al., 2022).

Another policy and strategy document with some level of detail on youth health and well-being is the STBBI strategy 2023–2030 (Ministry of Health, 2023a). However, it is also limited in scope, catering to youth aged 29 and younger, and categorising them as one of the seven priority groups covered by the strategy. As discussed earlier, it provides action points for the government and other actors in the SRH space to mitigate the spread of preventable sexual and blood-borne infections, as well as provide treatment and care to youth and other at-risk population groups in New Zealand. The strategy outlines actions such as strengthening surveillance and information systems, driving prevention through health promotion campaigns, reducing stigma and discrimination, and ensuring equitable access to culturally safe and responsive care. These measures remain largely adult-designed and top-down, positioning young people primarily as recipients of campaigns and services rather than active co-designers of prevention, monitoring, and care systems. These risks reproduce the familiar gap between policy ambition and the lived realities of rangatahi, particularly Māori, Pasifika, takatāpui, and migrant youth, whose voices are seldom integrated into national-level strategy (Castleton et al., 2025; Collura et al., 2019; Conn et al., 2017; Tyler et al., 2020).

The Women's Health Strategy (Ministry of Health, 2023c) was developed to ensure the health needs and experiences of all women in New Zealand are equitably addressed, fulfilling Treaty obligations to wāhine Māori and diverse women's groups. While this is a significant policy

commitment, the strategy remains largely adult-led and adult-centred with minimal reference to the young women's lived experiences (Lerner et al., 2021; Liebenberg et al., 2020). It is also good to see the commitment towards ensuring culturally responsive and safe services, gender-based care, and addressing stigma and discrimination; however, of equal importance, at least, would be the need to recognise how these experiences are different for young women in this digital age (Goodwin & Lyons, 2024; Prensky, 2001a, 2001b; Saeed & Masters, 2021).

Comparing New Zealand's youth-focused and SRH-related policies with those in other OECD countries, such as Australia, Canada, and the United States (Commonwealth of Australia, 2022; Government of Canada, 2019; Warwick-Booth et al., 2019), highlights differences in how youth participation is institutionally framed. As an example, Australia has the National Youth Policy Framework, which has been replicated by several states, like the 'Action Plan for Sexual and Reproductive Health' in Victoria, explicitly including rights-based language and intersectional frameworks that recognise age, ethnicity, gender, residence type, and geography as determinants of access to SRH services (Commonwealth of Australia, 2022; Phillips et al., 2024). While New Zealand policies clearly identify youth as a priority population group, Australian frameworks better define their mechanisms for youth partnership, including youth advisory councils that span policy design, implementation and evaluation.

In Canada, young people's participation in national SRH strategies is evident in the 2019 Canadian Youth Policy and the Sexual and Reproductive Health Fund, which sponsors youth-led, community-based activities. The Canadian Youth Engagement Framework (Government of Canada, 2019) prioritises co-ownership and co-design of SRH programmes with young people, institutionalising this across all its systems and structures. In this context, the youth participatory action research (YPAR) framework has gained popularity and effectiveness across the country and beyond.

The United Kingdom implements a curriculum-based approach to Relationships and Sex Education (RSE) alongside targeted interventions for young people (Melendez-Torres et al., 2024; Warwick-Booth et al., 2019), similar to the New Zealand RSE policy currently under review. However, critiques have highlighted inconsistent implementation and a lack of youth-led oversight (Formby, 2011; Melendez-Torres et al., 2024). While policies identify young people as a priority group, decision-making largely remains in the hands of adult experts and public health officials, reflecting similar limitations to those in New Zealand's Ministry of Health-led frameworks.

In the United States, youth SRH policy is primarily state-led, resulting in substantial variability in sexuality education and service provision (Santelli et al., 2017). Federal programmes like Teen Pregnancy Prevention and Personal Responsibility Education Program fund evidence-based initiatives, some of which incorporate co-design with marginalised youth (Decker et al., 2022). Compared with New Zealand's nationally coordinated youth health infrastructure, such as YOSS, the American model offers flexibility for grassroots innovation but remains fragmented. Both countries

struggle with institutionalising youth participation; in America, co-design is often limited to community-based and grant-funded initiatives (Guttmacher Institute, 2023), while in New Zealand, frameworks like Kaupapa Māori are inconsistently implemented (Garrett et al., 2020; Rose et al., 2024), underscoring the need for structural reforms to embed youth partnership in national and local SRH policies.

Across these OECD examples, youth marginalisation in policy development persists, even where consultation mechanisms exist. In New Zealand, as in the United Kingdom and Australia, youth are often consulted during review or implementation phases, but rarely positioned as equal policy partners in agenda setting or governance. This tokenism limits the transformational potential of co-design processes and reinforces adult-led control, especially in health systems where professional expertise dominates decision-making (Garrett et al., 2020; Rose et al., 2024).

By contrast, some OECD strategies exemplify more inclusive practices. For example, Scotland's "Year of Young People 2018" policy experiment demonstrated what youth-led health promotion can look like at scale, with national campaigns co-developed and fronted by youth panels (Scottish Government, 2019). Such a framework enables 'youth agency' by embedding power-sharing rather than treating youth voice as consultative input, aligning more closely with the CPYD principles described by Gonzalez et al. (2020).

Collectively, these policy documents reveal a consistent gap between recognising youth as a priority population and the mechanisms through which their participation is operationalised. While policies increasingly acknowledge social and structural determinants of YSRH, they remain limited in addressing how youth voice and agency are embedded within contemporary, digitally mediated health promotion environments. This missing link underpins the following section, which examines social media not simply as a communication tool but as a contested space where youth agency, participation, and power are negotiated in practice.

3.6. Social Media as a Tool for Health Promotion

In addition to policy reform and structural interventions, there is increasing recognition of the role of digital technologies, particularly social media, in shaping contemporary YRSH promotion. While often positioned as innovative tools for engagement, social media platforms are not neutral; they are embedded in existing power relations that shape whose knowledge is legitimised, whose voices are amplified, and how participation is structured. This section examines social media as a contested site of health promotion, asking whether digitally mediated participation translates into youth voice, understood as power, legitimacy, and influence over institutionally grounded SRH agendas.

Reflecting on the past 2 decades, exponential growth in digital connectivity and algorithmic capability, a trajectory further accelerated by the COVID-19 pandemic, has transformed how health

information is produced, distributed, and consumed (Flew, 2024; Mansfield et al., 2025; Mayer et al., 2016; Minister of Health, 2023). Through the evolution of Web 2.0 and the proliferation of mobile technologies, communication has shifted from largely one-directional information flow to participatory, user-generated, and data-mediated forms of engagement underlaid by algorithmic systems (Chang & Chang, 2023).

Social media platforms such as Facebook, YouTube, Instagram, TikTok, and X (formerly Twitter) have transformed how humans interact traditionally (person-to-person, traditional mail, print media, etc.) to a continuous, borderless dialogue mediated by algorithms that shape visibility, influence, and participation (Sewak et al., 2023; Wang et al., 2022). While this shift has expanded opportunities for accessing and co-creating health information, it has also introduced new forms of institutional control and exclusion issues, raising critical questions about whose voices are amplified and the extent to which young people can exercise their agency within digitally mediated health promotion spaces (Chidwick, 2023; Karra & RamaRao, 2025; Panahi, 2025). From a critical perspective, algorithms operate as a form of institutional gatekeeping that can suppress youth-generated SRH content through content moderation policies that often treat SRH content as 'adult material' and sensitive, thereby censoring its reach and constraining youth voice in digital health promotion (Albury et al., 2025).

From the literature (Decker et al., 2022; González & Veale, 2025; Klassman et al., 2024; Martin, Alberti, et al., 2020; Rose, Garrett, McKinlay, Morgan, et al., 2021), SRH providers are seen to mostly engage with young people from an authoritative position, such as service experts, caregivers, information gatekeepers, or channels for professional validation of young people's SRH concerns. This positioning reproduces an epistemic hierarchy in which biomedical and professional knowledge frameworks are accorded legitimacy, while youth experiential knowledge and peer-generated expertise remain subordinated or require adult approval. This structural positioning constrains shared authority, as young people remain positioned as knowledge recipients rather than producers within institutional SRH frameworks (Liebenberg et al., 2020; Nutbeam, 2021). Working with, rather than for, young people requires intentionality, including recognising young people as knowledge custodians of themselves and creating space for them to thrive in the change process (Gonzalez et al., 2020; Martin, Cousin, et al., 2020).

Within mainstream health promotion literature, social media is frequently positioned as a 'meaningful medium' for delivering culturally appropriate SRH messaging to young people (Rose et al., 2024; Rose et al., 2022). However, such framings typically emphasise information transmission and service accessibility constructs that position youth as consumers of adult-generated knowledge rather than as producers of SRH expertise. From a theoretical perspective, enhanced access to information does not automatically translate into youth voice or authority over institutional agendas; rather, such models may reproduce unidirectional health promotion paradigms within ostensibly participatory digital environments (Akom et al., 2008; Arnold & Silliman, 2017).

Several scholars (Akom et al., 2008; Cahill, 2014; Collura et al., 2019; Cortés-Ramos et al., 2021; Ginwright & Cammarota, 2007; Htong Kham & Ng, 2025) have positioned young people as change agents who are capable of mobilising, shaping narratives, and sustaining collective action in the community and within digitally mediated contexts. Campaigns such as Black Lives Matter, #MeToo, climate justice, and girl-child education, among others, illustrate how social media can serve as a site of political expression and collective agency. Aside from social activism, young people have also launched and promoted learning, entrepreneurial endeavours, and healthy lifestyles, including SRH-related awareness campaigns through social media platforms such as Instagram, Facebook, and TikTok (Lim et al., 2022; Liu, 2024; Serpagli & Mensah, 2021).

Within public health and health promotion contexts, scholarship documents several forms of youth health activism, ranging from community organising to digitally mediated collective action (Campbell & Cornish, 2021; Howson, 2021). Health activism encompasses collective efforts to challenge health inequalities, influence policy and improve health outcomes through community organising, advocacy, and public mobilisation (Howson, 2021; Parker et al., 2012; Surrenti & Di Felice, 2025). Digital activism, or net-activism, is an emergent form in which social media and other digital platforms enable new modes of collective action, information sharing, and channels for mounting political pressure (Campbell & Cornish, 2021; Surrenti & Di Felice, 2025).

Within the YSRH domain, digital activism has enabled movements such as the #ShoutYourAbortion campaign (Allan, 2021), where women, including young women, used X (formerly Twitter) to collectively challenge abortion stigma, resist reproductive rights restrictions, and reframe political discourse on reproductive autonomy. Scheadler et al. (2023) documented how LGBTQ+ grassroots activism against the ban on conversion therapy fostered collective resilience, enabled participants to strengthen their identities and cultivated agency and perseverance through collective action. Common to these forms of activism is the collective agency through organised action that has demonstrably influenced public health practice and policy (Ballard & Ozer, 2016; Ginwright & Cammarota, 2007; Petteway & González, 2022). For young people, it shows their capacity for political mobilisation and institutional influence when collective organising is supported through access to platforms, network solidarity, and autonomy from institutional control. A note of caution is, however, sounded by Ballard and Ozer (2016), that youth-led health activism is sometimes mediated, hence impacted by structural forces, including policy environments, resource access and institutional responsiveness, that could be beyond young activists' control. These examples demonstrate youth capacity for collective agency in health-related advocacy yet raise critical questions about whether similar capacity is recognised and enabled in adult-controlled SRH promotion contexts.

Scholarship on experiential learning and critical youth engagement suggests that agency does not emerge from participation alone, but from young people's involvement in knowledge-producing processes where they hold interpretive and decision-making authority (Cahill & Dadvand, 2018;

Cahill, 2014; Schön, 1987). Within youth studies, this position has been taken up to show that meaningful youth voice requires moving beyond consultation to shared authority in problem framing, agenda setting, and collective action for social change (Gonzalez et al., 2024; Lerner et al., 2021; Liebenberg et al., 2020). However, critical analyses by some authors have revealed that SRH providers, mostly adults, during youth engagement initiatives involved young people symbolically, not to lead or own the process, but rather to be 'used' to promote their superiority and adult realities (Akom et al., 2008; Ardizzone, 2007; Camino, 2005). In such contexts, youth were often constructed as inexperienced, uninformed, or developmentally incapable, reinforcing age-based or professional skills-based hierarchies that strengthened adult authority over youth agency.

This positioning changed significantly with the advent of the internet and other information and communication technologies (Albury et al., 2025; Chang & Chang, 2023). Young people have come to understand the potential of social participation on different social media platforms, which introduce new spaces for interaction, visibility, and collective expression. This has enabled engagement that extends beyond local and institutional boundaries, amplifying youth participation in public discourse and social change (Cortés-Ramos et al., 2021; Laor, 2022; Laranjo, 2016). At the same time, these digitally mediated environments remain structured and regulated by platform governance, algorithmic visibility, and adult-controlled norms and narratives, further raising questions about whether expanded participation truly translates into meaningful youth agency within health promotion contexts (Baraybar-Fernández et al., 2021; Goodwin & Lyons, 2024; Mansfield et al., 2025).

Recognising the transformative potential of social media and digital technology, young people are challenging the process of information sharing, daring to forge their own path by creating space for themselves or engaging with knowledge and practising experts to generate knowledge through a process of social change (Conn et al., 2017; Engel, 2023; Laor, 2022; Serpagli & Mensah, 2021; Sewak et al., 2023). As prosumers, they establish and sustain social media as a tool for information and communication, particularly for health promotion.

In developing a social media framework for youth health communication in Australia, Taba et al. (2025) used a different co-creation approach. Three iterative cycles staged input from young people and adult professionals as distinct groups, each contributing sequentially by phase rather than as joint, concurrent collaborators through the co-design process. Their exercise yielded five recommendations on how to communicate health messages succinctly to young people, centring on the efficacy of youth-adult partnerships in a non-traditional, digital setting. Separating their participation across the stages might have helped to prevent adult capture and power imbalance possible within a joint session (Camino, 2005); however, it might also have led to limited negotiation and missed opportunities that face-to-face negotiations on the framework development could have benefited from (Lerner et al., 2021; Liebenberg et al., 2020; Tyler et al., 2020).

A recent study in New Zealand by Goodwin and Lyons (2024) found that young people used an average of 7.5 social media platforms (with varying time spent), including Instagram, Snapchat, TikTok, YouTube, and several others. On these platforms, they seek to learn, socialise, and be entertained, including content prosumption (DataReportal, 2023; Pacheco & Melhuish, 2018). Further evidence gathered from these New Zealand studies (Goodwin & Boulton, 2024; Rose, Garrett, McKinlay, & Morgan, 2021; Stubbing & Gibson, 2021) showcased New Zealand youths as co-creators with adults and peers, self-experts, knowledge seekers, and informed on the importance of enabling authentic connections and trust-building over time. Recognising the limited evidence available within the New Zealand context on interventions that utilised social media for youth SRH promotion, other studies and different contexts that either applied co-design approaches in youth-adult collaborations or adopted social media as a tool on another public health issue (e.g., mental health) were considered.

In a New Zealand Ministry of Youth Development commissioned project, youth from ethnic migrant and refugee backgrounds worked with adult government staff to co-design a social innovation called ‘Connect & Kōrero’, aimed at improving youth participation in policymaking (Deane et al., 2025). Over 18 months, their interactions led to the development of the ‘Framework for Ethnic Youth Participation in Policymaking’, bringing together young people and policymakers for balanced and meaningful deliberations (Deane et al., 2023). This project provided a foundation for authentic youth-adult partnerships, opportunities for capacity building, peer support, and effective management of time and resources. It is relevant to the current study because it models the co-design process implemented through youth-adult partnerships, which is highly crucial to the success of youth-centred, digital SRH health promotion initiatives. However, the time committed to this project may not reflect the realities of a young social media prosumer's rapidly changing digital world (Conn et al., 2017; Goodwin & Lyons, 2024; Santomier & Hogan, 2013; Sewak et al., 2023).

In another study, researchers worked with a group of young people from across New Zealand to explore their views on designing youth-centred services and driving engagement (Stubbing & Gibson, 2021). In a series of collaborative workshops conducted with the researchers, the young participants identified social media and technology-based applications as effective tools for initiating early connections with service providers, establishing trust and confidence in their relationship (Goodwin & Lyons, 2024; Lipton, Dickinson, et al., 2025; Mansfield et al., 2025). Additional suggestions included using social media to promote mental health awareness and embed community-based practice through advertisements and campaigns that incorporated youth ideas, making them visually appealing and using youth-friendly language. This approach, applicable to YSRH promotion, supports inclusivity and cultural responsiveness while reflecting young people’s lived realities and digital cultures (Chang & Chang, 2023; Prensky, 2001a; Serpagli & Mensah, 2021; Sewak et al., 2023).

These insights collectively show that digital and social media platforms hold untapped potential to foster authentic, youth-led health engagement in New Zealand. When youth perspectives are integrated from conceptualisation through implementation and evaluation, such tools can move beyond tokenistic or opportunistic participation to create spaces of trust, empowerment, and meaningful collaboration. Therefore, integrating youth-centred and youth-led digital strategies into SRH promotion is both innovative and essential to ensuring inclusivity and relevance, and more likely to attain long-term impact.

3.6.1. An Emergent Analytical Framework for Youth-centred Social Media Health Promotion

Engagement with existing health promotion models and theories, CPYD principles, and literature on social media (earlier discussed in this chapter) informed the development of an emergent analytical framework that conceptualised social media as a collaborative space for youth health promotion. This preliminary framework, generated through initial engagement with empirical data and validated with research participants, synthesises key dimensions identified in both the literature and practice. It serves as the foundation for the critical youth-centred analysis presented in Chapter 6 where CPYD principles were applied to further interrogate power dynamics and youth agency.

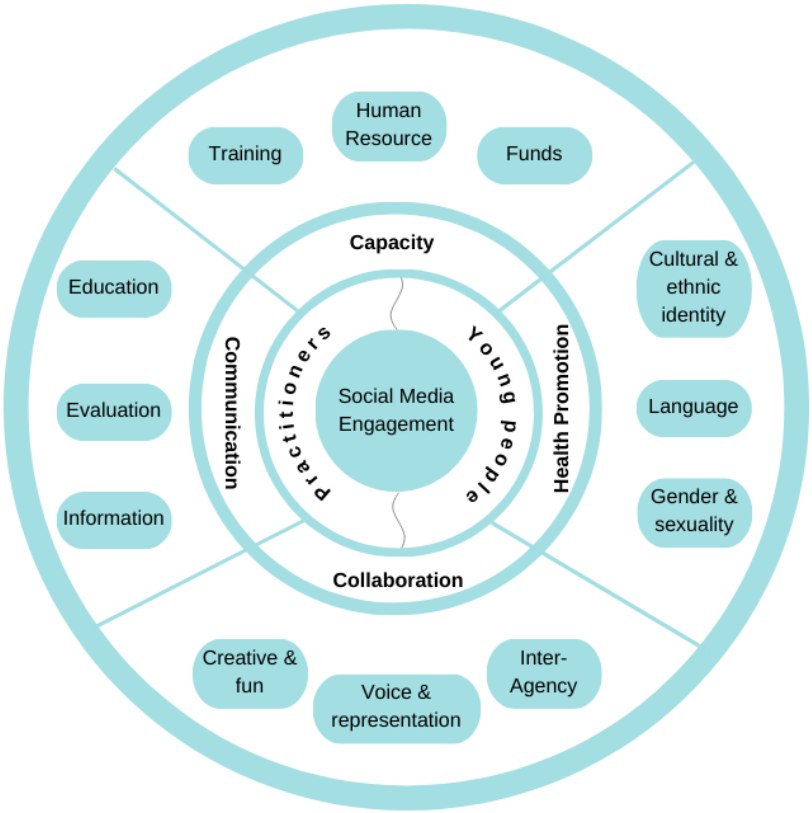
This conceptual framework (see Figure 15) presents a holistic model for leveraging social media to promote youth health. At its centre is social media engagement, foregrounded as a shared digital space where youth and adult providers intersect, communicate, and co-create meaning. Surrounding this are four interdependent pillars: Capacity, Communication, Collaboration, and Health Promotion, which are positioned as essential domains for meaningful youth-adult interaction in digital space (i.e., social media). These domains sit across a practitioner-youth continuum, with Communication primarily on the practitioners' side, Health Promotion on the young people's side, and Capacity and Collaboration bridging both sides through a wavy divide that acknowledges their relevance to both groups.

Importantly, despite their positioning, all four domains crosscut as essential structures for both practitioners and youth. Practitioners, for instance, need skills to collaborate and co-create with youth while navigating power tensions, and young people, as self-experts, can work with adult practitioners through role modelling and mentorship, each recognising shared governance and equitable partnership. This framework, therefore, underscores the mutual interdependence of the domains and the need for both parties to strengthen one another across the domains.

The outer ring contains categories derived from the descriptive preliminary data analysis, which informed each domain. Capacity (training, human resources, funds), Communication (education, evaluation, information), Collaboration (creative and fun, voice and representation, interagency), and Health Promotion (cultural and ethnic identity, language, gender and sexuality).

These categories ground the framework in empirical evidence while acknowledging both resource considerations and the diverse identities that shape adult-youth engagement on SRH promotion.

Figure 15.
Emergent analytical framework for social media as a tool for facilitating youth-adult collaboration in SRH promotion (Author-generated from initial data analysis, 2025)



Essentially, the framework underscores how the four domains depend on one another to create transformative spaces for youth-adult engagement. Capacity encompasses the foundational resources that enable equitable participation. Communication represents knowledge-based practices that shape practitioner and youth engagement. Collaboration bridges perspectives through creative and youth-friendly approaches, authentic voice and representation, and inter-agency partnerships. Health Promotion foregrounds young people's cultural, linguistic, and identity-based realities that shape their health-seeking behaviours and practices within the digital environment. Collectively, these domains situate social media as a dynamic space for authentic connection, shared learning, and equitable partnership for both young people and adult SRH providers.

3.7. The Future of Digital Health Promotion

The world has witnessed exponential growth in digital connectivity and algorithmic capability (Flew, 2024; Mansfield et al., 2025; Mayer et al., 2016), not forgetting the twisted turn that the

pandemic imposed on everyone (Minister of Health, 2023; Naseer et al., 2025). This digital transformation has also spurred a global health communication revolution, enabling communities and individuals to access, share, and co-create health information in real time (Chidwick, 2023; Karra & RamaRao, 2025; Panahi, 2025). This section projects into the near and distant future, intricately woven into what the present realities are for digital health promotion. By applying a critical and future-oriented lens to the next 5 to 20 years, the evolutionary patterns within the digital and technological space and its implications on the context, policy, and practice of SRH are considered to situate this study. In doing so, it envisions what disruptive, youth-centred SRH-focused organisations and providers might look like as agile and digitally fluent, while leaning more toward positive youth development, and thus better equipped to meet the expectations and needs of digital natives. Additionally, the brief review lays the conceptual groundwork for the creative component of this research, positioning it as both a theoretical and practical response to the rapidly evolving digital health promotion landscape.

3.7.1. Global Perspective into the Near and Distant Future of Digital Health Promotion

Parallel to the digital and technological paradigm shifts, the revolution within the healthcare industry has accelerated the convergence of data, connectivity, and computation. Advances in big-data analytics, machine learning, and mHealth technologies have transformed health systems from reactive and episodic care to data-driven, predictive, and personalised models (Karra & RamaRao, 2025; Panahi, 2025). The digital disruptions catalysed by the COVID-19 pandemic profoundly reconfigured social media as a participatory arena for youth engagement, communication, and learning (Minister of Health, 2023; Rose, Garrett, McKinlay, & Morgan, 2021). Once primarily social and recreational spaces, platforms such as Instagram, TikTok, YouTube, and X have become sites of health knowledge co-production, where young people act simultaneously as consumers and producers, ‘prosumers’ of digital content (Conn et al., 2017; Mansfield et al., 2025; Sewak et al., 2023). These cultural shifts, intensified by the pandemic’s restrictions on physical mobility, accelerated digital connectivity and normalised online forms of participation, non-traditional expression, and even remote consultation in healthcare services (Albury et al., 2025; Minister of Health, 2023; Rose, Garrett, McKinlay, & Morgan, 2021). Social media thus evolved into an interactive ecosystem that disseminates health information and shapes youth identities, peer influence, and civic participation across borders (Chidwick, 2023; Wang et al., 2022).

Globally, within SRH, these platforms have become powerful vehicles for advocacy, peer education, and youth-led storytelling (Baraitser, 2025; Goodwin & Lyons, 2024; Laor, 2022). Digital interventions, ranging from short-form videos and influencer-led campaigns to chatbot-based counselling, will continue to expand the possibilities for participatory health communication,

particularly among youth populations who face barriers to accessing traditional services. (Mansfield et al., 2025; Naseer et al., 2025; Wang et al., 2022).

A review of the literature (Butcher & Hussain, 2022; Lampersberger et al., 2025; Lipton, Dickinson, et al., 2025; Mannix & Albury, 2025; Mansfield et al., 2025; Pagoto et al., 2025) forecasts that digital SRH promotion in the next 5 years would be hybrid by default, shifting practice to align more with the realities of young people. In-person care will routinely be paired with virtual consults, remote health tracking systems, and digital app referrals; follow-ups will become the norm, and the need to normalise their uptake in practice will increase, making a case for more trials and implementation research. With advances in youth-led prosumption in digital spaces, more initiatives would adopt co-design models, navigating the challenges of power sharing across multi-disciplinary and multi-stakeholder partnerships, as is currently being witnessed in different countries around the world (Guglielmi et al., 2024; Hémono et al., 2024; Hirvonen et al., 2021; Kontak et al., 2025; Purcell et al., 2023). The need for stricter, yet inclusive, moderation of SRH messaging and content on social media and other digital spaces would also be heightened, so that government, organisations, and providers would have to consolidate their approach around participatory and youth-driven models that embrace co-creation and shared governance (Albury et al., 2025; Dictus et al., 2025; Mansfield et al., 2025; Merga, 2025). The New Zealand national health strategy is beginning to reflect some of these ideas; however, there is room for more targeted and mandated engagement of youth as policy co-authors and decision-making members of regulatory bodies (Minister of Health, 2023; Mujtaba, 2025).

By the mid-2030s, predictions suggest digital health integration ecosystems that enable AI-supported dialogue, peer-to-peer moderation, and adaptive learning within progressive youth-adult collaborations (Naseer et al., 2025; Ramachander et al., 2025; Rashid et al., 2025). Institutionalising youth-led SRH ecosystems would scale to strengthen young creators' technical skills, enable structured feedback, enhance workflows with providers, and shift to established co-governance partnership models. This aligns with Goodwin and Boulton's (2024) principle of kōtuitanga taurite (equal partnership) and global evidence on participatory digital health (Chidwick, 2023; Flew, 2024). However, the risks of data poverty, digital skills gap, data exploitation, and algorithmic bias against marginalised youths may surge, prompting the need for integrated and inclusive ethical oversight (González & Veale, 2025; Goodwin et al., 2025; Lipton, Dickinson, et al., 2025).

With fewer evidence-based insights, there are prospects for fully participatory, youth-governed ecosystems that combine youth agency with technology, framed within agentic layers in 2 decades from now (Albury et al., 2025; Baraitser, 2025; Mujtaba, 2025; Rashid et al., 2025). Advanced AI systems would enable young people to self-organise and negotiate directly with institutions, drawing on longitudinal study outcomes and multi-source data (Baraitser, 2025; Chang & Chang, 2023). However, achieving this outcome depends on resilient data governance structures and all stakeholders maintaining high ethical standards (Dictus et al., 2025; Karra & RamaRao, 2025).

Ultimately, digital and social media health promotion becomes a movement sustained by intergenerational collaboration, continuous and adaptive learning, and collective ownership of digital public content.

3.7.2. Navigating the Digital Disruptions Locally

In New Zealand, while national policies increasingly acknowledge the need for digital health innovations, a significant gap exists between political intent and practical implementation. Additionally, limited evidence supports integrating digital innovations within the YSRH space in the country, necessitating this research. As established in Chapter 2, the volume of policies and strategies, for example, the updated abortion legislation, the National Health Strategy and the Digital Health framework available in New Zealand, suggests a clear political will to advance in this area (Abortion Legislation Act 2020; Ministry of Health, 2021, 2023a, 2023c). However, the foundational governance structures that dictate practice remain heavily vested in traditional delivery models, which are often risk-averse and digitally non-fluent. Additionally, this directly contrasts with the need to involve young people, who are central to digital health's success in issues that affect them, by adopting co-design approaches through the entire lifecycle of the policy from conceptualisation and implementation through to evaluation (Goodwin & Boulton, 2024; Wang et al., 2022; Warwick-Booth et al., 2019). This fundamental governance misalignment impedes the adoption and utility of digital health innovations.

It is evident that since the early 2000s, successive government strategies have accentuated the integration of digital technologies into healthcare delivery (Ministry of Health, 2001, 2003; New Zealand Sexual Health Society, 2011), the expansion of broadband infrastructure, and the ethical use of data (Minister of Health, 2023; Ministry of Health, 2019a, 2021). The COVID-19 pandemic also catalysed the adoption of telehealth and digital-health promotion, embedding virtual service delivery within the New Zealand health system (Rose, Garrett, McKinlay, & Morgan, 2021). These efforts align with the country's approach and commitment to equitable access, Māori and Pacific data sovereignty, and cultural responsiveness in digital innovation (Minister of Health, 2023; Ministry of Health, 2024a), and with future aspirations and opportunities. However, the present-day realities conflict with YSRH outcomes.

Further, without absolute disregard for current efforts by SRH providers and organisations, I acknowledge that, to some extent, digital tools and social-media platforms are being harnessed for YSRH promotion in New Zealand (Patterson et al., 2019; Phillips et al., 2024; Rose, Garrett, McKinlay, & Morgan, 2021), but much more can be done to ensure they are youth-centred and youth-led. Recent strategies, frameworks and methodological approaches, the National Health Strategy, the Digital Health framework, Co-design Research Integrity Poutama, collaborative workshops methodology, could be considered a fundamental pedestal in the right direction for health professionals to be increasingly guided towards an improved digital and data capability across the

sector (Calder-Dawe & Gavey, 2019; Deane et al., 2023; Goodwin & Boulton, 2024; Goodwin et al., 2025; Ministry of Health, 2021; Nutbeam, 2021; Stubbing & Gibson, 2021). These concepts move beyond narrow notions of digital literacy to emphasise systemic capability-building, ethical practice, and participatory design, aligning with global shifts toward inclusive and reflexive health systems. The key challenge is bridging the gap between traditional governance models and the imperative for youth agency in digital health implementation.

These disruptive transformations have also been documented in New Zealand within the mental health space (Ludin et al., 2022; Mark & Hagen, 2020; Stubbing & Gibson, 2021). A good example is the successful digital youth-adult co-designed 'Aroha' app, developed during the pandemic to help manage anxiety. Within 2 weeks of its launch, young people (aged 13–24 years) comprised one-third of the nearly 400 registrations (Kang et al., 2023), and reported in an evaluation study after its trial that they found the chatbot's relatable conversation style supportive and less authoritative than typical adult providers (Ludin et al., 2022). Innovations such as this have blurred the boundaries between formal and informal health systems, positioning young people not just as recipients of information but as co-creators of digital health narratives (Ludin et al., 2022; Mukti & Putri, 2021; Naseer et al., 2025).

However, realising the full potential of initiatives like the 'Aroha app' is constantly undermined because many adult providers, functioning as digital immigrants, continue to struggle to keep pace with young people's digital fluency (Martin, Alberti, et al., 2020; Pang et al., 2023; Prensky, 2001a, 2001b). These challenges result in algorithmic visibility failures, where content is misdirected or suppressed, coupled with language barriers, connectivity gaps, and gender norms, contributing to widening structural inequities and determining whose voices are amplified and whose remain marginalised (Flew, 2024; Mansfield et al., 2025). As a result, providers and young people experience mismatched communication styles, differing preferences for accessing and providing care, and missed opportunities to foster genuine connection and trust (Phillips et al., 2024; Rose, Garrett, McKinlay, & Morgan, 2021; Sewak et al., 2023).

Considering this holistically, these transformations signify more than a technological revolution; they represent a sociotechnical re-imagining of health, communication, and agency (Panahi, 2025; Raymundo et al., 2021; Rose et al., 2024). This is what today's youth clamour for, underscoring the importance of a thriving youth agency (Palacios & Allen, 2019; Palfrey & Gasser, 2008). AI and social media, while still evolving, offer unprecedented opportunities to amplify youth voice, enhance collaborative SRH promotion with adult providers, and bridge systemic inequities in access and representation within New Zealand (Albury et al., 2025; Karra & RamaRao, 2025; Mayer et al., 2016). Yet their use also demands critical reflection on ethics, governance, and power, questions that are particularly salient for youth-focused and culturally diverse contexts, as in New Zealand (Mujtaba, 2025; Taba et al., 2025). The challenge and opportunity ahead lie in ensuring that the digitally driven health future remains inclusive, youth-centred, and socially accountable, reflecting

technological capability and collective values of trust, equity, and care (Flew, 2024; Mayer et al., 2016; Ministry of Health, 2021).

3.7.3. Lessons from Countries Leading in Youth-led and Youth-centred Practice

In countries like Australia, Canada, the United States, and the United Kingdom, as well as in some African countries, some commendable practices and attributes have been showcased to establish and strengthen youth-led and youth-centred projects. Two cases are presented briefly (see Appendix H for more details), highlighting them as best practices that can serve as a learning resource and be adopted to improve co-design and participatory approaches in New Zealand. Case studies are considered descriptive accounts of knowledge and experiences situated within specific contexts (Cleland et al., 2021). They are multidisciplinary in their application and could be adapted to suit a researcher's ontological and epistemological position. In this instance, the cases are used to construct meaning, inform youth-centred practice, and initiate policy shifts grounded in young people's real-world experience and critical engagement (Cahill, 2014; Deane et al., 2023; Lipton, Dickinson, et al., 2025).

Case study 1 describes how youth peers partnered with experts across multidisciplinary fields, using social media to initiate behavioural change communication and improve sexual health knowledge among school-based adolescents in the United Kingdom. Case study 2 highlighted Baltimore youth's work to improve data use and reporting across several youth-serving organisations, resulting in a secure, integrated data system and policy shifts. Both cases exemplify the shift from traditional, adult-controlled health promotion initiatives to ones that embraced youth autonomy, shared learning, and reflexivity.

Other notable examples of innovations and practices that challenge traditional models of youth engagement to an empowerment-focused, digitally fluent and youth-led solutions are described in CyberRwanda[5] (Hémono et al., 2024), an African-based initiative promoting cost-free access to information and low-cost health products, co-designed by youth and technical experts; the deployment of the ELLES app in Benin, West Africa (Guglielmi et al., 2024), to improve the knowledge and practice of under-25s about their SRH and rights; and the youth-centred knowledge mobilisation project in Nova Scotia, Canada (Kontak et al., 2025), that ensured young people could prioritise and communicate their needs through a series of joint workshops with researchers and youth representatives to lawmakers. All represented a shift towards youth engagement and active participation in defining issues that concern them, co-creating solutions, and leading collaborative efforts to achieve their desired change. Noteworthy are the emerging frameworks and local adaptations led by researchers and community organisations within New Zealand, which are gradually

[5] https://www.cyberrwanda.org/

gaining popularity to improve youth-centred and youth-led service delivery, including initiatives like the Connect & Korero, Co-designed Research Integrity Poutama, The Southern Initiative and its component, Auckland Co-design Lab, to name a few.

3.8. Conclusion

Like other health and well-being needs of young people in New Zealand, SRH promotion needs a boost, as it is currently fragmented and under-resourced (Rose et al., 2024). Prioritising at-risk and vulnerable groups, and supporting them through evidence-based, community-led interventions, is one way forward (Ministry of Health, 2023a). Additionally, Phillips et al. (2024) suggested that good-quality SRH messaging targeting young people should reflect the diversity of their lived experiences, catering to the needs of those with no past sexual and intimate relationships as well as those who have been sexually active, pregnant or not, and had an abortion or not. Rose et al. (2022) supported a similar position on providing high-quality, non-stigmatising SRH information and education to young people.

Conscientious efforts towards destigmatising and non-discrimination of youths with STIs are a major step towards improving their SRH outcomes. It begins with consistent messaging that fosters new, positive perspectives while promoting healthy sexual behaviours. Sharing health promotion messages targeting the increased uptake of reproductive healthcare to manage unplanned and unwanted pregnancies, seek professional care and treatment for pregnancy prevention and termination, and demystifying false information are some of the ways to go.

In this disruptive digital era, social media and digital technologies offer transformative opportunities to advance SRH promotion among youth. These platforms offer dynamic, interactive spaces where young people can access, share, and co-create knowledge that resonates with their realities (Goodwin & Lyons, 2024; Mansfield et al., 2025). Using social media to connect with digital natives can help adult SRH providers genuinely connect with young people, strengthen youth agency, and bridge persistent gaps left by traditional health systems and practices. When health promotion messages are designed collaboratively, digital platforms like social media can foster culturally responsive, youth-led health communication that enhances accessibility, relevance, and trust in SRH information.

Recognising the centrality of young people to this research, it was essential to understand how their perspectives and contributions are embedded in the development and delivery of social media health promotion initiatives. A critical analysis of how SRH providers conceptualise and implement social media strategies highlighted existing power dynamics and opportunities for more youth-driven engagement.

Chapter 4. Research Design

This chapter presents the methodological framework and design adopted to address the research aims, focusing on how SRH providers in New Zealand conceptualise and deliver YSRH promotion within digital spaces. Grounded in critical theory as its overarching paradigm, this study adopts a constructivist epistemology and is guided by a CPYD framework. Drawing on CPYD's positioning of young people as knowledge producers and capable agents, this approach is used to analyse provider narratives as institutional discourse that interrogates how youth capabilities and agency are constructed within professional practices, and examine the power dynamics, epistemic hierarchies, and structural constraints that shape youth voice and participation in YSRH promotion. The chapter then describes the fieldwork design, including local engagement, participant recruitment and selection, and procedures for data collection and analysis. The chapter concludes with a discussion of key ethical considerations, including Te Tiriti obligations and reflections on researcher positionality.

The overall research question is 'How do SRH providers in New Zealand leverage social media to promote YSRH?' To obtain rich and contextual insights, this question was broken down into the following sub-questions:

1. How do SRH providers' perspectives, including the challenges and opportunities they identify, shape the use of social media as a tool for YSRH promotion?
2. What systemic and structural factors shape SRH providers' digital health promotion practices, and how do these align with or diverge from a youth-centred approach?
3. What approaches do providers employ to navigate these factors, and what transformations are needed to enable genuine youth-centred digital SRH promotion?

4.1. Establishing the Research Paradigm

Epistemology refers to the nature of knowledge and the justification of the research strategy (Carter & Little, 2007; Harding, 1987; Schwandt, 2000). It is the theory of 'how we know what we know' (Crotty, 1998). It forms the pillar for knowledge generation and justifies the strategy that yielded it. Constructionism, influenced by one's values, translation, and synthesis of philosophical underpinnings, forms the epistemological basis for this study. Crotty (1998) and Thomas et al. (2020) described this phenomenon as the construction of meaning based on one's interaction with others, one's realities and the surrounding world; that is, context. In essence, both the researcher and participants are influenced by their lived experiences in knowledge creation and throughout the research process. "All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty, 1998, p. 42).

Constructionism is particularly relevant for examining how SRH knowledge is produced and legitimised in digitally mediated contexts, where social media platforms create new spaces for interaction between adult providers and young people, even as these interactions occur within power-laden institutional and algorithmic boundaries. Constructionism enables the examination of how youth capabilities and SRH knowledge are constructed differently within digital spaces compared to traditional media or clinical settings, and whose knowledge frameworks, either the professional or youth experts, are privileged when health promotion is done via social media platforms (Calder-Dawe & Gavey, 2019; Carter & Little, 2007; Schwandt, 2000). Constructionism and critical theory intersect through their shared recognition that knowledge is not neutral but socially constructed, contextually situated, and shaped by power relations (Crotty, 1998; Scotland, 2012). Constructionism rejects the positivist assumption of objective truth. Instead, it positions knowledge as emerging from interactions between humans and their social worlds, shaped by culture, language, and power relations. As Crotty (1998) explained, epistemological constructionism aligns with the view that meaning is co-created through interaction rather than discovered as a pre-existing reality. Within this framework, my role as the researcher is inherently interpretive and situated, and the knowledge produced is inseparable from the socio-political and historical conditions that inform it.

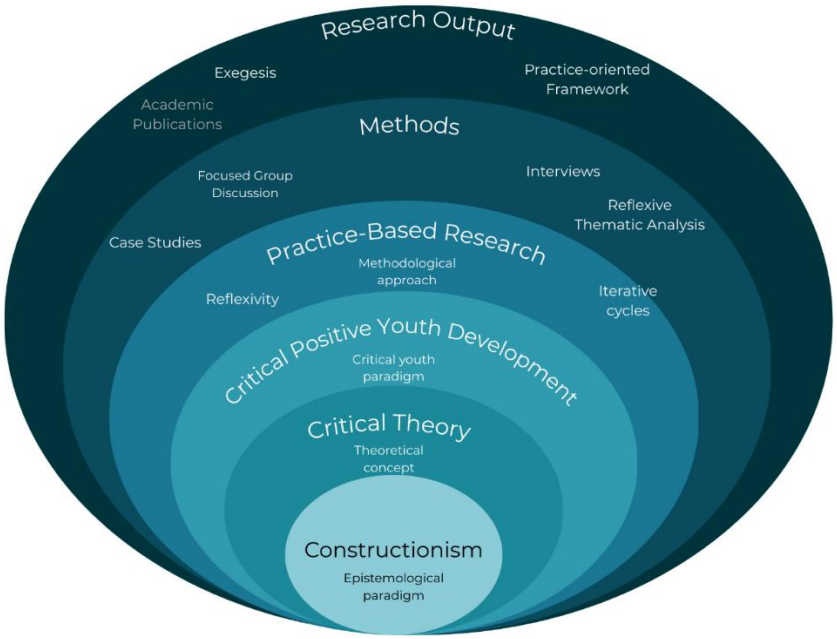
Critical theory, as the theoretical framework, shaped how this study understands knowledge production, power relations, and the structural forces that condition youth voice in YSRH promotion (Crotty, 1998; Scotland, 2012). It directs analytical attention to power relations, structural constraints, and whose knowledge is legitimised within institutional contexts (Horkheimer, year, cited in Crotty, 1998, p. 130). Within digital YSRH promotion, critical theory examines whether digital technologies democratise health promotion by enabling youth voice and peer-to-peer knowledge sharing, or whether they reproduce existing power hierarchies through adult and institutional control over content, algorithms, platform policies, and social media management. This paradigm is particularly relevant for examining how adult-controlled health promotion systems position young people, as it enables interrogation of the epistemic hierarchies and structural barriers that constrain youth voice despite participatory rhetoric (Cahill, 2016; Ginwright & Cammarota, 2007). Rather than engaging youth directly, this study analysed how adult providers construct youth capabilities and position young people within institutional practices, enabling examination of structural and epistemic barriers operating within adult-controlled SRH promotion settings (Bell, 2007; Gonzalez et al., 2020). As established in Chapter 3, critical theory informed the selection of CPYD as the framework for analysing adult SRH providers' narratives. CPYD positions youth voice as relational, political, and structurally mediated, not as individual expression or consultation, but as encompassing power, legitimacy and decision-making authority over institutional agendas (Ginwright & Cammarota, 2007; Gonzalez et al., 2020; Gonzalez et al., 2024). This conceptualisation is particularly important for examining youth engagement in digital YSRH promotion, where social media platforms offer visible

spaces for youth participation, even though such participation does not automatically influence institutional messaging strategies, content priorities, or resource allocation.

This conceptualisation of youth voice shaped this study's methodological approach in three ways. First, CPYD informed the decision to analyse adult SRH provider narratives as institutional discourse rather than to access youth perspectives directly. This choice reflects CPYD's emphasis on examining how adult-controlled structures position young people and whether institutional practice enables or constrains youth authority over knowledge production and decision-making. Second, CPYD informed the research questions and the design of the interview guide to illuminate how providers conceptualise youth capabilities, whether they recognise young people as knowledge producers, and how power is negotiated in provider-youth relationships within digital YSRH promotion contexts. Third, CPYD also provided an analytical lens for interrogating provider accounts, rather than taking descriptions of youth engagement at face value. The analysis examined whether such engagement constitutes a meaningful youth voice characterised by shared power, legitimacy, and autonomy or remained constrained within adult-determined frameworks. Section 4.5 further describes specific applications of CPYD principles to data analysis. Figure 16 illustrates the relationship between the study's epistemological position (constructionism), theoretical frameworks (critical theory and CPYD), methodology (practice-based research), and analytical approach to providers' narratives.

Figure 16.

Conceptualising the theoretical and epistemological framework



Consistent with constructionist epistemology, this research approach requires ongoing reflexivity about how my positioning as a researcher shapes interpretation. The participant-researcher

relationship, aligned with epistemic constructionism, will be examined further in the sections below (see Section 4.8), particularly in terms of research quality, voice, and critical discourse (Carter & Little, 2007). The quality of qualitative research is supported by its epistemic positions and the application of epistemology, methodology, and method variants, as well as by demonstrating internal consistency across these three major concepts (Carter & Little, 2007; Crotty, 1998; Thomas et al., 2020). Recognising and defending their connections matters more than isolating and discussing them separately.

The knowledge created by research participants is shaped by their voice, practice, context, social media fluency, and the technicality that comes with it (Creswell, 2007; Crotty, 1998). This subjective stance may differ, with some commonalities, if the same research is conducted with another group in a different context and time. Like the participants, I am an active contributor to the research process, reflecting on my interactions with them and my reflexivity as the researcher to establish subjectivity and transparency in the qualitative research journey. Carter and Little (2007, pp. 5-6) explained this epistemological reasoning by establishing how the participant-researcher relationship impacts different aspects of the research process, demonstrating the incomparability of epistemic positions in qualitative research. This supports the epistemological view that knowledge is co-constructed and contextually bound rather than a universal concept (Carter & Little, 2007; Creswell, 2007; Scotland, 2012). The following sections discuss these connections between epistemic positions, methodology, and methods.

4.2. Methodological Approach

Methodology informs the theoretical and analytical approach of conducting research (Carter & Little, 2007; Harding, 1987; Schwandt, 2000). Kaplan (1964, pp. 18, 23) emphasised that methodology is about the description, explanation, justification, and evaluation of methods, not simply the methods themselves. This study employed practice-based research (PBR) as a deliberate methodological approach, not simply because it produces a practice-oriented artefact but because the research design, data collection, analysis, and synthesis processes are structured specifically to enable artefact development (Candy, 2006; Candy et al., 2021). PBR is suitable as a methodological approach because digital SRH promotion with youth requires different knowledge, skills, and relational approaches than traditional forms of engagement (Rashid et al., 2025; Saeed & Masters, 2021); yet professional guidance on power-sharing, youth voice, and authentic co-design in digital contexts remains underdeveloped (Goodwin et al., 2025; Mannix & Albury, 2025; Mark & Hagen, 2020). By examining provider practice through this lens, PBR supports the development of a practice-oriented artefact that addresses the challenges and opportunities in digital YSRH promotion.

Differentiating between two distinctive forms of practice-oriented research, Candy (2006, p. 2) argued that research is considered to be practice-based if it is,

1. the basis of the contribution to knowledge is a creative artefact;
2. research aimed at generating culturally novel apprehensions, not just to the creator or observers; and
3. as a doctoral research outcome, it arises from a structured process defined within a university's examination regulations.

Based on the pre-outlined criteria, Candy (2006) defined PBR as "an original investigation undertaken in order to gain new knowledge partly by means of practice and the outcomes of that practice" (p. 3). The choice of methodological approach was informed by the previously established epistemological and theoretical underpinnings. One of its significances is placing the research practitioner at the centre of the research, recognising their voice in relation to the practice being examined and the theoretical lens applied in the process (Sade, 2021; Schön, 1987). In recent years, PBR has emerged as a necessary and relevant approach that can help public health providers and researchers collaborate better and bridge the gap between theory and practice (Ammerman et al., 2014; Michaels, 2021).

The historical origins of PBR (Candy et al., 2021) trace to the early 1970s, when practising clinicians challenged the academic dominance of evidence-based medicine and asserted their role in developing clinical knowledge beyond research hospital settings. Sir Jame McKenzie's landmark report recognised these contributions, while subsequent scholars extended PBR into a multidisciplinary concept. This includes Stenhouse in 1975, the teacher-as-researcher ideology in education, and Schön, in the mid-1980s, who introduced reflective practitioner theory. Jonathan Michaels, in the 1980s, further showed through cross-disciplinary analysis that PBR principles operate across surgery, medicine, education, and art despite different disciplinary boundaries.

At this point, it is important to state that simply producing a framework or model does not constitute PBR if that output is an incidental byproduct and not a methodologically grounded research contribution (Edmonds, 2021). By adopting PBR as the methodological approach, this study positioned artefact development as the research goal from the outset, with practice serving as the site of research and the artefact emerging from the systematic analysis and synthesis of data, not as an afterthought or illustrative application of findings (Candy et al., 2021).

Adopting the PBR methodology shaped the study's design in many ways. First, the research question was framed to both understand current provider practice and generate a practice framework that advances knowledge about meaningful collaboration and authentic connection between young people and adult providers in YSRH promotion settings. This is core to the research and to PBR as a methodology that simultaneously examines practice and produces practice knowledge in artefact form (Candy et al., 2021; Edmonds, 2021). Second, data collection focused on aspects of provider practice that could inform artefact design by examining how providers conceptualise youth capabilities, navigate power dynamics, structure engagement opportunities, and experience institutional constraints. All of these are essential to developing an artefact and do not merely describe practice.

Third, the analytical approach was designed to identify both current practice patterns (what providers do or think) and the gaps between current practice and CPYD principles (what meaningful youth voice requires). As a result, the analysis could inform the artefact's design by revealing the conditions and structures required for meaningful collaboration.

Having established the conceptual reasoning behind the choice of methodology, the 'Youth-Adult co-design model for digital SRH promotion' was developed through thematic analysis of adult providers' narratives, identifying how youth engagement is currently conceptualised and practised, the challenges providers encounter, and the institutional constraints they navigate. Additionally, the findings were critically interrogated through a youth lens to reveal epistemic hierarchies, power dynamics, and gaps between participatory rhetoric and structural practice. Scholarly materials were reviewed, and evidence supporting youth activism, health promotion models, the co-design approach, and CPYD processes were integrated. This contributed to the generated iterative design that reflects what current practice reveals about institutional barriers, what CPYD-informed youth voice means in YSRH promotion, and what counts as authentic youth-adult partnership architectures from the literature. The practice-based artefact was further refined based on the research participants' (adult SRH providers) feedback on preliminary findings and how the 'artefact' could be applied in SRH promotion, alongside theoretical coherence checking and critical feedback from my supervisors.

Systematically describing the processes undertaken supports the argument for detail, articulation, and accurate presentation of how, when, and why throughout the research (Carter & Little, 2007; Kaplan, 1964, 2017; Schön, 1987). By making practice 'the site of research' (Candy, 2006), this study generated new knowledge about provider practice regarding youth conceptualisation and engagement in health promotion, the use of social media and similar technology-driven platforms as resources, and the negotiation of institutional barriers and power dynamics. Thus, practice was positioned not merely as an object of study but as an active site of knowledge production, consistent with PBR methodology. Having outlined the methodological approach, the following section describes the fieldwork design, including participant selection, data collection methods, and the analytical processes.

4.3. Fieldwork Design

4.3.1. Local Networking and Collaboration

Before commencing data collection, I conducted strategic local consultations with key organisations and their staff, academic scholars, and community actors. This gave me a better understanding of the context and current practices. In addition, I participated in locally organised events and community activities, which provided insight into the diversity within the public health domain. Additionally, I studied and applied publications documenting best practices and lessons from other researchers who have engaged with organisations and their employees throughout the research.

4.3.2. Advertisement and Information Sharing

Some NGOs potentially meeting the inclusion criteria were identified on the New Zealand Health Promotion website[6] and a few others from Google search. Cold emails were sent out, including the introductory letter (see Appendix A), to inform NGOs about the study and the request for voluntary research participants. Prospective research participants in the organisation were encouraged to contact the researcher based on the details outlined in the introductory letter (see Appendix A). A one-time follow-up email was sent to organisations that did not respond initially in case they missed the first email and to ensure everyone had a fair chance of being included. Once interest was indicated, the full participant information sheet and consent forms for both the organisation and employee were shared.

Additionally, voluntary participants were encouraged to share the introductory letter within their network so that anyone interested could connect with the researcher. This ensured a larger audience was reached, and more participants who might not have known about the research or received an email directly from the researcher could participate. This strategy became necessary after exhausting the list of pre-identified organisations and needing more participants.

4.3.3. Recruitment and Selection of Participating Organisations

Approximately 50 provider-organisations were initially contacted for participation. Of these, 12 individual providers consented to participate, representing Te Whatu Ora Health New Zealand, non-governmental organisations (NGOs), and one youth-sector actor engaging personally rather than organisationally. Two participants later withdrew due to scheduling constraints, leaving 10 providers across 10 provider-organisations: eight NGOs, one national-level public provider (Te Whatu Ora), and one youth actor affiliated with a public organisation but participating in their own individual capacity. This produced 10 data collection sessions in the first phase, comprising eight one-on-one interviews and two group discussions (with two and three participants, respectively), totalling 13 participants. In the second phase of data collection, the team shared preliminary findings with all 13 primary participants for member validation, giving them the opportunity to review, comment on, and contribute to the emerging findings and research artefact. Of these, six participants engaged in follow-up validation sessions, comprising three individual interviews and one group discussion involving three participants. One Phase 1 participant was unable to take part in this phase; a colleague from the same organisation in an equivalent role participated in their place, ensuring continuity of organisational representation and a role-relevant perspective in the validation process.

The sampling strategy combined purposive and snowballing techniques (Thomas et al., 2022). Purposive sampling aims to “serve an investigative purpose rather than to be statistically

[6] https://hpfnz.org.nz/about-us/

representative" (Carter & Little, 2007, p. 4). Snowballing techniques were adopted without breaching privacy and confidentiality, so no person-to-person referrals were used in the recruitment process. Interested participants received a detailed participant information sheet with my contact details and had the opportunity to ask questions before giving consent (see Appendix B).

After acknowledging the introduction and agreeing to participate, I scheduled a virtual meeting. I adopted a virtual data collection approach because New Zealand was just easing out of the COVID-19 pandemic, and face-to-face meetings were not welcomed unless unavoidable. Further, protecting study participants was paramount; therefore, virtual data collection was the most appropriate option during this period. Gathering data online also saved me time, ensured interviews were scheduled at the convenience of both the participant and me, and helped minimise the effort and cost I might have incurred for logistics and transportation. To be recruited into the study, the research participant(s) had to meet the following eligibility criteria:

1. Work at a public or private organisation operating in New Zealand that offers SRH services.
2. Services include SRH promotion targeting young people in New Zealand.
3. The volunteering staff member is responsible for the organisation's social media strategy and/or interfacing with the young people in their role.

Based on the recruitment pattern, which involved identifying participants from SRH-focused organisations, the study involved both individual and group participants, and information gathering was facilitated through one-on-one interviews or focus group discussions. With group participants, consent was sought from individuals in addition to organisational consent.

4.3.4. Participants' Characteristics and Profile

Based on the eligibility criteria, participants included employees of public and private organisations as well as a YSRH advocate, whose routine work involves YSRH promotion. Services these organisations provide include awareness campaigns, counselling, testing and referrals, and behavioural change communication, among others. Most organisations (n=7) had an office in Auckland and elsewhere, while three were situated outside Auckland in other parts of the country. Only one youth actor responded to the call for participants and was included in the research. The study participants' job roles varied, including, but not limited to, SRH expert, youth worker/practitioner, communications coordinator, and chief executive officer.

To have basic knowledge of who the participants are and what they do before meeting them during the qualitative interview, as well as to manage the time spent in the first few minutes on introductions, I shared a Google Form that captured their basic information once participation was confirmed (see Appendix D). The form captured information including gender, the groups of young people they work with, and social media presence (see Table 7 for further details).

Table 7.

Demographics of the study participants

ID	Form of engagement	Descriptor	Gender	Organisational presence	Youth population served	Digital/Social media presence
T1	Interview	SRH expert	Woman	Auckland	Women (16+ years)	Website
T2	Group discussion (3 participants)	Youth practitioners	2 Men 1 Woman	Northland, Auckland, Waikato/Hamilton	Adolescents/teenagers (10-19 years) Young adults (16-24 years) Older youths (25+ years) Women (16+ years) Men (16+ years) Transgender/LGBTQI+	Facebook, Instagram
T3	Interview	Youth worker	1 Woman 1 Man	Wellington	Adolescents/Teenagers (10-19 years) Young adults (16-24 years)	Facebook, Instagram, TikTok
T4	Interview	Communications coordinator	Non-binary	Wellington	Adolescents/teenagers (10-19 years) Young adults (16-24 years) Transgender/LGBTQI+	Facebook, Instagram, Twitter
T5	Interview	Social media strategist	Man	Auckland, Wellington, Otago	Transgender/LGBTQI+	Facebook, Instagram, TikTok, Twitter, YouTube, LinkedIn
T6	Interview	National coordinator	Woman	Locally present across the different regions and notable cities in the country	Adolescents/teenagers (10-19 years) Young adults (16-24 years) Older youths (25+ years) Women (16+ years Transgender/LGBTQI+	Facebook, YouTube
T7	Group discussion (2 participants)	Project manager	1 Woman 1 Non-binary	Auckland	Young adults (16-24 years) Older youths (25+ years) Women (16+ years Transgender/LGBTQI+, Whānau with new pēpi	Facebook, Instagram, YouTube
T8	Interview	Community organisation lead	Man	Auckland	Young adults (16-24 years)	Facebook

ID	Form of engagement	Descriptor	Gender	Organisational presence	Youth population served	Digital/Social media presence
					Older youths (25+ years) Men (16+ years) Transgender/LGBTQI+	
T9	Interview	Youth advocate Community health worker, youth worker, and sex educator	Non-binary	Auckland	Adolescents/teenagers (10–19 years) Young adults (16-24 years) Transgender/LGBTQI+	Instagram
T10	Interview	Program director	Woman	Wellington, Canterbury, Dunedin	Adolescents/teenagers (10-19 years)	Facebook, Instagram, YouTube

As shown in

the majority of organisations reported working with young adults aged 16–24 years (n=8) and adolescents aged 10–19 years (n=6). Fewer indicated service provision for older adults aged 25 years and above (n=4). In terms of population groups, transgender/LGBTQI+ young people were the most frequently identified service users, followed by women and men, while only one organisation reported that they work with whānau with pēpi. In terms of the primary focus of the participants' organisations (see Figure 18), all participant organisations offered sexual health services (n=10). Other service areas included physical health and general well-being (n=6). Reproductive health (n=4) and mental health, including alcohol and drug use (n=4), were less frequently reported compared to sexual health, while transgender/LGBTQI+-specific organisations were the least frequently reported (n=2).

Figure 17.

Youth groups that participants provide SRH promotion and other services to (Research data)

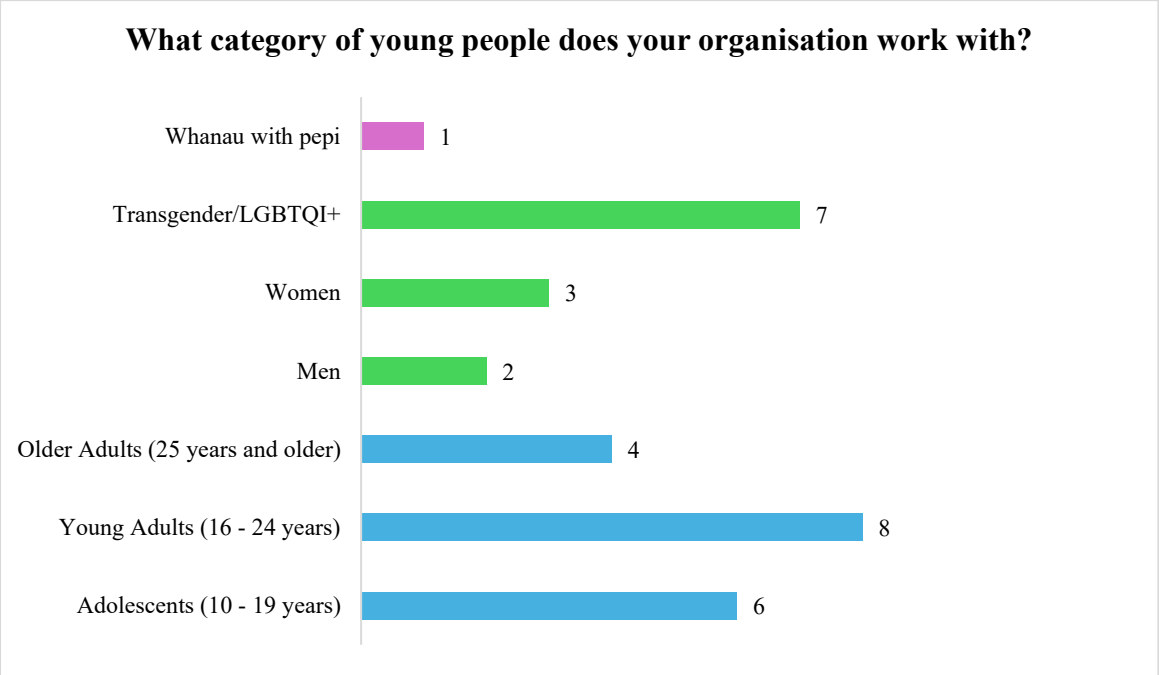
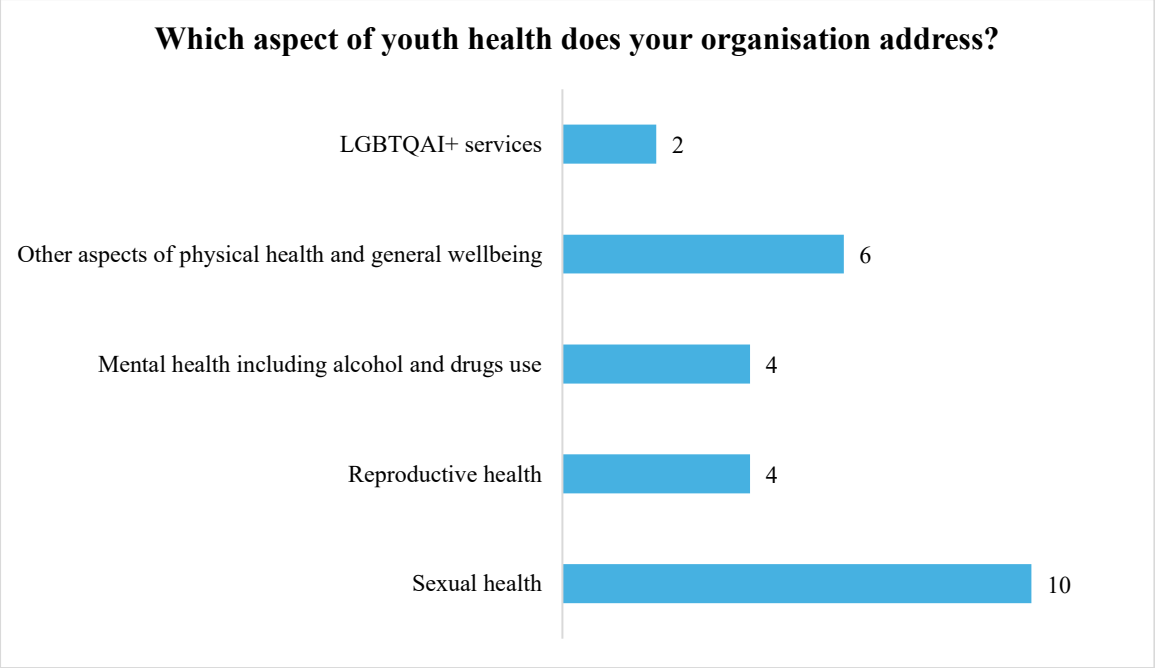


Figure 18.

Types of SRH promotion and other services offered to youth by participants (Research data)



Ten organisations had at least one social media account for work-related purposes, except for one that strictly used the website (see Table 8). The majority of social media accounts were on Facebook (n=9), Instagram (n=7), Twitter (n=3), and TikTok (n=3).

Table 8.

Social media platforms used by participating organisations

S/N	Platforms	Number of participants (n=10)
1	Facebook	9
2	Instagram	7
3	Twitter (including 'dark Twitter')	3
4	TikTok	3
5	Website	2
6	Others – Grindr, Tinder, YouTube, LinkedIn	5

4.4. Data Collection

Methods are the activities deployed for information gathering (Carter & Little, 2007; Crotty, 1998). They describe the strategies and techniques applied in the information gathering process, from defining the target population to establishing inclusion/exclusion criteria, recruiting research participants, collecting data, analysing and reporting results.

The use of semi-structured interviews and focused group discussions allowed for information to be shared as it applies in real-life situations rather than in a hypothetical context (Carter & Little, 2007). In qualitative research underpinned by critical theory and CPYD principles, interviews and focused group discussions are tools that enabled me to critically explore participants' worldviews, gaining depth into their meanings, expressions, and thought processes (Cahill, 2014; Crotty, 1998). Based on our interactions, I adapted the inquiry process to emerging insights that arose from our conversations (Braun & Clarke, 2013; Goodman-Scott et al., 2024).

Interviews and Focused Group Discussions

Open-ended, semi-structured interview questions were asked during the study. Participants could choose whether or not to answer questions, as participation was voluntary. Participants were informed of their right to withdraw without any consequences (see Appendix C for consent forms template).

Two data gathering sessions were held virtually, the first from August to December 2022, and the second in August 2023. In the first session, participants' ideas about social media as a tool for SRH promotion delivery and how they engage with young people in New Zealand on the different platforms were explored. In the second session, a summary of findings from the first session was shared and participants' opinions were sought on what these findings meant to them, including their implications in practice. This provided the participants with an opportunity to contribute to the

conceptualisation of the artefact that complements the research exegesis. Each interview session lasted about 60 minutes. Interviews were conducted by in English, audio-recorded on the Microsoft Teams or Zoom platform, and transcribed using Otter.AI computer software. Following, I reviewed each transcript to ensure language and meanings were accurately captioned and presented. Coding and categorisation were done using NVivo 14 software.

4.5. Analytical Methods

The analytical approach reflects a critical engagement with the qualitative data. Reflexive thematic analysis (RTA), underpinned by CPYD principles (discussed in sections 3.4 and 4.1 above) served as the primary analytical framework. Complementing this approach, case studies were employed as a comparative analytical tool to enhance interpretation and knowledge production. The following sections describe each of these methods.

4.5.1. Reflexive Thematic Analysis

The RTA process is iterative and reflexive, showing how meaning constructs for the categories, subthemes, and themes were derived from the data (Braun & Clarke, 2013). The iterative nature of RTA ensures that coding and thematising follow a 'zoom-in and zoom-out' approach (Braun & Clarke, 2019; Nicolini, 2009), enabling in-depth review, reflection, interpretation, and innovation in knowledge production (Braun & Clarke, 2022). By undertaking a reflexive approach to data analysis, I ensured I could 'ask questions of my qualitative data' as I worked to answer the main research questions. RTA moves beyond prioritising coding accuracy and reliability to give more weight to subjective interpretation, which accommodated my role in the research process (Braun & Clarke, 2021).

In addition to interrogating the data to elicit knowledge from the interviews with SRH providers, data analysis applied a critical youth lens whereby the inquiry and interpretation were made to unveil inequality, inclusion, and social justice issues (Ginwright & Cammarota, 2007; Gonzalez et al., 2020; Thomas et al., 2022). This aligns with Crotty (1998), Cahill (2014), and Gonzalez et al. (2024), who argued that critical research must review data through the lens of equality, emancipation, and inclusion.

The integration of RTA and CPYD principles followed a phased analytical process. Initial descriptive analysis and thematic development were validated with research participants before applying a critical youth lens to re-interrogate power relations and youth agency within the data. This analytical evolution aligns with the iterative and reflexive nature of qualitative inquiry described by Braun and Clarke (2019, 2021, 2022, 2024), where theoretical frameworks are developed and refined through engaged scholarship rather than a rigid, linear process.

RTA is most suitable in this context because it is a flexible approach that accommodates the researcher's active role in coding and analysing qualitative data (Braun & Clarke, 2013, 2022; Campbell et al., 2021). However, while RTA is gaining popularity in qualitative research, several authors (Braun & Clarke, 2024; Byrne, 2022; Campbell et al., 2021; Liebenberg et al., 2020; Trainor & Bundon, 2021) have argued that knowledge is scarce on the 'how-to' application of RTA as a method in the data analysis stage of research. Commonly referenced are the six steps to conducting thematic analysis by Braun and Clarke (2006), but RTA is unique in the application of its six recursive steps in the analysis stage (Braun & Clarke, 2021). One of its unique aspects is that RTA is not often applied as an analytical method because it can be complex, incubating researcher subjectivity in data interpretation, iterative data engagement, and conceptual and organic coding style throughout data analysis (Braun & Clarke, 2021, 2022, 2024; Liebenberg et al., 2020). Therefore, in this study, in addition to eliciting knowledge from the interviews with SRH providers, data analysis applied the researcher's subjectivity through a critical youth lens, such that the inquiry and interpretation could reveal any inequality, inclusion, and social justice issues emanating from the data (Thomas et al., 2022). This further justifies deploying RTA as the chosen method for analysing my research data.

Operationalising the Critical Youth Lens

To ensure CPYD principles were applied throughout the analytical process, I developed a set of interrogatory questions that guided my critical engagement with the SRH provider narratives. These questions were applied iteratively during coding and theme development to surface power relations, challenge adult-centric assumptions, and centre youth agency and lived realities.

Interrogatory Questions Challenging Power Relations and Adult-centrism

- What are providers' and my assumptions about young people's SRH needs, and how have they portrayed young people as incompetent in seeking information for and by themselves?
- How does this provider's view and use of technology and their organisational digital strategy measure up against the reality of youth as digital natives?
- What are the assumptions about young people's consumption of social media content and its use for SRH promotion?

Interrogatory Questions Foregrounding Youth Agency and Competence

- How has provider information validated youth, or not, as digital natives competent to seek information and support on their own?
- How has the data shaped my worldview, showcasing vulnerabilities and barriers demonstrated by providers, preventing them from recognising young people as competent experts about themselves?

Interrogatory Questions Validating Young People's Lived Experience as Digital Natives

- What evidential examples abound in literature to support the realities of young people as digital natives capable of seeking knowledge to make informed decisions?

- How do the cultural context and ethical concerns about digital spaces affect our (the researcher and providers) perception and acceptance of young people's realities as digital natives?

The above questions served as reflexive prompts throughout the analysis and interpretation stages, ensuring that the meaning-making process remained critically attuned to youth-adult power relations and structural inequalities. By applying these questions, I translated the descriptive insights into a more critically examined thematic construct, further establishing the analytical framework evolution detailed in Chapter 6, Section 6.2.

Applying the 6-steps of RTA in Data Analysis

Following the prescribed steps for RTA by Braun and Clarke (2021) and the worked example published by Byrne (2022), I have outlined and discussed how I iteratively engaged with the research data, developing and interpreting themes to inform the study findings. It is important to note that, being a recursive process, the analytic stage does not follow a linear path; therefore, efforts are directed towards achieving data adequacy for subjective interpretation, and not simply saturation (Braun & Clarke, 2012, 2022; Byrne, 2022).

1. Familiarisation with the research data

In this step, I looked for meanings and patterns that answered the research question by reading and re-reading the transcribed data (Braun & Clarke, 2022). This step informed the broad and preliminary categorisation of developing patterns and ideas from the dataset at this stage of the analytical process. I took notes in my research journal and created memos on NVivo. These served as interesting pointers that were followed up on in subsequent steps.

2. Organic coding

Coding of data was conducted organically and with continued engagement with the dataset, reflecting a shift in concept formation and data interpretation consistent with Braun and Clarke's (2022) reflexive approach. Initial inductive categorisation was informed by the research questions and qualitative interview guide, providing an organisational framework through which data points were systematically assigned to categories. Both the explicit and implicit meaning of the data were considered at this stage of the analysis (Byrne, 2022). Subsequently, deductive categorisation was carried out manually using Microsoft Word and Excel files to highlight patterns and codes, documenting annotations and reflections throughout the process (see Appendix G for the summary notes). Within this structured framework, organic coding continued as additional patterns emerged

inductively, and about 24 categories[7] (Appendix D) were finally identified through repeated engagement with the data. See Table 9 and further alignment to themes and subthemes in Table 10.

Table 9.

Developing categories inductively and deductively during the iterative analytical process

Relevant research question	Interview guide framing on NVivo (Inductive)[8]	Final analytical category (Deductive)	Meaning construct	Example codes
RQ 1	Use and user perspective	Use and user perspective	How practitioners currently use social media for YSRH promotion and their perspectives on its effectiveness	Benefits: Information sharing; Viral reach Downsides: Not sustainable for behavioural change; Difficult to measure impact; Allows uncontrolled interpretation;
RQ1	Social media content creation	Social media content creation	What informs messaging and information sharing on social media from organisational and practitioner perspectives	Quality and consistency crucial challenges; Limited/exhausted ideas for specific niches; Audiovisuals get more engagement, but costly and time-intensive
RQ2	Time, manpower, and funding	Time and manpower limitations	Financial, human resource, and time constraints facing organisations using social media for YSRH promotion	Dedicated personnel unaffordable; Government funding can restrict creativity
RQ2	Language	Language	Choice and tone of communication; Awareness and understanding of youth-oriented health promotion language in social media and digital space	Youth slogans/ terminologies constantly changing; Hard for practitioners to keep up; Managing diversity challenging
RQ2	Community and trust building	Community and trust building	Emphasises the importance of fostering community and trust between practitioners and	Community fosters trust through sharing/learning; Takes time and consistency; Practitioners need to approach without appearing judgmental

[7] This reduced from 33 parent and child nodes on NVivo.

[8] The category names shown here did not change much in the 'Final analytical category' because the examples listed were mostly parent nodes in NVivo. Upon consolidation, 24 final categories emerged after merging some child nodes into their parent nodes and merging categories with overlapping meanings. See Appendix G and Appendix E for more details.

Relevant research question	Interview guide framing on NVivo (Inductive)[8]	Final analytical category (Deductive)	Meaning construct	Example codes
			young people on social media	
RQ3	Training	Training	Capacity building opportunities for practitioners to effectively use social media for YSRH promotion	Social media technical to navigate; Training needed to effectively use as an SRH promotion tool, so young people can benefit
RQ3	Collaboration and outsourcing	Collaboration and outsourcing	Opportunities for organisations, practitioners, and young people to work together	Inter-agency partnerships address weaknesses Co-creation enables youth ownership

3. Initial themes generation

Following the development of categories, I reviewed each set with a focus on identifying patterns and aggregating meaning to develop themes or sub-themes. A theme "captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). The aim at this point is to understand how these patterns and their meaning construct respond to the research questions and inform the specific theme(s).

4. Themes construct

In this phase, SimpleMind Pro mind-mapping software was employed to visually map relationships between the developing themes, relevant categories, and their congruent codes. This ensured I could identify and map the connections, especially those overlapping (see Appendix F for the expanded themes and categories table). On the summary document, I noted down the reassignment of categories and codes across themes (Campbell et al., 2021). Further, I checked that the developing theme is distinctive in meaning and has sufficient and relevant codes to back it up; otherwise, I might have considered it as a subtheme or merged completely into another theme.

At this point, applying a critical youth lens to unpack the participants' responses to interview questions was useful for meaning construct (Creswell, 2007; Crotty, 1998). This ensured I could examine the research participants' narratives for their perspective on youth agency and opportunities for authentic connections, while revealing underlying power relations in the process. In practice, this involved developing a coherent thematic narrative based on emerging insights. I acknowledged that my past experiences and learnings shape my understanding of the data. This reflexive practice supported the critique of assumptions and interrogation of the meanings that were forming, ultimately enabling me to conceptualise the thematic patterns derived from the participants' narratives.

5. Finetuning and naming themes

Here, the themes were further refined to ensure that their definitions were clear, and the dataset coded in each expressly fit. With the possibility that meaning may overlap, there may be some intersection across themes (Braun & Clarke, 2006). Key quotes were highlighted to best capture the narrative in consonance with the research question(s) it answers, and its constitutive theme. By applying a critical, yet reflexive, lens to the interpretation of data, I aimed to harness the power dynamics from participants' expressions, then evaluate these based on CPYD principles earlier discussed (Uekusa, 2024). Doing so ensured the analysis went beyond descriptive to a more analytical depth (Byrne, 2022; Trainor & Bundon, 2021).

6. Writing the findings

This stage considered existing literature, implications for practice and policy, and suggestions for future research. It summarised all the processes undertaken, especially the presentation of themes and overall findings in a logical manner, ensuring they flowed as a continuum from one to another. Memos, notes, and sketches developed in the process of analysing the data were useful at this stage. The recommendation of Braun and Clarke (2013) is that report writing for a RTA research should depart from the traditional style of separate results and discussion sections; rather, data synthesis and reporting should be presented as one in the 'results' section (Braun & Clarke, 2013; Byrne, 2022) to better align with the analytical approach. In this exegesis, the 'results' section is presented in Chapter 6, describing the analytical interpretation of provider narratives and the underlying power dynamics reflected.

Table 10 outlines the categories and their alignment to themes and subthemes. The categories emerged through iterative engagement with the qualitative data, with some relevant across the research questions and themes. The categories reflect inductive coding of provider narratives, and the themes represent interpretive synthesis across research questions. More details on the categories description and codes are provided in Appendix D.

Table 10.

Aligning categories with themes and subthemes

S/N	Themes and subthemes	Overview of themes and subthemes	Example categories	How categories connect
1	Social but not socially connected Organisational context and digital strategy implications Resource limitations	Examines the persistent gap between adult SRH providers and youth, and how organisational mission, size, and resources	Use and user perspective, Alternative platforms, Topics-User engagement Presentation, Social media content creation, Social media restrictions, Technical	These categories collectively reveal how provider perspectives, platform constraints, skills gap, and resource limitations create a disconnect between young people and adult SRH providers.

S/N	Themes and subthemes	Overview of themes and subthemes	Example categories	How categories connect
		influence social media use for health promotion	capacity, Cost, Time/manpower/funding	Organisational capacity shapes what is possible, while provider sentiments about social media's effectiveness for behavioural change demonstrate adult-centric approaches.
2	Don't tell me what to do: The dilemma of language, community, and trust Youth-Adult tensions in religious and cultural contexts Stigma and risk aversion	Examines how adult providers' own experiences and cultural sensitivities clash with youth perspectives, creating barriers to trust and community building within and outside of the digital spaces	SRH communication barriers, Language, Acceptance; Community building Ethnicity and cultural inclination, Language, Relationship building, Community and trust building, Sense of responsibility	The categories reveal how stigma, religious, and cultural norms, as well as provider perspectives and dispositions about youth sexuality, create environments where young people feel judged, unsafe, and unwilling to engage, fundamentally affecting their health-seeking behaviour and a resultant effect of lack of trust and authentic connection
3	No one size fits all: Engage, adapt and collaborate Platform differentiation and targeted content Targeting niche audience	This takes the analysis beyond identifying and discussing the problems to exploring pathways for solution through collaboration, co-design, and holistic engagement across stakeholders	Training, Support (manpower/funds) needed, Challenges (multi-levels) hindering support; Collaboration and outsourcing	These categories reflect how inter-agency partnerships, youth co-creation, peer-influence and trust-building strategies can address the barriers identified in themes 1 and 2, while centring youth voice and agency.

It is important to note that RTA is not a linear process, as is the case with any form of thematic analysis (Auriacombe & Schurink, 2012; Braun & Clarke, 2012). Several iterations and reflexive thinking were applied, especially between steps 2 and 4. Codes were re-categorised, themes refined, and meanings constructed to reflect critical thinking and knowledge formation (Braun & Clarke, 2021, 2022).

4.5.2. Comparative Case Studies

Within this study, case studies served as context-based summaries that illustrated knowledge and practice (Cleland et al., 2021; Htong Kham & Ng, 2025). Their methodological flexibility across disciplines enables researchers to apply them within their ontological and epistemological paradigms (Mills et al., 2017; Takahashi & Araujo, 2020). In this study, case studies functioned both as a comparative analytical tool and as an interpretive tool in the meaning-making process, shaping youth-responsive practice, and contributing towards evidence-based policy development that is centred on young people's realities and critical perspectives (Cahill, 2014; Gonzalez et al., 2024; Lipton, Dickinson, et al., 2025). As employed in Section 3.7.3, and presented in Appendix H, cases were used as examples demonstrating youth autonomy, agency, and effective youth-adult partnerships in New Zealand and elsewhere. The analytical process involved identifying the commonalities and differences across cases to strengthen the interpretation and presentation of the findings. Adopting this comparative approach required explicit understanding that youth are not homogeneous; therefore, contextual implications were considered when applying it throughout the analytical process.

4.6. Research Trustworthiness and Rigour

The rigour of qualitative research has always been controversial (Carter & Little, 2007); however, with a methodological approach, the quality of the research and the reliability of its findings can be justified (Mays & Pope, 1995). In this study, rigour was maintained through strategies that aligned with RTA and CPYD principles.

Some of the ways for maintaining rigour were through a stepwise approach of planning, iterative data collection and analysis, and interpretation of findings. Audio-recorded interviews were transcribed using Otter.ai, a voice-to-text transcription software, and the text transcripts were coded and categorised using the NVivo computer software. The iterative engagement with data and the reflexive nature of RTA informed the preliminary findings that were fed back to the research participants. This process validated the emerging conceptual framework in alignment with participants' perspectives and experiences. At this stage, data interpretation was mostly descriptive and allowed the research participants to validate the shared preliminary interpretations and thematic patterns. Following this validation, and my deepened understanding of the CPYD principles, the analytical approach shifted from simply descriptive to a more critical stance, where I re-examined the data through a youth-centred lens to surface power dynamics and youth agency.

Triangulation of data sources was carried out by identifying patterns between the emerging themes and existing literature. Ensuring that the process of data collection and analysis is replicable, including intelligible interpretations from the data, assures trustworthiness and rigour in the research (Carter & Little, 2007; Creswell, 2007; Schön, 1987). According to these authors, validity in qualitative inquiry is also ascertained from the reflexive and continuous dialogue between the data,

the research participants, and the researcher across the multi-levels of analysis such as text, context, and individual interpretation.

4.7. Research Ethics and Treaty Obligations

Potential research organisations/participants were reached through an introductory letter and participant information sheets (see Appendix A and Appendix B), which contained the researcher's details. Once participation was confirmed and the consent form (see Appendix C) returned, the interview schedule was agreed on.

In this research, anonymity was not applicable because I was involved in data collection activities; therefore, I could identify the participants. While participant privacy was kept, confidentiality in the research is limited because participants were accessed primarily through their organisation, meaning that those within the organisation or other close associates might be able to identify 'who said what'. To manage this issue, the data were anonymised during analysis and interpretation of the research findings. I ensured that the data were not used for any other purpose other than the intended research and have been securely stored with access limited to myself and my supervisors. Participants can also access their own data in line with the study's ethical guidelines. The data will be disposed of following the established protocol by AUTEC.

The Treaty of Waitangi principles of partnership, participation, and protection mandate that all research done within New Zealand is such that contributes to outcomes that are useful and relevant, as well as fosters equality, equity, and justice in its diverse communities. Treaty obligations ensure the equitable distribution of health resources and provision of health care to everyone in New Zealand, regardless of ethnic background, which is relevant in this study, and that power between the researched and the researcher is fairly balanced and gives room for the representation of young people who were not directly involved in the study. Further, the Te Ara Tika – Guidelines for Māori Research Ethics (Hudson et al., 2010) encourages researchers in New Zealand to ensure they have meaningful engagement in addition to the consultations held with their participants. This is important for alignment between their aspirations and benefits from the research, while ensuring the uptake of research findings.

Partnership

Partnership aimed to provide an opportunity for critical engagement and collaborative decision-making between the SRH providers and me so that we could work together on our common interest, young people. This form of relationship is believed to thrive on mutual respect. The research blended the perspective and experience of academics and SRH providers within the community, each freely expressing their values and expertise as they co-constructed meaning on the use of social media as a tool for promoting SRH. This is fundamental to aligning with the real-world context about what works or could work, more so, one that embraces innovation and opportunities for collaboration.

Protection

Qualitative research is often expressive, supporting robust and rich information gathering (Braun & Clarke, 2013). As a result, participants must be protected and narratives that may cause harm were not discussed. In this study, the research participants' right to protection was ascertained by use of an introductory letter to identify voluntary participants and the participant information sheet to enlighten them about the research objectives and processes (Appendix A and Appendix B), and written consent to obtain evidence that research participants understood the demands and were willing to be a part of the research (Appendix C).

The potential benefits (e.g., opportunity to lend a voice and contribute to public health issues), as well as risks associated with group discussion (e.g., privacy), were discussed at the onset of the meeting to ensure it is clearly understood by prospective participants. Confidentiality was maintained, and all data were anonymised before sharing externally.

Participants had the opportunity to choose if they would like to be identified in the study as a form of acknowledgement. In line with the principles of protection and privacy, in instances where the organisation or the respective staff participant did not wish to be identified or acknowledged as a research contributor, this was maintained in the relevant section of the thesis. To ensure participants' privacy, all data are kept securely on an AUT password-protected server and solely used for research purposes or any other lawful purposes that may be required.

Throughout analysis and thesis writing, pseudonyms were used so no individual or organisation was identifiable by personal characteristics or information shared. It is important to note that the issue of anonymity is not absolute in this type of research, as I facilitated the data collection process and can identify the participants. It is equally important to note that participation in the research was voluntary, written consent obtained, and their right to withdraw at any point during the research process was maintained. Among those who participated, none withdrew during or after the data collection, but one participant had died by the time the preliminary findings were shared. All organisations and participating employees will be provided with a summary of findings and the artefact resulting from the research.

Participation

The ethics of mutual respect and meaningful participation were encouraged throughout the research process as the methodology hinged on the construct of meaning by the researcher and the participants. This approach made sure that the research participants could freely share their technical and experiential knowledge. Subsequently, sharing the findings from the primary data with the participants and allowing them to reflect on how it applied in their service delivery supported the principle of partnership (Cahill, 2010). In essence, the concept of critical engagement and reflexivity, as well as team spirit, was established.

4.8. Researcher Positionality and Reflexivity

I consider myself an active participant in this research, and I am aware of how this affected the exchange of opinions and stimulated conversations throughout data collection. My experience implementing health and livelihood programmes targeted at community-based youths, and later as a field-oriented researcher back in Nigeria, contributed to some of my assumptions while engaging with the participants. I acknowledge that the New Zealand context differs from my past work experience, and I remained open to learning throughout data collection and interpretation.

As a researcher, my worldview, knowledge, and reality played a critical role in adapting and adopting constructionism as the epistemological underpinning for this study. The epistemological approach adopted in research aligns with knowledge synthesis and methodological concepts (Thomas et al., 2020). A misalignment could negatively impact the research outcome in terms of knowledge synthesis and interpretation (Carter & Little, 2007; Crotty, 1998; Schön, 1987). As the researcher, I consciously navigated the research stages with an awareness of how the research questions fit within the epistemological concept and the chosen methods, in a way that could be justified and defended.

Another layer to my positionality was my direct participation in the research, as my prior experiences, biases, interviewing skills, and personal reactions all shaped the questions I asked and ultimately influenced the research process (Mays & Pope, 1995). Having worked with young people at the grassroots level back in Nigeria, I held some perceptions that shaped my thought process during the research design, data collection, analysis, and interpretation. While I was careful not to let this overwhelm the research process, I also made sure it did not disappear from the research.

As a volunteer, and later in my transition into programme and project officer roles, my work with NGOs involved interfacing with young people in educational settings (schools), workplaces (offices/apprentice settings), or their resident communities. My engagement would sometimes be in the position of a peer educator, pre/post-test counsellor, facilitator, researcher, or observer. Such activities helped to build my facilitation and communication skills, better understand participants' perspectives, and manage my bias. I learnt to critically review information, identify key issues, and prioritise them based on the research objectives and significance. My work with young participants empowered them to look within, leverage their strengths, and articulate their needs. During these sessions, I used critical reflections and participatory activities, including stakeholder mapping, fish-bone analysis for problem identification, and participatory rural appraisals. I carried these skills forward and built on them when I worked with the Global Fund's AIDS, Tuberculosis and Malaria project team in Ondo State as a State Communications Consultant with UNICEF and Oxford Policy Management in the Federal Capital Territory, Abuja.

My work with service providers on this study has shaped my understanding of youth perspectives. While SRH providers may act as bridges between young people's lived experiences and the broader systems they navigate, this role can be complex as they navigate youth worldviews.

Through my work on this study, I have seen how gaps in understanding youth perspectives can hinder meaningful engagement and enable control. During our discussions, I could perceive SRH providers' desire to support young people's desire for improved knowledge on SRH and control over their health outcomes; however, these two appear not to speak the same language. Among the digitally fluent younger generation, everyday communication has shifted into a coded, abbreviated form of expression that relies heavily on slogans, memes, and shorthand to convey meaning and identity (Cahill, 2014; Mansfield et al., 2025). As a result, many SRH providers struggle to fully comprehend or relate to their needs, making it harder to build a genuine connection or offer meaningful support.

I also noted that some providers are already on a positive trajectory, embracing approaches like co-designing health solutions with youth, encouraging advocacy, and empowering young people to take ownership of their health outcomes. These progressive providers appear more willing to listen to youth voices and collaborate as equal partners, reflecting a shift toward youth-led approaches. In contrast, others have remained entrenched in traditional practices with no social media presence, engaging adults to facilitate youth engagement sessions, an indication of their reluctance to yield control or adopt newer technologies that could foster authentic connections with young people more effectively in SRH promotion.

In summary, the gap between the worldviews of digital immigrants and digital natives highlights the ongoing challenge of providers not responding to the lived realities of the young people they serve. The insights from the qualitative data align with the research objective and address the questions about how social media can be used as a health promotion tool for young people's SRH and well-being. Adopting a critical youth lens in data analysis and interpretation further helped project the youth voice and inform a practice framework that providers can adopt to improve service delivery.

Chapter 5. Reflexivity in Research

5.1. Introduction

In this section of the exegesis, I have presented a critical account of how the research was conducted, from conceptualisation to implementation and artefact production, examined through the analytical lens of CPYD. This framework is rooted in critical youth theory, which examines the power dynamics and social inequalities that shape the experiences of young people (Akom et al., 2008; Gonzalez et al., 2020; Griffiths, 2009; Morrow & Brown, 1994). Applying a critical youth lens challenged deficit-based assumptions that youth are non-experts on matters concerning them and cannot shape their own lives (Gonzalez et al., 2020; Petrone et al., 2015). This lens shaped my reflexive practice in two ways: first, it required moving beyond descriptive accounts of what was done to critically examine why certain decisions were made and whose perspectives were at the centre of the discussion. Second, it demanded the explicit acknowledgement of how my positionality as an adult researcher informed what I observed, interpreted, and ultimately produced.

It is important to distinguish between reflection and reflexivity, as these terms are often conflated yet serve distinct purposes in critical research. Critical reflection is the practice of 'learning from experience' by looking back, examining what happened, what worked and what did not, and, at the same time, revealing powerful and hidden assumptions that illuminate a person's understanding of their own experience, fostering individual agency (Fook & Gardner, 2012; Schön, 1987). Reflexivity examines how the researcher's positionality, values, assumptions, and power relations actively shape the research process and its outcomes by interrogating why certain decisions were made, why certain perspectives were centred and why the research took the shape it did (Ide & Beddoe, 2024; Mauthner & Doucet, 2003). Critical reflection requires a retrospective examination of one's actions and thinking to challenge oppressive relations and hegemonic assumptions that cause inequality within broader systemic power structures (Fook & Gardner, 2012). In contrast, reflexivity is an iterative process of continuously examining how the researcher's positionality, particularly the power dynamics between the researcher and the researched, influences their practice and the production of knowledge (Ide & Beddoe, 2024).

The primary objective of this chapter is to critically examine two structural and institutional positions that shape how young people's SRH promotion needs are addressed. First is my position as an adult researcher, which influenced how I collected and interpreted data about youth SRH promotion on social media. Second is SRH providers' position as adult professionals operating within institutional settings that engage in SRH promotion on digital platforms, and how this shapes their practice and approach to youth engagement. By critically examining the intersection between my researcher worldview and the providers' practice and expert knowledge, I analysed how these perspectives collectively reproduce power asymmetries that undermine youth voice and agency in

SRH promotion. Therefore, the concept of adultism, which privileges adult perspectives over youth knowledge and experience, was applied as an analytical and reflexive lens to surface youth marginalisation in the New Zealand SRH promotion context.

In addition, my lived experience has shaped my reflexive practice. As an immigrant researcher in New Zealand, I have navigated cultural differences, encountered public health landscapes different from what I knew in Nigeria, and built working relationships across communities and with diverse stakeholders during my studies. These experiences shape my practice as a researcher, helping me negotiate my belonging within public health as a field of practice while attending to the dynamics that CPYD seeks to address in the health promotion domain.

As practice-oriented research aligned with the AUT format three pathway (AUT, 2026), this thesis comprises an exegesis complemented by an artefact, the 'Youth-Adult co-design model for digital YSRH promotion', a creative output of the practice-oriented work. The artefact showcases "the relationship between the central concept, key contexts, focus and methodology of the practice-oriented work, thereby setting the thesis in its relevant critical context" (AUT, 2026, p. 52). The exegesis comprises literature reviews and critical commentaries on the themes developed from the data, and how these informed the artefact. The artefact can serve as a framework to guide collaborative and innovative partnerships between SRH providers and young people, as well as other stakeholders relevant to their partnership within SRH promotion in New Zealand and beyond.

To understand how my researcher experience throughout the knowledge production journey intertwined, the reflexive practice is articulated in three phases: 1) Preparation and conceptualisation – examines the foundational assumptions and decisions that influenced the research design; 2) Reflexivity and working with SRH providers – interrogates how power operated in the research encounter (data collection and analysis) with SRH providers and its positioning of youth within these dynamics; and 3) Artefact development– reflects on what it meant to produce knowledge surfacing youth voice and meaningful participation within an adult-dominated professional landscape.

5.2. Preparation and Conceptualisation of the Research

In qualitative research, the conceptualisation and planning phase is essential to the questions asked, the methods deployed, and the interpretation of findings (Auriacombe & Schurink, 2012; Sveinson et al., 2025). Critical commentary on the sense-making process required me, as a reflexive researcher, to begin by 'turning the lens on ourselves' (Brummans, 2015; Buckley et al., 2024), starting from this foundational phase. My professional background before moving to New Zealand, which involved working with young people at the community level and through NGOs, shaped how this reflexive account proceeds (Brummans, 2015; Ide & Beddoe, 2024).

At the start of the research, I assumed that access to technology would not be a problem in New Zealand, a country with significantly better digital infrastructure than my home country, Nigeria.

Relatedly, I assumed that social media is widely used, particularly among young people; therefore, both SRH providers and young people would consider it an essential tool for health promotion. These assumptions were not neutral but externally imposed on young people what they need and how they engage with health promotion in the digital environment (Ginwright & Cammarota, 2002; Gonzalez et al., 2020). As I worked with my supervisors to conceptualise the research and continuously engaged with the literature, these assumptions shifted, giving way to a more culturally grounded and youth-oriented understanding of the New Zealand SRH landscape (Ide & Beddoe, 2024).

A significant methodological turning point in the preparatory phase was the shift from directly engaging young people as research participants to focusing on adult SRH providers as the primary participants, while maintaining young people's experiences as the core analytical focus. This shift was informed by two convergent institutional forces: the COVID-19 pandemic, which made the original design for in-person participatory research impracticable, and the AUT ethical review process, which identified the vulnerability of young people in a sensitive topic area, coupled with my limited contextual knowledge as a recent immigrant researcher, as a material risk. Several other researchers, like me, reported charting new territories, such as the rapid transition to digital methods and the disruption of field-based work during this same period (Akçay & Mısırlı, 2025; Sedysheva, 2020). This methodological shift helped me to confront the limits of my prior assumptions and the boundaries of my contextual knowledge of local communities, culture, and SRH systems.

This turning point represented a deeper reflexive positioning. The institutional gatekeeping exercised during the ethical review process, while necessary, effectively foreclosed more participatory, youth-empowering studies in favour of a practice-based methodology informed by critical theory and CPYD (Bailey et al., 2020; Gonzalez et al., 2020). This reflects a broader structural tension in research governance, where protective logics, however well-intentioned, can reproduce adult-centric assumptions that young people need protection rather than being considered capable agents in their own right (Ginwright & Cammarota, 2002; Gonzalez et al., 2020). Navigating these dynamics meant I recognised that the constraints imposed were not simply bureaucratic. They were sites of institutional power, which actively shape the kind of knowledge that can be produced, for whom, and by whom (Bailey et al., 2020). Nonetheless, the multiple iterations during the ethics application process deepened my understanding of the ethical and political dimensions of youth-centred research and strengthened the rigour and credibility of the final research design.

After several literature reviews and consultations with my supervisors and other local stakeholders, I finalised the redefinition of my research scope and context, while maintaining the core concepts—youth, technology-driven platforms (e.g., social media), and SRH as a public health domain. This stage concluded with the formulation of my current research topic, 'Exploring the perspectives of SRH providers on the use of social media as a tool for health promotion in New Zealand', as well as the research objectives and questions previously presented in Chapters 1 and 3.

5.3. Reflexivity and Working with SRH Providers

Engaging with adult SRH providers as the study's primary participants required sustained critical vigilance about the conditions under which knowledge was being produced. Research with adult SRH providers risks being framed through adult-centric perspectives, which shapes both participants' accounts and the researcher's interpretation of the data (Camino, 2005; Ginwright & Cammarota, 2002; Goodman-Scott et al., 2024). More than paying attention, reflexivity in this phase demanded that I actively interrogate the 'why' of particular framings of young people by SRH providers, their considerations around digital platforms and SRH promotion, examining whose interests they served and what assumptions about youth agency and adultism underpinned them (Gonzalez et al., 2020; Goodman-Scott et al., 2024). This informed the application of the critical youth analytical lens, ensuring I could deconstruct the information received beyond the explicit meaning of what the research participants said, interrogating power dynamics, and, ultimately, examining if it centres or further marginalises youth voice and self-determination (Ginwright & Cammarota, 2002; Gonzalez et al., 2020; Goodwin et al., 2025).

As the researcher, my positionality added complexity to this process. Formed within an African cultural context, where respect for elder authority is deeply ingrained in social relations and intergenerational dynamics, I understood how epistemic hierarchies function as a culturally coherent system of meaning (Owoaje, 2022). My background offered genuine insight into the complexities of youth-adult power dynamics as I could simultaneously recognise providers' genuine concern for young people's well-being while critically analysing how that concern, when expressed through paternalistic or controlling framings, reproduces the same power asymmetries that CPYD seeks to disrupt (Ginwright & Cammarota, 2002; Gonzalez et al., 2020). More importantly, it extended to my own reflexive practice, ensuring I interrogated providers' adult-centric language without unintentionally reproducing it in my analysis and interpretation of data (Buckley et al., 2024; Ide & Beddoe, 2024).

Qualitative data collection methods, such as interviews and focus group discussions, were selected for their capacity to generate contextually rich, participant-centred accounts of SRH provider perspectives and their implications for youth SRH promotion experience (Carter & Little, 2007; Creswell, 2007). These methods have limitations, especially regarding the power dynamics in researcher-participant relationships, which require ongoing reflexive management (Mauthner & Doucet, 2003). As noted in the preparatory phase, the pandemic necessitated a shift to virtual data collection. This transition introduced a specific methodological challenge. In qualitative research, data extends beyond written or spoken words, including gestures and gesticulations that may not translate well in virtual settings (Onwuegbuzie & Byers, 2014). I was challenged to sharpen my listening skills and be more attuned to the non-verbal cues I observed during the interviews. I recorded my reflections in my research journal, which prompted me to refine my approach, ask new questions, and challenge

my assumptions and biases. For example, I noted that the participant (National Coordinator, T6) struggled to articulate their organisation's digital engagement strategies, revealing a significant disconnect, as their practice remained anchored in in-person facilitation, a contrast to the digital environments that young people typically inhabit (Cahill, 2014; Haruna et al., 2018). With this understanding, I interrogated subsequent interviews and data analysis for similar perspectives and opportunities to bridge the gap.

Another reflexive moment while working with providers arose when one of them unequivocally stated that they would not engage young people on sensitive topics such as SRH through social media platforms. This prompted an immediate methodological adaptation of the interview guides, so subsequent interviews captured the full range of digital platforms SRH providers use for health promotion messaging. These include websites, newsletters, blogs, and vlogs. Analytically, this adaptation illustrates the power dynamics between providers' desire to control institutionally managed platforms and the more interactive, equitable platforms young people thrive in. It reflects the risk-averse, adult-centred logic that CPYD critiques, prioritising institutional comfort over young people's rights to access SRH information in the environments they naturally function (Ginwright & Cammarota, 2002; Gonzalez et al., 2020).

This observation also created an opportunity for further reflexivity. From a CPYD perspective, young people are not passive recipients of provider-designed content but active and capable prosumers who produce, share, and critically engage with information on their own terms within digital environments (Cahill, 2014; Chang & Chang, 2023). Digital fluency among young people, however, is neither uniform nor unconditional; access, culture, and context mediate it (Rose, Garrett, McKinlay, & Morgan, 2021; Saeed & Masters, 2021). This realisation informed my analysis, allowing me to view providers' digital practices not just as a matter of organisational capacity, but through the lens of how those practices align with, or diverge from, the attitude and prosumer nature of young people in technology-based settings like social media (Cahill, 2014; Haruna et al., 2018; Rose, Garrett, McKinlay, & Morgan, 2021). Thus, the analysis surfaced adult-centric assumptions, which occur when digital health promotion content is framed around adult perspectives rather than what young people have identified as needs and how they have defined ways to address them (Ginwright & Cammarota, 2002; Gonzalez et al., 2020).

One of the significant moments that enriched my reflexive practice came up when I spoke with some providers who shared how they navigated constraints encountered due to cultural, religious, and parental restrictions on SRH content that could be addressed, taught, or supported within school environments. It revealed that they too operated within structural constraints that limited their support even when young people's demand and need for such support were evident. This disrupted my assumption that providers' limitations in delivering youth-centred SRH promotion were primarily bound by their organisational or personal values. It brought me to the realisation that adultism is not simply an individual behaviour, but a systemic condition reproduced through

institutional, cultural, and community pressures that constrain SRH providers as well as young people, although in fundamentally different ways and with different outcomes (Ginwright & Cammarota, 2007; González & Veale, 2025). Therefore, while I acknowledged this as a structural constraint for SRH providers, it was not sufficient to justify displacing young people's unmet SRH needs from the centre of the analysis. Combining these two realities strengthens how I have applied the CPYD framework to examine the youth-adult tension in the data interpretation (Akom et al., 2008; Gonzalez et al., 2020).

Prior consultancy experiences had led me to expect that a formal pilot of the research instrument was essential before the research protocol could be considered appropriate and workable. However, as a student researcher navigating a new cultural context during the pandemic, a formal pilot exercise was impractical. The pandemic significantly reduced research participation rates as potential participants were managing their own institutional and personal uncertainties at the same time (Akçay & Mısırlı, 2025; Sedysheva, 2020). This made it ethically and practically reasonable to direct every willing participant toward the main study. Resource constraints inherent to doctoral research further limited this option. It also provided another way reflexivity manifested as a critical and iterative practice throughout my study (Uekusa, 2024). To address this limitation, I shared my interview guide with a research evaluator from a local NGO and conducted virtual practice sessions with fellow student researchers, testing both my interview questions and commonly used technological platforms (Microsoft Teams, Zoom, Skype, and Google Meet) as I prepared to adjust to participants' preferences during the interviews.

This reflexive exercise challenged my prior assumptions about specific research processes and was crucial for adapting my practice to a more culturally relevant and ethical paradigm relevant to the youth-centred commitments of this study. The evaluators' feedback proved highly valuable, highlighting culturally specific nuances I had overlooked. For instance, they recommended adding a new question to explore the nuanced connection between mental health and youth SRH, a topic my initial questions had not adequately addressed. This consultation also fine-tuned the language in my research information sheet and email invitation, ensuring participants understood how the study aligned with their organisational interests. Critically, this process reflects what Ide and Beddoe (2024) affirmed as a core dimension of reflexive research: the continuous interrogation of the researcher's own assumptions against participant-centred and culturally grounded knowledge.

5.4. Reflexivity in Conceptualising and Developing the Artefact

The development of an artefact was anticipated from the conceptualisation phase, but its specific form, in terms of what it would look like, what it would produce, and how it would function in practice, evolved iteratively throughout the research process. This evolution was not a research design weakness but demonstrated reflexivity and theoretical rigour, as each phase generated new

insights that shaped and reshaped what the artefact needed to do, how it would function, and for whom it was developed. Despite multiple iterations, the artefact's objective has remained consistent: to foster authentic youth-adult partnerships (Gonzalez et al., 2020). This meant resisting two competing pressures identified as barriers to genuine youth-adult partnerships: the pressure of "get out of the way and give up power" pushed on adults (Camino, 2005, p. 75), and the assumption that "youth must and should do everything of importance" (Camino, 2005, p. 77). The artefact was, therefore, conceptualised as a relational and structural tool, one that redistributes rather than abandons adult responsibility, while creating enabling conditions for youth agency and self-determination.

To stay grounded within the critical youth paradigm required sustained awareness of my dual position, both as researcher and adult, while navigating the complex interplay of power, representation, and participation within a youth-centred and youth-led framework (Brummans, 2015; Crotty, 1998; Ide & Beddoe, 2024). This was not always straightforward. There were moments I caught myself adult-framing; that is, when my interpretive choices inadvertently reproduced the controlling tendencies that CPYD seeks to challenge. For example, changing from 'Providers identify…' to 'Youth self-identify as creators…' in the co-design model was one way I challenged this adult-controlling mindset to enable youth agency (Braun & Clarke, 2024; Gonzalez et al., 2020). Interrogating moments, as this was itself a reflexive practice.

In the same vein, the artefact became a site of active reflexive practice as I visualised and interpreted shared governance, intergenerational dialogue, and equitable representation in youth-adult partnerships throughout the iterative phases. A pivotal moment was reconceptualising the model's operating logic from a linear, sequential process to an iterative, continuous loop. This shift was theoretically consequential in that it reflected the recognition that youth-adult power dynamics cannot be resolved through a one-off procedural intervention but require a continuous, context-responsive learning process that shifts and adapts based on the topic, the partnership, and the communities involved. This is also reflected in the naming convention for the artefact itself, from the initial '5-steps framework for youth-adult co-design SRH promotion' to the current 'Youth-Adult co-design model for digital YSRH promotion', deliberately replacing the stepwise, linear connotation with a language that foregrounds iterative, inclusive, and collaborative practice (Braun & Clarke, 2024; Gonzalez et al., 2020).

I was intentional about conceptualising an artefact that does not fit into a hierarchical and layered flow, which would contrast with the iterative cycles depicted across the model. Therefore, I explored a circular flow with leading arrows and symbols that represent partnership and fluidity, rather than authority and control (Ide & Beddoe, 2024). These reflections and iterations, in my view, situate the framework as contextually relevant because it embeds the principles of partnership, participation, and protection, which are integral to Māori and Pacific worldviews (Auriacombe & Schurink, 2012; Brummans, 2015; Buckley et al., 2024).

This stage was a defining moment in my research journey because it integrated my educational and experiential knowledge into a tangible, practice-oriented artefact. Navigating the ideas that ultimately informed the artefact was neither linear nor straightforward, but seeing the alignment between the research findings and CPYD principles reflected in the co-design model affirms the coherence of the theoretical and methodological positions throughout this study. It deepened my understanding that artefact production in practice-based research is not primarily a creative exercise but a rigorous act of knowledge synthesis, demanding theoretical accountability and reflexive scrutiny (Candy, 2006; Ide & Beddoe, 2024).

5.5. Conclusion

This chapter has presented a critical reflexive account of the research process across three phases: preparation and conceptualisation, reflexivity while working with SRH providers, and artefact development, all interrogated from a CPYD perspective, examining how practice legitimises or further marginalises youth agency. The reflexive practice was conducted as a continuous, theoretically informed interrogation of how my positionality as an adult researcher shaped what was seen, asked, heard, and ultimately produced (Ide & Beddoe, 2024; Mauthner & Doucet, 2003).

Across all three phases, a consistent tension surfaced between adult-centred assumptions that I carried as a researcher, formed by my professional, cultural, and institutional contexts, and the application of a critical youth lens through CPYD to centre youth voice, agency, and self-determination (Gonzalez et al., 2020; Ide & Beddoe, 2024). This tension was not resolved but continuously negotiated and constitutes the reflexive practice described across this chapter. From the interrogation of early assumptions about technology access and social media use, through the critical engagement with institutional gatekeeping during the ethics process, to the deliberate design decisions embedded in the co-design model, reflexivity functioned as a substantive analytical practice that shaped the research at every stage (Brummans, 2015; Buckley et al., 2024).

Lastly, this reflexive practice did not position my background as noise. Rather, it amplified my voice as a critical dimension of the research, which, when interrogated, deepened rather than compromised research rigour and credibility. The insights generated through this process informed the findings presented in Chapter 6 and how the artefact was developed in Chapter 7.

Chapter 6. Beyond Adult-centric Views to Empowering Youth

6.1. Introduction

This chapter critically interprets the data by interrogating adult narratives through a critical youth lens (Camino, 2005; Gonzalez et al., 2020; Goodman-Scott et al., 2024). The analytical presentation of the findings situates the practice-oriented approach and how it informed the development of the artefact, the 'Youth-Adult co-design model for digital SRH promotion' (discussed in Chapter 7). Specifically, I integrated RTA with critical theory and CPYD principles.

RTA is an analytical method that uses a flexible interpretative approach to present a pattern-based, critically considered set of findings (Braun & Clarke, 2024; Byrne, 2022). As one type of thematic analysis, RTA is unique in that it acknowledges my role as the researcher in interpreting the data, moving beyond coding accuracy and reliability (Braun & Clarke, 2024; Braun et al., 2019). Reflexivity enabled me to interrogate the underlying meaning in the data (Braun et al., 2019), guiding me through the journey of knowledge production from the unknown (before analysis) to the known (after analysis) outcome of the research. This process was fundamental to conceptualising and developing the artefact that complements this exegesis.

Applying a critical youth lens infused the analysis of adult provider information with a perspective balanced by the realities of young people. This practice involved critically interrogating adult narratives to surface power dynamics, structural inequalities, and opportunities for authentic youth agency that may be obscured within provider-centric positions (Cahill & Dadvand, 2018). Specifically, the CPYD principles described in Chapter 3, Section 3.4 have guided the analytical interpretation of the data and subsequent knowledge production. It has informed the asking of critical questions that authors like Ginwright and Cammarota (2007) and Gonzalez et al. (2020) suggested: 'Whose voice is centred?' 'Where do power tensions appear?' 'How do institutional structures enable or constrain youth participation and leadership?' 'What assumptions about youth capability and risk are embedded in SRH provider practices?' These questions align with the interrogatory questions outlined earlier under the research analytical methods (Chapter 4, Section 4.5) to illustrate the operationalisation of the critical youth lens while engaging with the data. This practice, combined with reflexivity, moves data interpretation beyond simple description to more conceptually formulated knowledge, ultimately enabling youth voice to be heard and critically examined within adult worldviews.

6.2. Analytical Framework Evolution

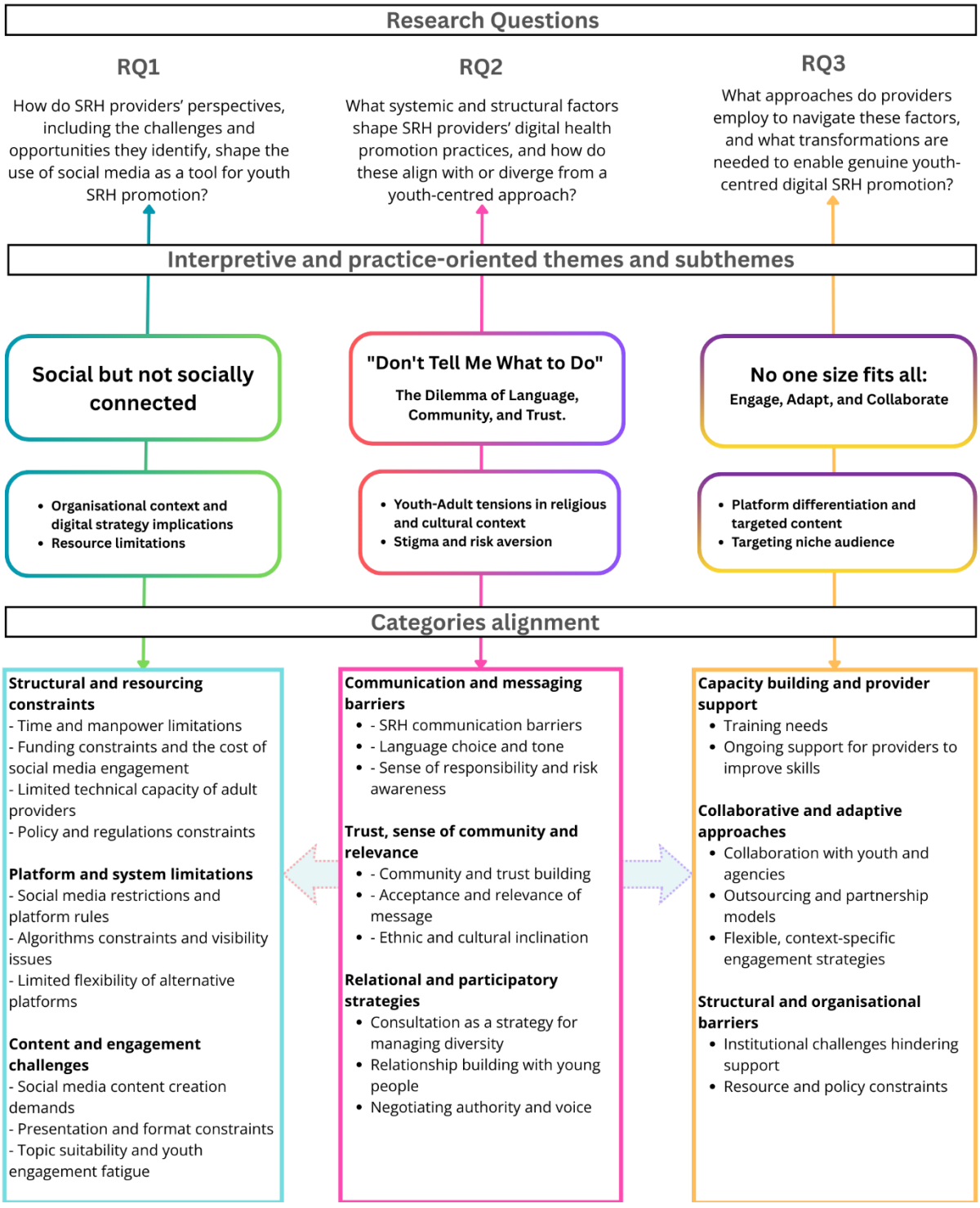
The analytical path of the research evolved in phases, reflecting the reflexive and critical engagement with the data. Initially, the review of the qualitative data generated a preliminary framework (also known as the emergent analytical framework; see Section 3.6, Figure 15) that

conceptualised social media engagement as a principle. It features four interdependent domains: Capacity, Communication, Collaboration, and Health Promotion. This emergent analytical framework was presented to research participants for validation and feedback on the preliminary findings. As the researcher, this framework casts an aspirational vision of what an effective youth-adult partnership in health promotion would look like, using social media or similar digital environments as the platform.

After further reading and understanding of the critical youth paradigm, I re-examined the data through the CPYD lens (Braun & Clarke, 2019, 2021) to reveal significant tensions between SRH providers' narratives and young people's realities. Applying a critical youth lens transformed the descriptive analysis into a more critically interpretive one (Byrne, 2022), revealing power relations and structural constraints in adult narratives on New Zealand YSRH promotion (Deane et al., 2023; Goodwin & Boulton, 2024). This deeper interrogation yielded three themes, illustrated in Figure 19. Each theme directly corresponds to one research question and is analysed to reveal critical tensions between SRH providers and young people in New Zealand. The alignment between categories and themes/subthemes was established in Chapter 4 (Section 4.5, Table 10).

Figure 19.

Critical analytical framework showing interpretive themes, subthemes, and category alignment



The emergent analytical framework (Figure 15, p. 79) emphasised the potential for all four domains to influence how young people and adults operationalise social media engagement while navigating their power dynamics. The critical analytical framework above (Figure 18) foregrounds how structural, communication, and capacity-related barriers constrain authentic youth-adult

partnerships, while surfacing potential pathways to address them. This subsequently informed the development of the practice-oriented artefact, the 'Youth-Adult co-design model for digital SRH promotion' discussed in Chapter 7.

1. **Theme 1 – Social, but not socially connected:** Identifies the gap between young people and adults in digital spaces, including social media, and responds to research question 1 by revealing how organisational context (*subtheme 1*) and resource limitations (*subtheme 2*) impact the use of social media for health promotion purposes.
2. **Theme 2 – 'Don't tell me what to do' – The dilemma of language, trust, and community building:** Reveals the level of disconnection between the worldview of young people as digital natives and adult SRH providers as digital immigrants. It responds to research question 2, showing how narratives about challenges create youth-adult power tensions (*subtheme 1*) and stigma and risk aversion (*subtheme 2*), complicating interactions, especially in SRH promotion and the health care system more broadly.
3. **Theme 3 – No one size fits all – Engage, adapt and collaborate:** Beyond the problems identified in themes 1 and 2, this theme offers a solution-based approach developed from the data to address the systemic and structural barriers identified by SRH providers. It addresses research questions 2 and 3 by identifying opportunities for meaningful partnerships between SRH providers and young people on social media, while presenting alternatives for targeted, improved collaboration. It ultimately complements the conceptualisation of the research artefact.

The evolution of the emergent analytical framework into the critical analytical framework does not negate the relevance of the former; rather, it deepens interpretation through a critical youth lens. This youth-centred perspective was operationalised through three analytical dimensions, challenging assumptions, foregrounding youth agency, and validating youth's lived realities as digital natives (refer to Chapter 4, Section 4.5 for interrogatory questions applied across these dimensions). The following sections present each theme and corresponding subthemes in detail.

6.3. Theme 1: Social, But Not Socially Connected

This theme critically examines the persistent gap between SRH promotion providers and the youth audiences they aim to engage through digital campaigns and educational content on social media. It examines how organisational constraints, including mission, size, and resources, funding limitations, and policy environments, directly shape their capacity for social media-based health promotion. These institutional contexts create competing pressures for providers: on one hand, awareness of youth digital capabilities and preferences; on the other, professional norms that emphasise expertise, risk-management imperatives, and accountability requirements that prioritise institutional protection over youth autonomy. This gap reflects differences in digital fluency between youth and adult SRH providers, what scholars describe as the digital-native-immigrant divide (Cahill,

2014; Prensky, 2001). Together, these pressures and fluency gaps lead providers to prioritise control within institutional settings while expressing scepticism about social media's capacity to facilitate lasting behavioural change, despite evidence demonstrating digital platforms' success in YSRH promotion (Condran, 2017; Engel, 2023; Sewak et al., 2023).

Prensky (2001a, b) defined digital immigrants as individuals born before the digital revolution or who were not exposed to digital technology while growing up and had to adapt to it later in life. Digital natives are described as young millennials with vast access to digital technology and the essential skills to use it (Palfrey & Gasser, 2008; Prensky, 2001b). Compared with digital immigrants, digital natives are more fluent in using and understanding digital media and the internet, unlike the traditional press and libraries, which were more prominent before the digital age (Cahill, 2014). SRH providers demonstrated varied social media engagement for SRH promotion and recognised it as a place to meaningfully connect with young people.

> *We do use social media, and we see it as important moving forward. Because that's how young people connect with each other. So, if we're not involved in that space, then we're not accepting that part of them. So, I think that it's about understanding the people that we work with and saying, like, this is like a big part of their lives. So, we need to involve ourselves in the space. [T10]*

> *I think particularly for young people, there is an opportunity there to talk about kind of the really basic stuff around SRH that we often have and the burden that is left to schools ... in which schools don't actually, at the moment, I believe, have a particular curriculum they're supposed to follow. [T7]*

> *It's useful for sharing information ... it's useful for gathering data ... That's what the tool was intended for ... and it's good for that first point of call. [T9]*

However, digital presence does not connote relevance or meaningful connection with the youth audience. As some of the providers shared, their responsiveness and engagement with young people on social media and similar digital platforms are constrained by organisational priorities and resources.

> *We are so broad, and our priority is seeing people face-to-face. So, it makes sense that social media comes last for us. [T10]*

> *In the virtual space, it's mostly the young people that we serve, but our organisation also works with schools, with families, with government, so our ability to develop content* [is] *limited in how directly we can be. [T4]*

> *I think it would be a very expensive experiment [working with young people as educators], I guess. Yeah. I mean, if we put something together, a training module or something for use, and it didn't get used, or the uptake wasn't there. But you know, maybe we're just being a bit blinkered as well, you know, maybe we just need some young people on board who tell us how to do it, and then it would work. [T6]*

Putting the label of "expensive experiment" [T6] on the idea that young people can be involved in the design and delivery of health promotion reveals a fundamental devaluation of youth

expertise and partnership. This disconnect aligns with what Cahill (2014) described as a failure to ensure youth-centredness in practice, where rhetorical commitments to youth voice are undermined by institutional investments that maintain adult control. Providers maintain digital footprints designed to suit adult institutional logics rather than youth communicative practices and cultural norms within New Zealand's diverse digital landscape.

To critically examine how this divide shapes power dynamics in the New Zealand digital SRH promotion spaces, this theme conceptualises SRH providers and their organisations as 'digital immigrants' and young people as 'digital natives' (Cahill, 2014; Prensky, 2001a). Applying this framing centres on how adult-centric organisational structures and practices undermine youth expertise, positioning youth as recipients of knowledge rather than digitally competent agents whose native fluency could inform more effective engagement strategies. More on this in the following subthemes.

6.3.1. Organisational Context and Digital Strategy Implications

Provider narratives reveal how organisational deficits such as a lack of organisational strategy, digital non-fluency of SRH providers, and algorithmic volatility are framed as technical barriers to youth engagement. Examining this through the CPYD theoretical framework, these barriers expose deeper issues of institutional unwillingness to yield epistemic authority to digitally native youth or to restructure adult-centred organisational practices around youth expertise (Cahill & Dadvand, 2018; Cahill, 2014). Evidence from the literature suggests that young people are not as keen about the digital competence of SRH providers as they are about their autonomy, which would ensure they can develop and deploy their capabilities, digital and non-digital, without judgment, fear, or lack of trust (Cahill, 2014; Engel, 2023; Gonzalez et al., 2020; Rose et al., 2024). From this study, providers appeared to agree with young people in their desire for autonomy,

> *Hey, guys, look what we have prepared. Here is someone going into an STI clinic. What challenges are they going to face? You know, I think young people would be like, 'No, I do not want to see that. Do not tell me what to do. I can see right through you'. [T1]*

> *We do use social media, and we see it as important moving forward. Because that's how young people connect with each other. So, if we're not involved in that space, then we're not accepting that part of them. [T10]*

> *So, I guess one of the things our organisation is going to have to look into is actually building focus groups of young people to actually give us feedback more directly about our content and whether it's working, because it's just really difficult other than by using likes and views. [T4]*

Another provider echoed this recognition for independence by youth, noting that, "Gen Z will smell bullshit a mile away. They know if it is not genuine and authentic" [T5], further establishing the youths' need for genuine and empowering connections, void of unwanted dominance. While SRH

providers are aware of youths' desire for autonomy, this recognition fails to translate into practice as they struggle to negotiate and balance power dynamics that position them as gatekeepers of health knowledge, while viewing youth as passive recipients.

During interviews, providers strongly indicated that they maintained institutional control over digital engagement strategies with young people. While acknowledging the difficulties of connecting with youth, SRH providers' perspectives revealed that they retained decision-making authority over key strategies, including which social media influencers to work with, and made decisions based on adult judgment rather than youth input. This was primarily evident in their perception of digital platforms as a barrier to their professional practice, as depicted by the following excerpts:

> *There are a lot of skills that I think, as SRH providers, we rely on in a face-to-face session. ... I feel like online, there would be a big barrier. [T2]*

> *Like the target audience is young Pasifika people. It's reasonably effective, and it's reach, but no one really liked the comments, or no one really interacts with the posts. There was paid promotion to boost the posts to get more interaction and reach. And then lots of it's just been word of mouth." [T3]*

> *I think like utilising people who are influencers already, when they like, would be the ultimate thing to get young people and like, engage. [T10]*

Another provider said to adopt social media, "it has to be a private, very controlled, very monitored sort of approach to it" [T1], and they further concluded that the youths whom they support would not be interested in engaging with social media for health promotion because of the sensitivities of the topic they deal with.

> *Our young people really are on the same page. They are like, 'No, we cannot have a social media campaign that's like in the* [referencing other developed and liberal countries] *[T1].*

This contradiction reveals a fundamental tension in youth-adult power relations, where SRH providers intellectually recognise youth agency but simultaneously dominate young people through their practice (Ginwright & Cammarota, 2007). The insistence on "*private, very controlled, very monitored*" [T1] approaches reflects how institutional risk aversion and adult professional authority oppose their stated commitments to youth autonomy. This reflects what Cahill (2014) noted: youth are constructed as vulnerable, too risky, or too sensitive to engage authentically on social media, thereby justifying providers' gatekeeping perspective and positioning. Additionally, T1's claim that "*our young people really are on the same*" demonstrates how providers project their own conservative framing of youth, erasing youth voice under the idea of protecting or representing them (Noer et al., 2024; Wong, 2023). The speaking on behalf, often done by adults, while actually silencing youth perspectives, is a classic example of adult power relations in youth-serving platforms (Cahill & Dadvand, 2018; Martin, Alberti, et al., 2020).

Provider perceptions of face-to-face interactions as the ideal for health promotion and healthcare service delivery, with digital spaces barriers, position institutional authority over youth agency (Cahill & Dadvand, 2018). Studies in the New Zealand context (Rose et al., 2024; Rose et al., 2022) show that physical clinical spaces are sites of adult authority that inhibit youth access because of fear, judgment, and limited control over privacy. Digital platforms, including social media, however, offer youth greater autonomy, anonymity, and control over their engagement (Engel, 2023; Patterson et al., 2019). Furthermore, SRH providers' resistance to evidence-based digital interventions (Martin, Alberti, et al., 2020; Pang et al., 2023; Wang et al., 2022), signals not a lack of evidence, but a lack of institutional will to adopt youth-centred practices. When youth expertise in digital spaces threatens professional authority, institutional structures tend to protect adult power rather than centring youth voice (Htong Kham & Ng, 2025; Sewak et al., 2023).

Another example of potential conflict between SRH promotion providers' worldviews and the realities of young people in New Zealand is reflected in providers' lack of confidence in social media as a behavioural change tool or a suitable platform for meaningful youth engagement. T6 stated that the power of personal story "*is lost when you do it online or in social media format*". This scepticism further illustrates the digital native-immigrant divide and its implications for power relations in youth health promotion, evident across multiple provider statements:

> *I don't think social media is going to create sustainable long-term behaviour change or attitude shifts. [T1]*
>
> *But I think the power is in the personal story, it's about people being able to see somebody who lives with HIV, who can really share from a lived experience. And so I think that is powerful. Yeah, which is lost when you do it online, or in social media format. [T6]*
>
> *It's [social media] just difficult to assess that sometimes, and to assess why some things perform well and why some things don't. And also, to actually see whether there is an in good engagement with the content. [T4]*
>
> *There are a lot of skills that I think practitioners rely on in a face-to-face session. So, we're relying on posture, on tone of voice on all these micro-expressions that help frame how we work. So, I feel like online there would be a big barrier. [T2]*
>
> *I think social media has effectiveness up until a certain point. Maybe raising awareness, maybe social media is good for raising awareness of certain topics like queer issues. [T9]*

Framing of platform limitations is further fuelled by the rapid content turnover on social media, youth scrolling past information, risk of misinformation and disinformation, attention constraints, and information brevity, summing up the reasons shared by providers.

> *The platforms are limited in the amount of information you can actually provide, and there is only so much attention space that you can take up ... The virality and the speed at which the information moves through the Internet have*

kind of called us as organisations to think about how we would respond. Yeah, I think that there is a challenge as to how to actually do that effectively. Yeah, and I do not have answers. [T4]

Sometimes when you post stuff online, it can be misconstrued. Yeah. Like the way that we interpret it may not be the way that the client or whoever is doing it may interpret it and then the information might be, I don't know, read in the wrong way where they do that something else and then becomes something else. And then then we get blamed for it. [T2]

I think the lack of fact checking that goes on to a lot of information, and the ability of people to legitimize themselves and social media spaces without having the necessary qualifications. So yeah, I think there's a real risk of people speaking from a place of ignorance and an influential way. So, the lack of safeguarding around that, the lack of not quite sure what the word I'm going for here is like legitimacy and legitimizing that has to happen for information to go onto social media means that it's a bit of like the Wild West when you're sifting through what information is good information? Yeah. [T7]

These narratives reveal several interlocking power dynamics that privilege adult epistemologies over youth realities (Akom et al., 2008; Cahill, 2016). The framing of social media as ineffective for behaviour change contradicts substantial evidence demonstrating that digital interventions, including social media campaigns, chatbots, and multi-platform strategies, effectively improve youth access to sexual health information and sustain behaviour change (Condran et al., 2017; Engel, 2023; Martin, Alberti, et al., 2020; Mason, 2017; Rose, Garrett, McKinlay, & Morgan, 2021; Sewak et al., 2023). Significantly, research in the New Zealand and Australian contexts shows young people actively prefer digital services precisely because they eliminate the power imbalances and intimidation or control inherent in in-person adult-youth clinical interaction (Phillips et al., 2024; Raymundo et al., 2021; Rose et al., 2024; Rose et al., 2022).

Ginwright and Cammarota (2002, 2007) called this contrasting position adult-centric paradigms that devalue youth knowledge systems. Such perspectives undermine young people's digital fluency and their preference for autonomous engagement by framing them as deficits, rather than evidence that traditional, information-dense models and adult-controlled environments may be ineffective for digitally native youth (Gonzalez et al., 2020; Goodwin & Lyons, 2024). By framing social media as risky, ineffective, or too complex, organisations justify maintaining adult-controlled service models that preserve professional authority while limiting youth autonomy and access (Goodwin & Boulton, 2024; Rose, Garrett, McKinlay, Morgan, et al., 2021). It is therefore safe to say that the 'challenges' identified by adults are less a technological issue than a structural one, because social media disrupts epistemic hierarchies and enables youth, when collaborating, to produce knowledge and contribute to youth SRH promotion in New Zealand.

The characterisation of social media's "virality and speed" [T4] as a challenge revealed how institutional structures and adult views are incompatible with youth communication and interaction models. From a critical youth lens, this perspective is seen as the unwillingness of adults and

institutions to give up their control; nor are they willing to approach youth from a shared governance position within the digital environment, where young people are more dominant and expressive (Decker et al., 2022; Gonzalez et al., 2024).

The review of SRH providers' narratives in this subtheme shows that the constraints shared are more structural than technological. This reveals the tension evident across the digital native-immigrant divide, and the resistance towards digital platforms where young people exercise greater influence and communicative power. Beyond organisational context, however, SRH providers also face constraints related to resources and capacity, which is what the next subtheme addresses.

6.3.2. Resource Limitations

Young people want to talk about sex and other sensitive topics while learning at the same time. Social media, like other similar digital and web-based platforms, has been reported to offer this opportunity by providing education, entertainment, privacy, and unjudged spaces for young users (Engel, 2023; Healy-Cullen et al., 2023; McCarthy et al., 2012; Wang et al., 2022). SRH promotion providers, however, shared that their use of social networks and other technology-driven platforms is hindered by insufficient digital skills, including personnel and funds, to match the unending demand for content creation and management for New Zealand's ethnically diverse youth population. Several statements from providers revealed their struggles while attempting to keep pace with digital natives.

> *It's really hard to appeal to young people, … and you can tell that we don't really understand our market ... I think we are really behind the times, especially our organisation. [T10]*

> *We don't do advertising ... because it's expensive ... to do ads. And they're just like little banners or pop-ups. And I don't know how effective they are. I think it's more rather than doing push messaging that people scroll by this gives people an opportunity to actually engage and ask questions. [T8]*

These quotes showcase a worldview that is struggling with the disruptions of a fluid and collaborative space, and reflects a fixed mindset stuck on what is 'appealing' to youth vis-à-vis the lack of resources, technical and otherwise, to address this gap. T2 commented, "I think one of the big issues we have is that we run out of ideas for content. We often struggle to find new ideas, new ways to engage young people" [T2]. Similarly, T9 reflected,

> *Because social media is a tool. So, it's not what is on it, it's how you use it, right? Yeah. I'm yet to see a really good social media engagement for sex health promotion. I'd love to see what that looks like. [T9]*

These narratives illustrate how providers conceptualise resource limitations as deficits in skills, personnel, and funding, rather than as an epistemological issue. By positioning themselves as sole knowledge producers who have to "appeal to" young people as their passive recipients, but not co-creators and self-experts, or attain a high standard of curating "sex health promotion messages in a

really good" [T9] manner, reveals adult-centric perspectives and the power dynamics in their relationships (Cahill, 2014; Gonzalez et al., 2020). Phrases such as "appealing to" and "understanding our market" [T10] expose a form of transactional mindset by the SRH providers and not that of a collaborative relationship, which ensures young people are considered as partners sufficiently skilled to contribute to the production and dissemination of SRH promotion messages on digital platforms (Ginwright & Cammarota, 2007; Goodwin et al., 2025).

By recognising young people as digital natives and prosumers who create, remix, and share content across social media and digital platforms, SRH providers could strengthen their creative capabilities and digital fluency (Ardizzone, 2007; Cahill, 2014; Vaughn & Jacquez, 2020). The challenges of insufficient digital skills and limited funding for youth-centred initiatives are not particular to New Zealand providers alone; they are part of a broader, systemic issue (Iyanna et al., 2022; Saeed & Masters, 2021). Resourcing constraints result from positioning youth as resource takers rather than resource generators, reflecting the deficit-based approaches portrayed about youth engagement (Cahill & Dadvand, 2018).

Challenging this mindset opens up an avenue for providers to embrace participatory strategies, such as co-design and community-based participatory research, as a crucial step toward addressing health inequity and inequality in New Zealand (Aibangbee et al., 2023; Ministry of Health, 2023a; Palacios & Allen, 2019). Empirical evidence from several authors (Conn et al., 2017; Martin, Alberti, et al., 2020; Ministry of Health, 2023a; Paltrinieri & Esposti, 2013) supports the narratives that youth-led and youth-centred interventions have higher uptake and are more sustainable because of the sense of ownership, community building, and trust solidified by partnership and collaboration, rather than imbalanced adult-youth relationships characterised by dominant influence, fear of judgment, and limited expression for younger participants.

Beyond shortages of personnel and digital skills, rigid funding models driven by organisational priorities and government mandates present a significant barrier to authentic youth engagement (Klassman et al., 2024; Lipton, Dickinson, et al., 2025; McGinn & Wise, 2024). This financial architecture creates a multilayered power dynamic, where providers are not fully autonomous but are constrained by a top-down system that stipulates which funds can and cannot be used (Came et al., 2018; Goodyear-Smith & Ashton, 2019). This presents a barrier for SRH providers to centre the youth voice, as shared by several providers,

> *I suppose the other limitation for us, being not-for-profit and being government funded, is that there are limitations on what we can and cannot do as a team, because it is stipulated by the government essentially what that money can be used for. And we have to be quite apolitical as well as government funded organisations. There's been times where we wanted to comment on, you know, things happening in the political arena. But we, we can't really take sides. [T5]*

> *I think easier access to specific funding, or if we could have funding to pay someone to do this work? Or to help us with it to assist us with it, that'd be*

> *great. So, I think it's a seeing it as the actual organisation seeing it as something they want to put resources into, and something that they want to prioritise, because if it's not prioritised, then, you know, it just won't be able to move forward in a way that's like, sustainable or fear for the people that work here, because I think I reckon that I could do a good job, but it would need to be like, it would need to be paid for. [T10]*

The above quote demonstrates how the funding structure functions as a mechanism of control, shaping whose voice is heard and valued, and whose participation is resourced and prioritised. The control over "what that money can be used for" does not reflect a budgetary constraint but a structural limitation on practice. For example, if the conditions of funding do not prioritise co-design with young people, provision of stipends for youth-led content creation, or funds for training providers as skilled youth professionals, then youth would always be seen from the 'passive recipients and beneficiaries' lens, rather than as collaborators and co-creators (Cahill, 2014; Collura et al., 2019; Condran et al., 2017; Sprague Martinez et al., 2020).

Critically, this perpetuates a cycle where providers, feeling disempowered by their funders (Came et al., 2018), struggle to engage with young people (Collura et al., 2019; Rose et al., 2022). This dual positioning reflects significant structural constraints: while SRH providers may intellectually recognise the value of youth-centred approaches, they lack the institutional autonomy to operationalise them within funding models that are strict on compliance and resource utilisation (Came et al., 2018; Goodyear-Smith & Ashton, 2019). For marginalised Indigenous youth and ethnic minorities, who often require culturally responsive, community-specific approaches, funding rigidity from a top-down system becomes a double disadvantage to their engagement (Came et al., 2018). When resources cannot be deployed flexibly and adaptably to match the needs and cultural framing of the diverse populations they serve, it can be argued that such a system is designed to perpetuate health inequities, not accidentally (Goodyear-Smith & Ashton, 2019).

Furthermore, this has significant implications for New Zealand youth engagement because when providers are restricted to function within a boundary, they, in turn, reproduce that constraint through youth exclusion and active participation (Cahill & Dadvand, 2018). This essentially is a crucial aspect of the 'Social, but not socially connected' gap that this study identifies. It reveals that the digital divide between young people and SRH providers is not just technological or organisationally driven, but is also perpetuated by structural barriers within funding architectures that do not recognise or engage young people as capable agents who can co-create and co-produce knowledge (Cahill, 2014; Deane et al., 2025).

A critical reflection of funding mechanisms and their impact on youth-adult partnerships suggests that, beyond money as a resource, the core issue is more about 'he who plays the piper, dictates the tune'. These funding structures reflect whose priorities are met and whose remain marginalised. Therefore, in addition to increasing funding allocations, there is a need to redistribute power across the funding channels to build social capital (Ginwright & Cammarota, 2007), such that

providers can exercise their autonomy to engage with youth as partners and co-producers of knowledge (Lipton, Dickinson, et al., 2025).

6.4. Theme 2: "Don't Tell Me What To Do" – The Dilemma of Language, Community, and Trust

This theme critically examines the profound dilemma SRH promotion providers face in building trust and community with young people. Though well-intentioned, they are often constrained by their own experiences and cultural sensitivities, which clash with the youths' evolving perspectives. This tension is heightened by providers' own aversions to risk (e.g., adopting new technologies, sharing governance with youth, etc.) and engaging in sensitive topics like STIs that could be associated with stigma, which, in turn, limits the scope and language of health messaging (Carroll et al., 2023; González & Veale, 2025; Martin, Alberti, et al., 2020). SRH promotion providers' narratives revealed how institutional positioning and professional identity create barriers to the trust and sense of belonging that young people seek.

> *Because they won't come to us. They won't ask their doctor. They won't ask their peers, but they will ask somebody on Grindr, because that's where they feel comfortable having those conversations. [T8]*

> *One thing that I've noticed, because I also do some work with young people running workshops in schools, as I worked with one school over the whole year, this year, and I built enough trust that I know that I could ask them and I would get a better answer. So, I think it's like getting information from people that work with young people every day, and aren't just like the teacher has to be someone that is like someone that they trust is like a person to person, sort of like not teacher-student. So, I think that you could get some honest answers like that. [T10]*

> *You can pick up fairly easily if they're withholding something, and then you make a mental note of that, like, OK, they're not comfortable with this topic yet. I'm gonna reopen this conversation 2 months down the line after I've worked with them for a while. We've got a rapport. [T2]*

> *They* [youth] *need to feel like you're actually invested in them. And that is partly around, you know, speaking the language. But also, like we do a lot of we like to engage with community members to help share our message. And a big learning for us is just how long-term that relationship building is, like, if you want, so we don't have it many Māori staff. So, when we want to do anything in that space, sometimes we'll talk to community members and see how they can amplify messages or get involved themselves. But that relationship building can't be done quickly. So, you know, and it's an ongoing journey as well. You're constantly needing to engage. [T5]*

This theme also reveals an interesting counter-narrative of youth agency and capacity, reflecting another perspective on what institutional structures and professionals struggle within their practice. By sharing their observation of an online youth-led sexual health programme in New

Zealand, one of the providers reflected on how youth autonomy and agency are demonstrated within digital spaces:

> *They've got young people talking about their journeys, and it was really the panel that I watched, which had about six people. And they all had very different experiences and different takes on sex... And they actually talked about it, because they had different views, and nobody's view was wrong. [T8]*

The above quote highlights the importance of youth operating within a no-judgement zone, where they can freely express themselves. It also shows how institutional structures in New Zealand's SRH promotion position providers as 'outsiders' to youth and marginalised communities, while these youths demonstrate the capacity to create a judgement-free, peer-based space for themselves, navigating their diversities without adult control (Cahill & Dadvand, 2018; Cahill, 2014). The following subthemes discuss these tensions in youth-adult relationships.

6.4.1. Youth-Adult Tensions in Religious and Cultural Context

Youth seeking independence and adult recognition of their decision-making capacity frequently encounter institutional barriers within family, religious, and community settings that position them as needing protection rather than capable agents (Aibangbee et al., 2023; Cook & Wynn, 2020; Engel, 2023; Healy-Cullen et al., 2023). For New Zealand SRH promotion providers working in culturally and religiously affiliated settings, such as schools, faith-based spaces, and community groups, it is paramount to learn how to balance the sensitivities of their contexts with youth-centred practice (Conti, 2025; Palm & Gaum, 2021). As a result, they may have to prioritise adult and institutional values over youth autonomy in some instances. T2 commented, "Some of the schools we go to … It is very religion-based in the way they approach sexual health at school" [T2]. While T1 said,

> *The community groups that the programme works with are groups that are vulnerable, marginalised, and already have difficulty seeking adequate health services, so it makes it harder to then go ... 'Here's a social media campaign that highlights everything that's wrong with your culture' and makes mainstream people uncomfortable and be like a saviour complex that also occurs as well that they want to save women that are affected, which I think is quite damaging at times. [T1]*

T2 and T1's statements expose how cultural and religious institutional contexts function as gatekeepers, controlling what youth can know, when, and how. When providers must navigate cultural and religion-based approaches to sexual health, youth autonomy is subjugated under adult-centred authority (Conti, 2025; Healy-Cullen et al., 2023). The need for alternative spaces where youth can freely discuss sensitive topics (Condran et al., 2017; MacDonald, 2018) reflects an institutional failure, and not a youth deficit. T2 recognises the need for youth to freely express themselves without

adult control or judgement when they shared that "I [social media] gives them another means to have those conversations and have a space where they can feel free to talk about it."

Having 'another space' for young people to have free, healthy, and important conversations about themselves naturally emerges, not out of secrecy or disobedience, but because adult-controlled institutions and their need to want to 'protect' young people clash with youths' rights to information and quality health services. This pattern reflects what Cahill and Dadvand (2018) and González and Veale (2025) describe as rhetorical commitments to youth well-being, undermined by institutional structures set up to control rather than enable and support youth agency.

This scenario is further complicated when traditional practices within diaspora communities conflict with youth autonomy and rights to quality SRH. Tension exists between adult power shaped by transgenerational patterns and youth critical consciousness (Akom et al., 2008). This is revealed in an encounter that one of the providers had with a student in an academic environment who questioned the sustained practice of a harmful tradition that affects girls and young women, despite being in New Zealand, a Western culture. The student had asked, "Why is this practice still in existence? It is so barbaric" [T1]. This encounter marks a critical juncture where youth agency and rights assertion challenge deeply rooted sociocultural norms carried across generations through adult and community control (Cammock et al., 2023; Mohyeddin, 2024). The questioning of the 'barbaric' act does not reflect cultural ignorance but a rights-based critique of traditions that violate bodily autonomy and of adults taking away power from young people over their choice and sexual dignity. It challenges the notion that older individuals automatically possess superior cultural wisdom or that cultural practices should be unquestioningly accepted (Conti, 2025; Mayall, 2008), especially in this age when youth are increasingly exposed to diverse knowledge systems through digital platforms (Mukoro et al., 2025; Santomier & Hogan, 2013; Sewak et al., 2023).

For SRH providers, this foregrounds the dilemma of navigating the tension between 'respecting culture' and supporting youth to have dignified SRH. When culture is promoted over youth autonomy, by taking away consent and causing physical harm, providers are forced to practice between a conscientious middle of centring youth voice and rights, and honouring cultural identity (Conti, 2025; Palm & Gaum, 2021). This raises questions such as, 'Who controls young people's body?', 'Who decides when a young girl marries or gives birth?', 'Who decides a young person's future?'; and 'Whose voice is silenced by tradition and archaic practices?' Having a young person question such a practice typically illustrates what the CPYD framework addresses: a critical examination of power, legitimacy, and agency, even when rooted in culture and tradition (Cahill & Dadvand, 2018; Gonzalez et al., 2020).

Building a community of trust and respect between youth and adults is a gradual and relational process. Several provider narratives alluded to this:

> *They* [youth] *need to feel like you are actually invested in them. Moreover, that is partly around, you know, speaking the language. But also, we like to engage*

with community members to help share our message. And a big learning for us is just how long-term that relationship-building is, like, if you want, so we do not have many Māori staff. So, when we want to do anything in that space, sometimes we will talk to community members and see how they can amplify messages or get involved themselves. But that relationship building cannot be done quickly. So, you know, and it is an ongoing journey as well. You are constantly needing to engage. [T5]

You can pick up fairly easily if they are withholding something, and then you make a mental note of that, like, OK, they are not comfortable with this topic yet. I am gonna reopen this conversation 2 months down the line after I have worked with them for a while. We have got a rapport. [T2]

One thing that I've noticed, because I also do some work with young people running workshops in schools, as I worked with one school over the whole year this year, and I built enough trust that I know that I could ask them and I would get a better answer. [T10]

Recognition is more critical within many cultural and religious contexts, particularly for marginalised communities such as MSM and LGBTQIA+ individuals in New Zealand, where questioning adult and intolerant authority of heterosexuality can be especially difficult, thereby adding a layer of complexity to health promotion efforts (MacDonald, 2018; Palm & Gaum, 2021). This tension can lead to family rejection, community ostracism, or violence, making trust-building with providers essential yet difficult (MacDonald, 2018). In the professional practice related to LGBTQIA+ health promotion in New Zealand, these struggles are equally evident. Some of the providers expressed their challenge navigating these communities, saying:

So, for straight MSM or closeted men or down-low men … our messaging does not resonate. I would imagine they do not like our messaging, particularly because it is so queer-focused. [T5]

We [provider identifying as part of the youth minority group] are made vulnerable in multiple ways. And not only are we more vulnerable to those harms, but when we try to access support afterwards, we are also marginalised from accessing it. So, like it's both about prevention and also response, you know, and the mental health consequences of all these sides, they are compounded. [T4]

These quotes highlight the dilemma of language and sense of community. They question whose voice is being centred and show how identity-based organising can create unintended hierarchies (Cahill & Dadvand, 2018; Ginwright & Cammarota, 2007). It foregrounds the risk of exclusion when providers assume homogeneity within communities (González & Veale, 2025). In this instance, young, out, urban queer people with social capital are prioritised over men, who may be young or older, but choose not to be visibly identified as queer due to cultural, familial, religious, or personal preferences (Ginwright & Cammarota, 2007). This can inadvertently lead to unmet SRH needs and services, including targeted health promotion messaging, that could be co-produced with

providers if they were recognised and engaged in that capacity (González & Veale, 2025; Scheadler et al., 2023).

Across diverse communities, such as Pacific Islander men operating within fa'afafine or fakaleiti frameworks (McGlashan Fainu & Uasike Allen, 2024); African diaspora men practising 'down-low' to mask their sexual preferences and identity (Han et al., 2014); or men and women confined by their religious or gender-assigned roles (MacDonald, 2018), having to navigate these complexities makes it more challenging for providers. While not undermining the essence of community, it raises concerns about whose voice is being centred across these tensions, especially when the realities of youth and marginalised groups are not reflected (Mukoro et al., 2025), and there is inadequate capacity for managing multiple, often conflicting identity and sexuality demands among providers (Carroll et al., 2023; Rose et al., 2024).

This subtheme has revealed fundamental tensions between youth-adult relationships. Insights on how institutional sensitivities restrict providers' capacity to enable youth autonomy and agency and, at the same time, force young people to seek 'alternative spaces' have been highlighted. It has been established that cultural respect is no justification for propagating harmful practices or silencing youth voice; rather, it creates an avenue to interrogate these barriers to youth well-being. The next subtheme expands on this issue, examining how stigma and risk aversion compound existing marginalisation among youth population groups.

6.4.2. Stigma and Risk Aversion

As an ethnically diverse country with a significant migrant population, New Zealand has a knowledge-transfer gap between older and younger generations (Aibangbee et al., 2023; Conti, 2025; Wong, 2023). As a result, there is limited discourse around public health issues like HIV and AIDS, which are low-prevalence health concerns in New Zealand (PHF Science, 2024; Rose et al., 2024; Saxton et al., 2022). This limited intergenerational exchange, fuelled by low perceived risk, allows stigma to persist in younger generations, especially among migrant communities, as it remains invisible and conversation-averse (Aibangbee et al., 2023; Henrickson et al., 2015).

The New Zealand educational curriculum on relationships and sexuality education, under revision, requires multi-stakeholder input, such as parents and teachers, before it can be adopted and taught in schools (Dixon et al., 2022; Sexual Wellbeing Aotearoa, 2025). This gatekeeping structure poses a risk, as discussed in the preceding subtheme, by functioning as adult control over young people's right to quality information and education about their health, which runs counter to SDGs 3.7, 3.3, 3.8, 5.6 and 5.b, discussed in Chapter 1. It heightens their risk of misconceptions and misinformation from informal, unguided, and potentially inaccurate sources (Baraybar-Fernández et al., 2021; DeLacy et al., 2019).

Furthermore, this research found that targeting young people living with HIV and other STIs through social media is difficult due to stigma, as noted by T6, "Working with youth living with HIV

and their families in New Zealand is very difficult because of the stigma". It deters them from volunteering as "youth advocates and youth educators". The fear of having their health status known is real and poses a looming danger to the general public's health if not managed properly (Patterson et al., 2019). This sentiment of secrecy is one that I personally share from my past work experiences as an HIV/AIDS Programme Officer in Nigeria.

The risk of stigma and discrimination prevented one of the interviewed SRH providers from disclosing their HIV status for almost 2 decades, a silencing effect that they observe has continued to constrain younger people's engagement in health promotion today. This stigma also drives at-risk populations, youth inclusive, to avoid professional SRH settings, instead seeking support through social networks and casual meetup sites, where anonymity and peer connection offer them a sense of safety from judgment.

> *I think one of the biggest things that affected me throughout my journey was stigma and discrimination. Not so much discrimination, but stigma. Because of the stigma, I was silent for the first 17 years; I did not really tell anybody. [T6]*

> *I guess that's, that's the issue we have with youth. We don't have any youth educators. So, a lot of our educators are older. We do have a couple of young girls who have come forward, but they're still young, and they're not keen for the whole world to know that they've got HIV. Because they haven't got, they're not in relationships. [T6]*

> *I have a person who does outreach for me on Grindr as an outreach person ... So people ask him about PrEP [Pre-Exposure Prophylaxis], they ask him where they can go to get tested, they asked him all these other questions around, you know, sexual health, essentially, because that's the place that they feel safe to ask those questions. Yeah. Because they won't come to us. They won't ask their doctor. They won't ask their peers, but they will ask somebody on Grindr, because that's where they feel comfortable having those conversations. [T8]*

The provider's decision to stay silent for about 17 years reveals the way that stigma can operate as a control even in health promotion spaces, and how it can function as a structural violence that isolates, silences, and denies both the infected person and their affected families or acquaintances, the needed support and care from the community (King et al., 2024; Patterson et al., 2019). This is rational and arguably based on the consequences of discrimination and loss of anonymity in the community, which could result in social ostracism within a closely knit society, as in New Zealand.

Within marginalised communities, navigating intersecting identities can also be complex. One provider from the Rainbow Community described this experience, saying, "Not only are we more vulnerable to harm, but then when we try actually to access support afterwards, we are also marginalised from accessing the support" [T4].

This is what scholars González and Veale (2025), Han et al. (2014), and Wong (2023) referred to as a double jeopardy or a compounded form of marginalisation where young people, living with HIV and identifying as LGBTQIA+, are subjected to a heightened vulnerability (discrimination,

rejection, violence) and systemic marginalisation that hinders access to care. These reflections highlight how health promotion delivered broadly to young people, without accounting for intersecting identities and needs within this group, can translate into systemic exclusion that is not adapted to accommodate these diversities. This again reveals institutional failure whereby systems gatekeep access and information based on who fits a normative stereotype, and exclude the most deserving, a demonstration of power relations: 'Who decides who gets what?'

Stigma perpetuates silence and silence breeds misinformation (Henrickson et al., 2015; Rose et al., 2024). When young people's sexual identity or health status makes them invisible and unsupported, and institutions fail to engage with them to address this inequity meaningfully, then the cycle of marginalisation deepens and continues. Demonstrating their competence in digital self-governance, young people have displayed a remarkable capacity to build and regulate their own knowledge systems and communities online (Cahill & Dadvand, 2018; Wang et al., 2022). While providers may worry about a toxic digital environment, they also acknowledged young people's capacity to participate and make meaningful contributions to youth-centred practices led by SRH providers and services in New Zealand.

> *A group of health promoters [here in New Zealand] ... run a programme called the peer support sexuality program, which I volunteered on 1 year. So, what they do is they run a bunch of in-person hui at the start of the year, and it was ... a week-long camp with young people, and they do education sessions with young school-aged 15, 16, 17-year-old people about all things sexual health. So, consent, pornography, healthy relationships, drug use, or just reproductive biology, anatomy, all of that stuff. And then the young people go back to their schools. And they are like peer support leaders, providing sexual health at their schools. And a lot of their programme after their initial in-person training is run on social media, and it's peer-led. So, it's the young people using their own social media platforms to connect with other young people from the school. [T7-1]*
>
> *Young people already a part of our ecosystem. Like, they're not only delivering education to their peers, but they're also informing, and sort of not just informing, but actively are designing what is going on the website, what is happening on if we were to go down the social media, they're actively a part of that design process. [T1]*
>
> *For a lot of people, so we do get some hate messaging on the stuff that we post, and it kind of moderates itself. [T8]*

The above statements align with scholarly evidence that young people are active and capable participants in cultivating safe online spaces (Martin, Alberti, et al., 2020; Wang et al., 2022). This self-moderation capability challenges the adult-centric assumption that youth online spaces are inherently unmanageable or require constant external control (Cahill & Dadvand, 2018; Cahill, 2014). It showcases youths' agency and their ability to establish and enforce their own community norms, providing compelling evidence that they are not just passive recipients of information but active builders of digital communities.

This demonstrated capacity for self-governance stands in stark contrast to how providers often use social media and other technology-based platforms for health promotion (Decker et al., 2022; Hirvonen et al., 2021). While these platforms excel as tools for broad awareness and demystifying sensitive health topics for the general population (Lim et al., 2022; Sewak et al., 2023), they can become ineffective tools for engaging young people due to the fear of stigma and risk aversion from adult providers (Martin, Alberti, et al., 2020; McGarry, 2015). First, the contrasting positioning on social media use reveals how adult-controlled systems undermine youth agency, especially in recognising that youth are more digitally fluent (Gonzalez et al., 2020; Gonzalez et al., 2024). Second, it shows how adult risk aversion can complicate the sense of community, trust, and partnership that they pursue with youth because of their institutional positioning. To demonstrate their recognition of this dynamic, that is, the need for youth to be actively involved and responsible for leading the change process by themselves, these providers phrased it as follows:

> *I think that it all has to do with young people advocating for their own learning. [T10]*

> *I'll start by saying that I think definitely we need organisations and practitioners to have real relationships with young people to actually do this work ... Young people are more likely to trust people in their own communities or other young people speaking to those experiences. [T4]*

> *The hardest part probably for us in New Zealand is that we don't have a lot of youths living with HIV, and the ones that are, are not really out about being positive. So often older people are talking to the youths, and while it's still informative, I think the gap there is that it would be better to have youths talking to youths. [T6]*

These statements challenge provider-centric approaches by positioning young people, not as passive recipients of health promotion communication, but recognising them as the primary custodians of their own health narratives and capable organisers of digital community spaces (Engel, 2023; Gabarron & Wynn, 2016). Reflecting on this, the question then becomes, if youth are considered to have these capabilities, why are systems set up to undermine youth agency, requiring adult management and control?

Another layer of stigma and risk aversion stems from a systemic angle, whereby providers are faced with algorithmic restrictions and policy limitations, negatively impacting their ability to reach young people. This was described as a form of corporate risk aversion from digital and technology-based platforms such as Meta and Google by T5:

> *I think there's a big gap ... on social media, like getting our ads disapproved, and content flagged as inappropriate ... We also run Google ads, and we have the same issues. In fact, I think the policies are a little stricter than on Meta. I'm sure that every organisation within sexual health is probably feeling that pain, and it does limit our ability. [T5]*

This is not a minor inconvenience as it significantly hinders health promotion efforts. When a paid advertisement is rejected, organisations are forced to rely on organic posts, which only reach a small fraction of their intended audience. T5 further noted that social media content that is not ads-related are equally subject to platform-specific algorithms that control content visibility:

> *Because if we can't run an ad, and we can only run it via organic posting, and that only reaches 5% of our audience at most and might get pushed to other people. But it really depends on whether Meta wants to promote it.*

Platform censorship of sexual health content is a form of corporate gatekeeping similar to the attributes of adult institutional control previously discussed. While tech companies have appointed themselves as 'protectors' of youth by controlling what sexual health content is allowed to reach them, they are equally restricting young people's rights to accurate and comprehensive information about their well-being. This is a full-blown suppression of provider autonomy and, in turn, youth autonomy, contradicting their realities as prosumers (Conn et al., 2017; Ginwright & Cammarota, 2002, 2007; Gonzalez et al., 2024). To address this challenge, providers see a critical need for advocacy to influence major digital platforms' policies. T5 commented, "So, advocacy, actually, in improving policy, in social media, I think would really help". At the same time, T7-2 noted, "that process kind of looks like taking the knowledge that we have from working with stakeholders and communities, and translating that into helping to inform proposed legislation".

Recognising the need for advocacy to improve policies on social media regulations is more about challenging corporate power structures than simply producing 'allowable' content. A key part of advocacy is youth voice and ensuring young people are actively involved in the policy review process. Failure to do so may reproduce the same adult-centric practices that yielded the current experience. Authentic youth participation requires involving young people in policy development and positioning them as experts on their own information needs, and not recipients of corporate protection (Cahill & Dadvand, 2018; Deane et al., 2025; Goodwin et al., 2025).

Ultimately, platform censorship operationalises power across scales (family, institution, community, corporate levels), from familial silence about sexuality to institutional gatekeeping on information and education, and corporate algorithmic control (Ginwright & Cammarota, 2002, 2007). All of these, at the periphery, present a 'protecting' youth but functionally deny them autonomy, agency, and access. Therefore, breaking the cycles of stigma, silence, and marginalisation requires confronting power at each level it operates, recognising youth as capable agents whose digital competence exceeds that of adults and institutions governing the health systems (Goodwin et al., 2025; Rose et al., 2024).

6.5. Theme 3: No One Size Fits All: Engage, Adapt, and Collaborate

Given the systemic barriers, cultural dilemmas, and digital disconnect identified in previous themes, and the misalignment between youth realities and institutional practices, this third theme

addresses the gap through platform differentiation, targeted content, and stakeholder collaboration. To avoid the pitfall of delivering top-down interventions and communicating messages that do not resonate with youth audiences, SRH providers shared their perspectives on active youth engagement for digital health promotion messaging (Cahill & Dadvand, 2018; Collura et al., 2019). Provider narratives showed that diverse youth populations require tailored approaches rather than universal messaging, hence the theme, 'No one size fits all'.

> *Young people do not really use Facebook. [T3]*
>
> *So, Instagram is the primary place where we do the sharing of content via social media. Facebook is not really used by young people. [T4]*
>
> *The audience that we're targeting is mostly on Instagram. And in fact, I think we're recognising that they are, especially today, increasingly on TikTok and with Instagram moving to prioritise reels. [T4]*
>
> *Because they won't come to us. They won't ask their doctor. They won't ask their peers, but they will ask somebody on Grindr, because that's where they feel safe and comfortable having those conversations. [T8]*

Providers' awareness of platform differences and their implications on reaching the targeted audience, as suggested in the excerpts above, strengthens youth autonomy and agency. Nonetheless, tensions remain, as reflected in the perspectives shared by the interviewed SRH providers. Some approaches reveal a continued adult focus on content, platform choice, and engagement strategies. The following subthemes critically examine how providers conceptualise adaptation and collaboration, and consider if these approaches genuinely redistribute power or refine adult-centric models to appear youth-centred.

6.5.1. Platform Differentiation and Targeted Content

Throughout the data, providers described the various social media platforms and web-based technologies they use to disseminate information and engage youth audiences. A key finding was their recognition of each platform's strengths for content delivery and community engagement. Regarding Facebook, Baraybar-Fernández et al. (2021) identified it as the dominant network for sharing news, noting that it surpasses other platforms in influence. Their study also found that users engage more actively with social issues on this platform than with political or health-related content. Mukti and Putri (2021) also used Instagram for health education. In alignment, SRH providers suggested that Facebook, like other social and digital platforms, serves distinct purposes and is useful for reaching diverse youth groups. "If the purpose is to reach the community, then a closed Facebook group may be the ideal" [T1]. At the same time, T9 also noted "Facebook was created to help people develop and maintain connections with people. That is where the beginning of social media comes from" [T9].

However, providers' preference for Facebook reveals a tension between their commitment to meaningful youth engagement and their need to maintain control. Keeping a closed group raises

questions such as: ‘Who is in control? Whose voice is heard and centred? Whose agenda is being prioritised within the closed setting?’ Closed groups are another form of adult gatekeeping when providers determine membership, moderate content, and set operating guidelines while claiming to build “community” (Martin, Alberti, et al., 2020; Paltrinieri & Esposti, 2013). Several CPYD and critical youth studies scholars have documented what meaningful engagement with young people looks like (Cahill, 2016; Cahill & Dadvand, 2018; Cahill, 2014; Ginwright & Cammarota, 2007; Gonzalez et al., 2024). The framing of providers building communities for youth rather than supporting youth-built communities to thrive reveals how ‘engagement’ strategies can reproduce adult-controlled systems (Cahill, 2016; Cahill & Dadvand, 2018)

Balancing providers’ awareness with the value of platform differentiation while maintaining youth-centredness appeared to be somewhat challenging, as supported by the literature and provider narratives. Facebook is considered less popular among young people, adolescents, and under-25s (Lim et al., 2022), who are more active on Instagram, TikTok, and Snapchat because they perceive these other platforms as more engaging and better suited to interaction and self-expression (Laor, 2022). Instagram, in particular, was described as fun and visually dynamic, with short videos and large followings enhancing its appeal. YouTube is believed to appeal to older youth, between 18 and 29 years old (CensusAtSchool New Zealand, 2023). These platform differences were captured by providers as follows:

> *The audience that we’re targeting is mostly on Instagram. And in fact, I think we’re recognising that they are, especially today, increasingly on TikTok and with Instagram moving to prioritise reels. [T4]*

> *I think we have quite a large group of highly engaged people, especially on Instagram. And if you post the right kind of content and the right kind of way, it can really help bring communities together. [T5]*

The above framings, “the audience that we’re targeting” [T4], “if you post the right kind of content” [T5], position youth as audiences to be reached, rather than partners to co-create and co-produce content (Cahill, 2014; Chadha & Jha, 2025). Emphasising providers posting the right content undermines youth autonomy and agency while retaining adult expertise and control.

Similar positions were shared about other social media platforms. While TikTok has gained wide popularity among young New Zealanders since the pandemic (Goodwin & Boulton, 2024; Laor, 2022), and has recently been overtaken by Snapchat (CensusAtSchool New Zealand, 2023), the digital fluency young people show on these platforms raises concerns among SRH providers. T3 highlighted limited regulation and the heightened risk of inaccurate or misleading messaging on this platform: “TikTok is less regulated, so it’s harder to use”. This perception is not about technicality but the platform’s resistance to institutional control. As discussed earlier, such views indicate power tensions and clashes with the reality of young people as digital natives (Chang & Chang, 2023; Prensky, 2001a, 2001b). Considering it as “less regulated” demonstrates provider discomfort with

limited institutional oversight and greater youth governance (Ginwright & Cammarota, 2002; Gonzalez et al., 2024).

Other social networking sites highlighted by providers include 'After-dark' Twitter and Grindr, which were reported as safe online spaces for those seeking some privacy and peer validation (Conn et al., 2017; Goodwin & Lyons, 2024).

> *I have a person who does outreach for me on Grindr … he does engagement through that app, to give education to people. So, people ask him about PrEP, they ask him where they can go to get tested, they ask him about sexual health … Because they won't come to us. They won't ask their doctor. They won't ask their peers, but they will ask somebody on Grindr, because that's where they feel safe and comfortable having those conversations. [T8]*

LinkedIn, however, was identified by providers as a platform for corporate branding, representation, and professional networking, in alignment with some past studies (Mahoney et al., 2022; Paltrinieri & Esposti, 2013).

In addition to recognising providers of platforms serving specific populations, T8's quote highlights youths' capacity to bypass institutional healthcare spaces for peer-based digital platforms. As discussed in theme 2, youth preferring anonymous peer educators on dating apps over trained professionals shows how institutional positioning affects trust and belonging in youth-adult interactions, which is essential for safe, confidential conversations (Ginwright & Cammarota, 2002; Goodwin & Lyons, 2024). This platform diversity resonates with this theme's principle that 'no one size fits all', especially as youth navigate multiple, intersecting identities and needs across different digital spaces.

Platform differentiation alone does not ensure engagement; the content must also resonate with youth audiences. Providers expressed concern about limited two-way communication on digital platforms, with T4 lamenting the "absence of feedback", noting that while they are quick to receive negative feedback, they rarely get positive feedback for their efforts. Another provider linked this engagement challenge to representation, emphasising the need for strong youth and ethnic representation in social media content, especially audiovisuals.

> *I think that the thing is, there is an absence of feedback. Is these informing people? Is these changing people? Do they already know this? The thing is, we are more likely to get negative feedback if we do screw up, but we don't get the positive feedback when we're doing it well always and not with the fidelity that we need. [T4]*

> *Another limitation … especially when it comes to engaging with young people, obviously, video content is the most important thing now … So, for us, who have such a broad audience, we want to have video content that our audience can see themselves in. But at the same time, we don't have all the different demographics within the team. So how do we partner with other community members to make sure that we've got representation for Māori or gender-diverse people? So, we're not just having the same talent over and over again on social media. [T5]*

By applying a critical youth lens to the provider's observation, the "absence of feedback" can be seen not as a youth deficit, since youth are known prosumers (Conn et al., 2017; Lim et al., 2022). Rather, it can be seen as a rational response to extractive relationships where SRH providers seek information from young people but are unwilling to share and balance power in that space (Arnold & Silliman, 2017). This chapter has discussed and established young people's capacity for community building, peer feedback, and content co-creation, rather than the feedback providers claim is missing. The question to be asked, therefore, is 'why are young people comfortable sharing among peers but not with institutional authorities and providers'? Without hesitation, this question has also been answered earlier. It lies in the relational dynamics of SRH providers with young people. The need to maintain control over youth contrasts with youth autonomy and agency, resulting in their resistance to such power dynamics (Akom et al., 2008; Ginwright & Cammarota, 2007; Lim et al., 2022; Scheadler et al., 2023).

Authentic two-way communication is what Cahill (2016) and Liebenberg et al. (2020) referred to as power-sharing, whereby young people are not limited to tokenistic consultation only but are engaged as equal partners with shared governance to shape strategy, co-create content, and co-produce knowledge. As T5 quoted earlier said, "Gen Z will smell bullshit a mile away" and they want nothing to do with such. However, when the connection is genuine, and their influence is accorded a balanced recognition, as with SRH providers, their input is taken and implemented, then they engage meaningfully (Cahill, 2016; Cahill & Dadvand, 2018)

This subtheme has helped to establish that providers' recognition of platform differentiation for youth engagement indicates progress and persistent limitations. Having awareness is commendable, but beyond this, are providers' strategies aimed at improving youth-centredness or basically refining adult-centric practices for better targeting of youth audiences? Authentic connection requires recognising young people as co-creators of content and co-producers of knowledge, and would require power sharing, enabling youth autonomy and agency. Young people are not just an audience to be targeted or one for extractive relationships but have demonstrated capabilities of self-governance within peer spaces without institutions positioned as controlling or moderating their agenda. The next subtheme examines whether providers' approach to targeting niche audiences supports youth agency or is a refined form of adult-control in youth-centred practice.

6.5.2. Targeting Niche Audiences

To extend providers' recognition of the functionality of the different social platforms, they must identify niche audiences rather than universal approaches to effectively and genuinely connect with young people. Within the New Zealand context, young people are multi-ethnic and diverse in sexual identity and orientation (Ellis & Aitken, 2020; Goodwin & Lyons, 2024). As already established, it is imperative to engage with them from this standpoint, prioritising them as key stakeholders and partners with other stakeholders.

Providers' narratives described strategies for reaching specific communities through targeted content, platform features, and partnerships. Platform features that enable privacy and anonymity, such as Instagram's anonymous question and poll functions, were identified as valuable for addressing stigma and discrimination issues (Engel, 2023; Sewak et al., 2023). Providers also emphasised the importance of inter-agency and youth-adult collaborations, particularly partnerships with youth themselves, media outlets, and other community-based organisations, as essential for strengthening their reach and credibility with youth audiences.

> *When I was working as a sex educator for adults, I would sometimes do anonymous questions on Instagram stories. And that's quite handy for people …So the polls are quite helpful for people to ask about sensitive topics, e.g., STIs, erectile dysfunction, or something else, and they can just tick the things that they want to know about. So, it's useful for gathering data. [T9]*
>
> *I think that's something we could work more on, is just engaging with young people on a personal level, so we can understand what they're thinking on social media … I also think that having young people promote their own material. So, working with young people on a level where they are actually promoting it to each other. [T10]*
>
> *As I said, talk in language that communities understand, but I'd say the biggest thing is getting outside eyes. Because when you're in the work, it's just it's sometimes impossible to be objective. Yeah, you're so tunnel vision, and you can read something and be like, yeah, that's like really clear. And then you get someone else to read it. And they're like, I don't know what you're saying. And you're like, what? So, I think it's very easy to underestimate the simplicity that language needs to be. [T5]*
>
> *And I think, as far as in the New Zealand context, news outlets, specifically our e-news has been doing really, really great work … They are putting research in journalistic writing out in the digital space. That is inclusive of rainbow people and the experiences of marginalised folks. And they consult with our organisation to make sure that they are being responsive to our communities. And so, there's that kind of reciprocal relationship where we build relationships with those journalists and those accounts, and they seek feedback and commentary from us, and then we feel that good about the stuff that they put out. [T4]*

Reflecting on this data through the lens of understanding power dynamics, raises questions like, 'Whose interest is being served by the partnerships?' Are young people involved in informing the partnership terms and partner composition, or are all decisions left to the SRH providers to make? Is it a form of extractive relationship where youth give information, and providers use this to validate their practice and institutional positioning (Cahill, 2016; Lipton, Dickinson, et al., 2025)? When providers 'gather data' from youth to improve provider-designed health promotion content without youth input in the design or decision-making process, then such engagement presents as extractive and an imbalanced power sharing despite appearing youth-centred (Ginwright & Cammarota, 2007; Gonzalez et al., 2024).

To further establish the importance of targeting a niche audience, providers expressed that the value of genuine connection and significant reach to ethnic groups is better cultivated from within the community.

> *In terms of posting, we've had a few social influencers who have a small following in the Pacific community, and their posts have usually been successful because they have the biggest reach to the community. So, if they do a story like a video story, then we get more interaction from them than we do on a video by an SRH provider. And regularly posting on Instagram as well helps. [T3]*

> *I'll start by saying that I think definitely we need organisations and practitioners to have real relationships with young people to actually do this work … I think that another way that that can look like is using those in real feedback systems with young people to develop resources and then taking those resources and then making those parts of those resources shareable in the digital space … Young people are more likely to trust people in their own communities or other young people speaking to those experiences. [T4]*

The use of captivating audiovisuals in the form of a video story crafted by a social influencer who identifies as a Pasifika seems to have a bigger impact than one from "a video by an SRH provider" [T3]. It reflects critical insights about whose voices youth trust and are keener to engage with. It exposes the limits of institutional authority and professional credentials over youth voice and representation (Ardizzone, 2007; Martin, Cousin, et al., 2020). It also acknowledges what CPYD explicitly foregrounds: that is, youth are experts on their own cultures and the most effective communicators of culturally grounded messages addressing them (Cahill & Dadvand, 2018; Collura et al., 2019). When young social influencers from the Pacific community create content, they draw on linguistic and cultural knowledge, humour, and storytelling skills that resonate more with youth than SRH providers' content, which is likely too technical (youth-friendly language deficit) and less humorous (Gonzalez et al., 2024).

However, it is also important to examine the power relationships between SRH providers and these 'influencers' by asking critical questions about 'Who controls the messages delivered by the influencers?''Do they have equal partnerships on the content delivered, or do they have to do what the providers tell them?'; 'Are they appropriately compensated for their expertise and labour?' Examining these and similar questions can reveal the power dynamics in this relationship (Cavalieri & Almeida, 2018; Chadha & Jha, 2025; Gonzalez et al., 2020).

While there are evident challenges, including cultural and corporate barriers, the use of platform advertising tools to focus on specific demographics (e.g., ethnicity, sexual orientation, location and socioeconomic status) creates room for SRH promotion providers to promote youth identity and culture through collaboration and authentic messaging (Goodwin & Lyons, 2024). "I would say, we've got one big group who probably like, Pākehā-centric, probably like more urban,

quite highly engaged in our messaging, middle to upper middle class" [T5]. The provider further acknowledged the gaps in reaching marginalised populations:

> *The data is showing that there's a high number of Māori and Pasifika users on TikTok. And that's, you know, a group that it's hard to ethnically target on social media. But that is one way that we can hopefully get more of the right messages to the right people, by using a platform that they use more often. So that's an opportunity that we're, you know, exploring how to leverage. [T5]*

These statements expose critical equity issues in digital health promotion. The provider's successful engagement with "Pākehā-centric, more urban, highly engaged ...middle to upper class" [T5] youth audiences while struggling to reach young Māori and Pasifika youths reveals how digital health promotion can reproduce and deepen existing health inequities (Te Morenga et al., 2018; Zampas & Nihlén, 2025). This is not simply a technical or technological limitation, but a structural deficit that perpetuates the exclusion of marginalised youth. If a Pākehā-centric organisation designs a health promotion message, it is bound to resonate more with Pākehā youth audiences. This implies that Māori and Pasifika youth are not necessarily 'hard to reach' but that providers' messaging is culturally misaligned with their communication preferences, values, and information needs.

Authentic connection that fosters equity in health promotion for Māori and Pasifika youth requires a more culturally representative and balanced approach, engaging Māori and Pasifika youth as designers, creators, and leaders of campaign messages (Liebenberg et al., 2020; Lipton, Dickinson, et al., 2025). The need for intra- and inter-agency collaboration also aligns with targeting niche audiences, so stakeholders can share skills and resources to build stronger, more meaningful connections with young people. Describing the need for such collaboration, several providers shared that,

> *In the New Zealand context, news outlets consult with our organisation to make sure that they are being responsive to our communities. And so there's that kind of reciprocal relationship where we build relationships with those journalists, and they seek feedback and commentary from us. [T4]*

> *As I said, talk in language that communities understand, but I'd say the biggest thing is getting outside eyes. Because when you're in the work, it's just it's sometimes impossible to be objective. Yeah, you're so tunnel vision, and you can read something and be like, yeah, that's like really clear. And then you get someone else to read it. And they're like, I don't know what you're saying. And you're like, what? So, I think it's very easy to underestimate the simplicity that language needs to be. [T5]*

> *So I think opportunities for practitioners to network with organisations and other practitioners in this space to strategise around that is really important. Yeah, I think that cross-organisational cross-sector kind of collaboration is super necessary to kind of saturate the space … So I think it's about recognising where you don't have the expertise and the resources and actually doing the due diligence of like organising and communicating where those resources can be found out there. [T4]*

The above statements demonstrate an institutional partnership where expertise is mutually recognised for community responsiveness. While this is commendable, the question from a CPYD position becomes whether similar reciprocal relationships exist between young people and SRH promotion providers. If there is an expectation from the experts to be consulted and partnered with when a target audience is to be reached, do they do the same when they address youth SRH issues, or does the power dynamics shift?

Furthermore, it is interesting to note that providers are also aware that their institutional affiliations, particularly with government, can undermine trust with young people. As duly noted by one of the providers who said they did not want their project to look **'***governmentee*'**,** and as a result, they partnered with a local provider to host their website and manage the social media engagements.

> *When developing this project was that we didn't want our project to look 'governmentee', even though we are government, which is why we connected with a local provider and he essentially owns the website and the social media stuff now, but we're just checking that everything's sound, giving the back-end support on what to say, like technical [terms]. [T5]*

Here, significant insights on trust, authenticity and power are revealed. SRH promotion providers recognise that such a relationship affects their positioning; that is, by having government identity, it signals authority, surveillance, and institutional control, qualities that are contrasting to the peer-based, authentic form of engagement that young people seek. However, by maintaining backend control on what the local partner does, it reveals tension in transferring ownership and falls short of genuine power redistribution (Ginwright & Cammarota, 2002, 2007).

Another interesting point is that providers feeling compelled to hide their identity reveals that institutional legitimacy comes from community trust and not government authority. While young people in New Zealand are not averse to government health promotion efforts, they are more resistant to surveillance, control, and top-down mandates that are void of youth voice (McGlashan Fainu & Uasike Allen, 2024; Nairn et al., 2021; Scheadler et al., 2023). To this end, should government entities disguise to gain trust, or should they fundamentally address their power relations with stakeholders and communities, positioning themselves as supporters, mentors, and role models, rather than 'experts' who know what is best technically and professionally to drive youth SRH promotion initiatives? The answer is obvious. Disguising reflects holding on to control, while redistributing power enables a structural shift, which institutional authorities find somewhat challenging (Htong Kham & Ng, 2025; Martin, Alberti, et al., 2020).

This subtheme has revealed that SRH providers' strategies for targeting niche audiences recognise the diversity of platforms and their persistent limitations in achieving equity. Beyond demographic targeting is the need for the redistribution of power when applying community-responsive approaches. It is important that communities and actors can define and create their messages with professional support and not control (Ginwright & Cammarota, 2002; Gonzalez et al.,

2020). Balancing this is fundamental to positioning youth as self-experts and shifting health promotion from campaigns delivered to communities to initiatives led by them (Cahill & Dadvand, 2018; Gonzalez et al., 2024).

6.6. Summary

The three themes examined in this chapter, 'Social, but not socially connected', 'Don't tell me what to do' – The dilemma of language, community and trust, and 'No one size fits all – Engage, Adapt and Collaborate' collectively reflect the persistent gap between health promotion providers' rhetorical commitments to youth-centred practice and the structural realities that maintain adult-centric control in digital spaces. Providers' narratives reveal their awareness that effective youth health promotion requires centring youth voice and recognising them as capable agents. However, this often clashes with systemic practices, including prioritising face-to-face interactions over digital engagement with youth, dismissing platforms where young people exercise communicative power, restricting or controlling sexual health content due to risk aversion, and maintaining moderate 'closed' digital communities. These practices run counter to youth realities and expose a structural deficit in health promotion and health service delivery in New Zealand. Organisations and SRH providers are not designed to engage young people as equal partners, and any resistance is met with the same institutional responses.

Power relations in the digital health promotion space operate across several levels. At the organisational level, funding structures that fail to recognise youth voice dictate practice models. Resource limitations are treated as barriers rather than opportunities to leverage youth expertise. At the cultural and institutional level, religious gatekeeping, parental control over information and education access, and provider risk aversion present as 'protection' for young people while silencing their voice. Corporate gatekeeping also shows up in platform censorship, denying young people their fundamental right to quality information. All of these are masked behind youth protections while retaining power and control over what youth can know, access, and participate in.

From the evolution of the analytical framework to the critical analytical framework presented earlier in this chapter, it is evident that barriers to youth-adult partnerships for effective health promotion are not simply technical, resource, or communication issues but matters of power balance. Critical analysis of provider narratives has exposed structural constraints, gatekeeping mechanisms, and institutional risk aversion as the main culprits behind the failure to achieve authentic youth-adult connections. This strengthens the argument for structural transformation, which involves deliberately redistributing power to youth and communities; resourcing through support, not control; community-led initiatives; and addressing power dynamics across organisational, cultural, and corporate levels that currently silence youth voices under the guise of protection.

All of these factors culminated in the conceptualisation of the artefact, ‘Youth-Adult co-design model for digital SRH promotion,” presented next in Chapter 7, whose findings shaped the interpretation of its fundamental principles for transforming power relations in youth SRH promotion. Chapter 8 considers the implications of these findings for policy, practice, and research, as well as recommendations for achieving the structural changes needed for genuine youth-adult partnerships in the New Zealand SRH promotion landscape.

Chapter 7. Artefact Development

7.1. Introduction

This chapter provides the conceptual basis for developing the practice-oriented artefact, as well as the mechanics guiding its application in practice. Grounded in constructionist epistemology, the artefact was built through interactions between the researcher and the researched, embedded in an examination of power relations between practice and the domain of practice. The research and its creative output, 'Youth-Adult co-design model for digital YSRH promotion', use critical theory as the theoretical lens and CPYD as the analytical lens to achieve equitable and balanced power dynamics between young people and SRH promotion providers in New Zealand.

The critical youth paradigm, established in Chapter 3, requires youth-centred concepts and practices that enable the redistribution of power, critical consciousness, and culturally grounded co-leadership approaches that move beyond improved healthcare service delivery to transform youth-adult interactions. The CPYD framework positions young people as agents who can create spaces that enable them to thrive and challenge restrictive structural forces (Ginwright & Cammarota, 2002, 2007; Gonzalez et al., 2020). To this end, frameworks need to dismantle adult gatekeeping rather than refine it, and create equitable governance structures that enable youth autonomy and agency rather than engage in tokenistic consultation (Cahill, 2016; Cahill & Dadvand, 2018; Cahill, 2014).

Analytical insights from Chapter 6 revealed the multiple, interconnected dimensions of the power dynamics between SRH promotion providers and young people seeking SRH promotion. This included the struggle to communicate without expressing dominance, to maintain balanced power relations in digital environments, the persistence of stigma and discrimination in youth-centred practices, and platform differentiation for diverse audiences (Calder-Dawe & Gavey, 2019; Carroll et al., 2023). Taken together, the literature and empirical findings suggest a relational and systemic gap, not simply a technical or informational one. Providers do not lack the knowledge of social media, nor do youth lack access to information; however, epistemic hierarchies enable institutional authority over youth, affecting their autonomous and agentic capabilities (Akom et al., 2008; Ardizzone, 2007; Cahill, 2016).

The artefact development draws on the epistemological position of constructionism, that meaning is constructed through social interactions between the researcher and the researched (Crotty, 1998). Critical theory served as the theoretical paradigm for examining power dynamics in youth-adult partnerships (Arnold & Silliman, 2017; Cahill & Dadvand, 2018) while CPYD principles were applied to establish youth agency and legitimacy (Ginwright & Cammarota, 2007; Gonzalez et al., 2020). Table 11 maps these theoretical commitments to the framework's functional design, ensuring critical questions can be asked about who sets the engagement agenda, for what purpose, and who

benefits, and that these commitments are structurally embedded rather than aspirational (Gonzalez et al., 2020).

Table 11.

Theoretical alignments underpinning the artefact development

Theoretical domain	**Principle**	**Operationalisation within the framework**
Constructionism (Crotty, 1998)	Knowledge co-constructed through social interaction	Tripartite governance ensures meaning emerges from youth-provider-researcher dialogue. The framework is iterative and relevant to the context in which it operates. All participants are knowledge producers with equitable responsibilities to one another.
Critical theory (Arnold & Silliman, 2017; Cahill & Dadvand, 2018)	Exposes and transforms power dynamics	Redistributes power to achieve an equitable, balanced partnership. Accountability mechanisms ensure power relations are visible. Framework challenges adult and academic gatekeeping. Youth-provider partnership retains control over external relationships, including academia.
CPYD (Gonzalez et al., 2020)	Posits that youth agency demands structural changes, not refined 'youth-friendly' approaches or controlling adults	Youth hold decision-making authority and meaningful participation, not tokenistic consultation. Pathways from participation into leadership are structurally embedded. Youth are recognised as researchers of their own experience and co-learners of the knowledge production and dissemination process.
Culturally responsive frameworks (Goodwin & Boulton, 2024; Goodwin et al., 2025)	Indigenous self-determination and relational accountability are enacted	Rangatiratanga includes sovereignty over knowledge production. Kaitiakitanga extends to guardianship of co-produced knowledge. Talanoa, Ubuntu, and other collective frameworks constitute, not supplement, the design. Cultural framing is foundational to youth engagement and partnership outcomes.
PBR (Candy, 2006)	Knowledge emerges from and transforms practice	Framework developed iteratively through engagement. Creative output embodies equitable knowledge production and builds analytical capacities among both young people and SRH providers. External researchers provide support in the knowledge production journey rather than extract information.

The following sections detail the conceptual journey from the limitations of provider-centred frameworks (Section 7.2), to the rationale for adopting a youth-adult co-design approach for the artefact (Section 7.3), then to the framework's foundational design principles and tripartite governance structure (Section 7.4), before finally describing the practical application of the artefact (Section 7.5).

7.2. Limitations of Provider-Centred Frameworks

Research that engaged with SRH promotion providers who are adults, rather than youth directly, typically applied dominant frameworks, including Knowledge-Attitudes-Practice (KAP) models, youth-friendly service delivery frameworks, behavioural and implementation Science frameworks, and professionalism and capacity-building frameworks (Denno et al., 2021; Kang & Bagaoisan, 2024; Raingruber, 2014; Sharma, 2021). While these frameworks have been successfully applied to improve access to and quality of healthcare, they are conceptually limited to examining youth-adult power relations (Akom et al., 2008; Gonzalez et al., 2020; Gonzalez et al., 2024).

The fundamental challenge with these frameworks is that they reproduce the power asymmetries that they claim to address by positioning providers as the agents of change (Chadha & Jha, 2025). Even when refined to be youth-friendly or collaborative, adults design them for adults to 'better' serve young people (Martin, Alberti, et al., 2020; Ministry of Social Development, 2024). As a result, young people are positioned as passive recipients and beneficiaries with little to no input in the interventions delivered, while adults maintain dominant authority. This orientation directly opposes CPYD principles, which require young people to be enabled to challenge structures that shape their health outcomes (Akom et al., 2008; Gonzalez et al., 2020), not just receive better health promotion interventions from unchanged adult-centric institutions.

Provider-centred frameworks are often formulated to improve individual competencies (Denno et al., 2021; Kang & Bagaoisan, 2024), contrasting with the evidence emanating from this research that the barriers to effective youth-adult engagement are structurally embedded in institutional hierarchies and practices that exclude youth voice and representation (Goodyear-Smith & Ashton, 2019; Klassman et al., 2024). In these frameworks, provider expertise remains uncontested, while youth expertise and culturally relevant frameworks are treated as complementary rather than foundational and integral components of genuine youth-centred engagement. Training SRH providers to become more youth-friendly would not redistribute decision-making authority or transform the existing governance structures.

7.3. Why Youth-Adult Co-design Approach?

In this section, the origin of co-design as a concept is described (Section 7.3.1), and situates how contemporary co-design thinking, further shaped by critical youth and Indigenous lenses, aligns with the practice-oriented framework developed from this study, the 'Youth-Adult co-design model for digital YSRH promotion'. Section 7.3.2 discusses the significance of framing the creative output as a co-design approach rather than an alternative artefact type, arguing that it is theoretically appropriate for addressing the power dynamics identified in Chapter 6.

7.3.1. Origin of the Co-design Approach and Its Alignment with the Artefact

Co-design evolved from Kurt Lewin's mid-20th century action research cycles, which emphasised working 'with' rather than 'on' marginalised groups (McShane & Gustafsson, 2024). This evolution is reflected in Paulo Freire's (1970) critical pedagogy and the Scandinavian participatory design movements, which engage end users in design and production processes (Lipton, Bailie, et al., 2025; McShane & Gustafsson, 2024). Stanford University's 'Design Thinking' model represents a contemporary formalisation of the co-design concept. This model is articulated as an iterative, co-design five-stage process: empathise, define, ideate, prototype, and test; a process that enables design thinkers to move fluidly across the five stages based on user feedback (Plattner, 2010). According to Plattner (2010), the 'Design Thinker' occupies a central function as the problem-solver, who is designing for users, rather than with or by those directly affected by the 'problem'. Separating these two identities distinguishes Stanford's model from other traditional participatory approaches and youth-led social change movements (Ginwright & Cammarota, 2002; Lerner et al., 2005; Liebenberg et al., 2020), where young people actively participate in defining and proffering solutions to issues that affect them.

Despite these differences, the five stages of the Design Thinking model align with the Youth-Adult co-design model's phases, with the latter shaped by critical youth and Indigenous lenses. 'Empathise' corresponds to the 'reach' and 'engage' phases, creating opportunities to understand youth digital realities while enabling youth to collaboratively define the problem and partnership scope with SRH providers. 'Define' also aligns with the reach phase, the first phase of the co-design model emanating from this study, where problem framing occurs. Most importantly, the CPYD perspective positions youth authority over problem definition, and not adult framing of what young people need (Akom et al., 2008; Gonzalez et al., 2020). This conceptual grounding enables a foundational shift from a youth-centred to a youth-led paradigm, diffusing power tensions and structurally establishing youth agency.

The co-design model's third phase, 'referral', aligns with Stanford's 'ideate' stage, where youth function as prosumers and peer influencers, creating health promotion content, shaping discourse through digital platforms, and leading peer navigation to youth-friendly services. This youth-led solution generation directly addresses barriers identified in the literature (Rose et al., 2024; Rose et al., 2022; Rose, Garrett, McKinlay, Morgan, et al., 2021) and discussed in Chapter 6, including poor SRH clinic access, delayed health-seeking, stigma, discrimination, and fear of judgment. Stanford's 'prototype' and 'test' stages correspond to 'uptake' and 'transform' phases in the co-design model, where youth-led initiatives are implemented and evaluated at individual and community levels.

While both models use iterative, non-linear processes, the 'Youth-Adult co-design model for digital YSRH promotion' differs fundamentally by explicitly interrogating power dynamics.

Stanford's model centres users around design thinkers, whereas the Youth-Adult co-design model redistributes governance authority by integrating critical consciousness and Indigenous self-determination principles (Rangatiratanga, Kaitiakitanga) (Gonzalez et al., 2020; Goodwin & Boulton, 2024; Goodwin et al., 2025). Thus, youth are positioned as critical determinants of what health promotion messaging should look like, rather than as an extractive relationship that consults youth for suggestions to improve existing systems and practices (Goodwin & Boulton, 2024). Having established the conceptual foundations of co-design thinking and how the 'Youth-Adult co-design model for digital YSRH promotion' builds upon and transforms this concept, the following section articulates how the model's specific design features respond to empirical gaps identified throughout the research.

7.3.2. Significance of a Co-design Model to Frame the Artefact

The choice of artefact was informed by the nature of the gaps identified in this research: relational and systemic power imbalance in youth-adult relationships. Hence the reason for rejecting other alternative artefact types. For example, if knowledge deficit among providers or young people was identified as the problem, training to improve individual capacity or the design of an educational resource or toolkit to guide provider practice might be appropriate. However, this would be inadequate for addressing structural adult gatekeeping and the relational power dynamics between young people and SRH providers. If the challenge were purely technical incompetence among SRH providers, a digital platform or technological design to improve their digital skills could have been useful, but it would not redistribute power or dismantle organisational and professional hierarchies.

Based on the above critical considerations, a practice-oriented co-design framework emerged as the theoretically appropriate outcome of the research because it addresses the relational fundamentals governing meaningful youth engagement (Goodwin & Boulton, 2024; Mark & Hagen, 2020). Furthermore, such a framework is essential for transforming governance structures and enabling equitable distribution of power across stakeholders. By grounding the practice-oriented co-design framework within cultural epistemologies (Goodwin & Boulton, 2024; Goodwin et al., 2025), it retains its relevance in fostering youth agency while maintaining contextual applicability across multiple governance levels.

Therefore, the artefact resulting from this research was developed not to 'train' SRH promotion providers to become better in their practice but to support them in 'critically examining and understanding how power dynamics operate' based on their institutional positioning. The framework does not aim to make adult-led systems more efficient or youth-friendly. However, it seeks to dismantle adult dominance by creating pathways for youth to shape, govern, and, ultimately, lead digital YSRH promotion initiatives in New Zealand (Cahill, 2016; Ginwright & Cammarota, 2007). This supports a practice-oriented framework that describes SRH providers' practice transformation from consultative and tokenistic engagement to one that helps young people thrive in their agentic

capabilities. It is constructed as a model to dismantle adult dominance by creating pathways for youth to shape, govern, and ultimately lead digital YSRH promotion initiatives in New Zealand.

7.4. Conceptualising the Framework Design

The 'Youth-Adult co-design model for digital YSRH promotion' operates as a conceptual bridge between the theoretical perspectives established in this research and the practical realities of provider-youth engagement in New Zealand. Its primary aim is to foster a crucial mindset shift that bridges the relational and systemic gaps identified in this research, leading to enhanced SRH promotion practices across social media and digital platforms, enabling youth agency. It is important to reiterate that, as a study involving mainly adult SRH promotion providers, the model is conceptualised as a framework to influence transformational shifts in practice among providers, so they are more welcoming of equitable youth partnerships. On the youth side, it is formulated as a guidance tool for collaborating with SRH providers through a pathway of shared governance and a collective goal for digital SRH promotion.

The framework development process involved synthesising findings from Chapter 6 with evidence from the literature on what works to improve youth-adult synergies for collaborative work in New Zealand and internationally. This evidence base was considered from a CPYD perspective to understand what enables youth agency; how cultural frameworks support young people to thrive by challenging existing power structures; and how to address adult gatekeeping in youth-friendly and participatory models. The following categories of literature were consulted to inform the design of the artefact:

1. **Co-design for health equity in New Zealand:** These studies (Goodwin & Boulton, 2024; Goodwin et al., 2025; Taba et al., 2025) describe what effective co-design intervention between young people and SRH providers must incorporate in its design and implementation, particularly one engaging youth from Māori and Pacific communities, to achieve equitable outcomes. Goodwin and Boulton (2024) articulated nine foundational domains: relationship building, accountability, time, flexibility, transparency, capacity building, involving the right people, adequate resourcing, and sustainability. Goodwin et al. (2025) identified four further culturally grounded principles as essential for such interventions to be considered truly 'good': Te mātauranga o tētahi hapori (cultural framing), Te kōtuitanga taurite (equal partnership), Kaitiakitanga (guardianship), and Rangatiratanga (leadership and authority). Taba et al. (2025) demonstrated a practical example of how co-design works between young people and professionals. Together, these principles ensure the co-design framework is methodologically sound, culturally responsive, empowering, and reflective of the values and aspirations of the communities it serves.

2. **Culturally-responsive practices and principles**: Further to the above, Kaupapa Māori approaches (Te Hiranga Mahara, 2022; Te Morenga et al., 2018; Te Taiwhanga Rangatahi, 2022) demonstrated how Indigenous self-determination and relational accountability can be institutionalised through governance structures that acknowledge whakapapa, whanaukitanga, and tino rangatiratanga. These are concepts that challenge Western hierarchical models and centre collective well-being over individual expertise. For Pasifika youth, the Talanoa methodology is one such approach widely used in youth-centred and youth-led projects because it supports youth voice and enables meaningful engagement (Cammock et al., 2024; Veukiso-Ulugia, 2013a, 2013b). It also aligns with storytelling as a "vehicle for social change" (Gonzalez et al., 2024, p. 10). For other ethnic minorities, the importance of cultural competence in health promotion has been argued and justified as well. For instance, Ubuntu and the African philosophical framework, meaning "I am because we are", value the principles of recognition, respect, reciprocity, and collective action (Kuyini et al., 2024; Zaid, 2025). Similarly, culturally responsive practice with Asian youth must adopt philosophical frameworks such as Kapwa (Filipino), Jeong (Korean relational care), Confucian relational ethics or Gotong Royong (Indonesian), which centre collective well-being and relational interdependence rather than Western individualistic models of youth agency (Kovach, 2021; Pe-Pua & Protacio-Marcelino, 2000).
3. **Youth Participatory Action Research (YPAR):** In line with the findings and recommendations of Goodwin and Boulton (2024) and Mark and Hagen (2020), meaningful youth-adult collaboration in the New Zealand SRH promotion space should aim for shared governance and equal and balanced decision-making power. Throughout the process, youth and adults are involved from the conceptualisation phase, where they collectively agree on the governance structure, design, implementation, and evaluation of outcomes without one dominating the other. A similar approach is described in the United Kingdom STASH study, which showed how young people, through a series of joint and iterative workshops with professionals, co-designed a social media platform that enabled peer education among school-based adolescents (Hirvonen et al., 2021; Purcell et al., 2023). The YPAR perspective emphasises youth-led inquiry and structural critique, ensuring the framework does not merely make existing systems more participatory but instead redistributes epistemic authority to young people (Cahill, 2016; Cahill & Dadvand, 2018).

Governance Model Guiding the Framework

Central to this framework is an advocacy for a balanced governance structure that brings together youth self-experts through their voice and lived experience, provider expertise and institutional resources, and research capacity for knowledge production and dissemination as three essential functions throughout the design, implementation, and evaluation of digital YSRH promotion initiatives (see Figure 20). Most importantly, the tripartite structure should not be read as three fixed

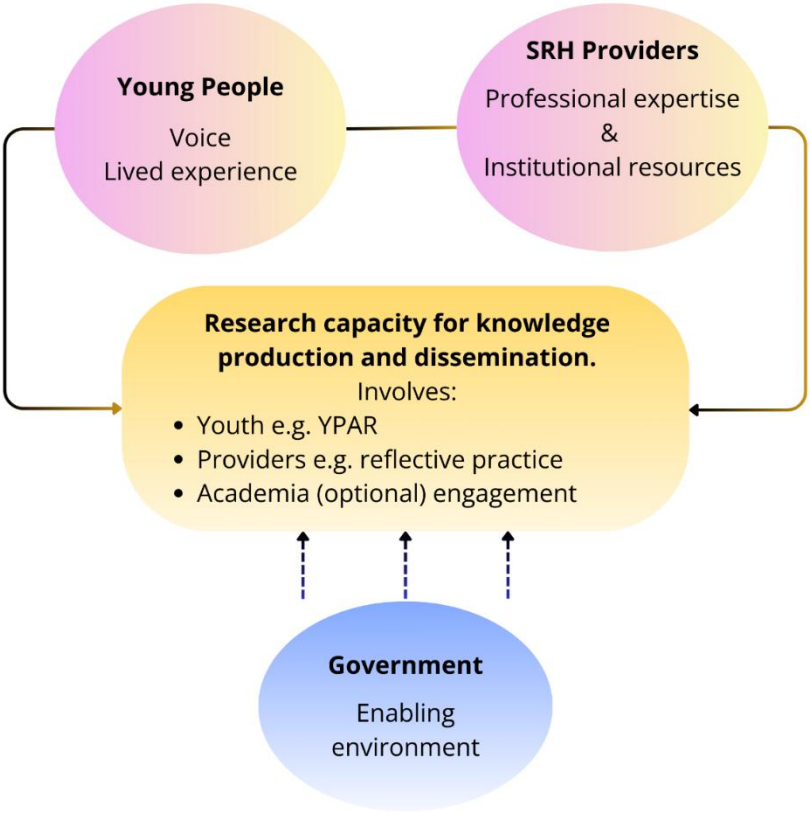
stakeholder identities; that is, youth, providers, and academic researchers, but rather as three interdependent functions that enable effective co-design.

The research function encompassing critical analysis, documentation, evaluation, and knowledge communication is primarily undertaken by youth and providers themselves, developing their research literacies through the co-design process, not simply involved as research subjects. According to Cahill (2016), they are the "subjects and architects of research" (p. 157), balancing power relations, accommodating diverse perspectives, and contributing meaningfully to the co-design process (Cahill & Dadvand, 2018). Youth become researchers of their own experiences, relationships, and communities, while SRH providers may undertake reflective practice, PBR, and participatory evaluation, altogether documenting and analysing their collaborative work. In line with CPYD principles, both youth and providers are recognised as knowledge producers, not simply implementers of an externally moderated research process.

External academic researchers can still be engaged; however, their purpose must serve the youth-provider partnership goals. For example, to access specialised and methodological expertise, facilitate communication with policy or academic audiences, secure research funding, or support rigorous evaluation, as demonstrated in the United Kingdom STASH study (Purcell et al., 2023) and encouraged by scholarly evidence emerging from New Zealand (Goodwin & Boulton, 2024; Goodwin et al., 2025). Such engagement operates on non-extractive, facilitative terms and academic researchers do not legitimise or validate youth-provider partnership, but amplify and enable their capacity to produce, document, and disseminate knowledge. Youth and SRH providers share governance authority over the scope of engagement and terms of collaboration. This prevents academic gatekeeping and ensures knowledge production serves youth-identified priorities, not institutional agendas.

Figure 20.

Tripartite governance structure for effective youth-adult co-design



The fluid conception of the research function aligns with Kaupapa Māori principles of research sovereignty, where Indigenous communities retain control over research processes and outcomes (Te Morenga et al., 2018; Te Taiwhanga Rangatahi, 2022), and with CPYD's emphasis on youth as critical analysts capable of examining and transforming the structures affecting their lives (Cahill, 2014; Gonzalez et al., 2020). The tripartite structure fosters mutual accountability and distributed expertise while generating evidence-based interventions that drive meaningful social change. The framework also recognises the government's enabling role in equitable and balanced youth-adult partnerships through policy development, funding mechanisms, and regulatory frameworks that support youth agency (Wijamuni et al., 2025).

This tripartite domain operates within a constructionist epistemology in which meaning and knowledge are co-constructed through interaction among actors with different forms of expertise. It aligns with critical theory by exposing and transforming power relations, creating governance mechanisms that institutionalise youth agency, rather than make it the discretionary responsibility of SRH providers. Without this structural support, the tripartite relationship risks becoming a mandate that youth, providers, and researchers cannot sustain.

Aligning the Artefact with the Critical Participatory Youth Development Framework

Following Gonzalez et al.'s (2020) demonstration of how the seven components of CPYD were operationalised in the #PassTheMicYouth pilot project, a similar approach was adopted to illustrate how the 7 Cs are embedded within each phase of the 'Youth-Adult co-design model for digital YSRH promotion'. Originally developed as Positive Youth Development (PYD) (Lerner et al., 2005), it focuses on building individual assets, that is, the 6 Cs (confidence, competence, character, connection, care, and contribution). Expanding on this theoretical framing, Gonzalez et al. articulated that youth engagement involves critical reflection and political efficacy, which translates into 'contribution through critical action' and, as the fundamental PYD components, they iteratively make up critical consciousness (critical reflection, political efficacy and critical action), as the seventh C. By onboarding critical consciousness, it shifts the focus from individual agency to the collective agency of youth, meaning youth's contribution towards critical action is elevated by their critical consciousness to resist epistemic hierarchies and institutional authority, amplifying youth voice.

Across the five iterative phases of the 'Youth-Adult co-design model for digital YSRH promotion', the 7 Cs are relevant to youth and SRH providers; hence, incorporated as follows: *competence* by recognising young people as self-experts on their own SRH needs, in digital engagement, peer culture, and network while providers demonstrate their capability to support youth agency; *confidence* through the redistribution of authority to enable youth agenda-setting and resource allocation from primary contact; *connection* by facilitating tripartite governance functions for meaningful collaboration across stakeholders; *character* through providers' transformative accountability and youths' leadership in ethical conduct and equitable partnerships; *caring* through relational accountability structures and mutual respect to one another; *contribution through critical action* enables youth to lead the co-design process, facilitate peer navigation through digital spaces, and advocate for policy changes and institutional transformation; *critical consciousness* by demonstrating critical reflection (interrogate power dynamics), political efficacy (contribute to sustainable social change); and *critical action* (resist social injustices) amplifying youth voice throughout the entire framework (Gonzalez et al., 2020, pp. 35-36).

How the Artefact Addresses Provider Constraints Identified in Chapter 6

Having discussed the theoretical principles that informed the artefact design, including the tripartite governance structure and its alignment with the 7 Cs, a critical question emerges: 'How does the co-design model address the provider constraints; that is, institutional hierarchies, professional gatekeeping, funding precarity, and risk aversion, identified in Chapter 6? Will these same constraints limit the functionality of the co-design model, or can they be reframed as targets of the structural transformation that the framework addresses?'

The framework does not assume that individual SRH providers can unilaterally overcome these structural barriers; it clearly articulates that systemic changes are critical and necessary to achieve meaningful partnership and equitable power distribution among key stakeholders. Therefore,

the ‘Youth-Adult co-design model for digital YSRH promotion’ proposes governance restructuring (the tripartite governance structure), policy changes, and funding reforms that recognise youth as essential partners and capable agents in YSRH promotion, and transformative accountability through the collective shift in practice and cultural norms. The framework calls on SRH promotion professionals and their organisations, funders, policymakers, and youth themselves to drive this transformation. Chapter 8, Sections 8.3 and 8.4, elaborates on this call by discussing implications for practice and opportunities for future research, particularly in light of the developing global discourse around social media bans.

7.5. Youth-Adult Co-design Model for Digital Youth Sexual and Reproductive Health Promotion

The ‘Youth-Adult co-design model for digital YSRH promotion’ (see **Error! Reference source not found.** and **Error! Reference source not found.**) is a non-linear framework operational across five iterative phases: (1) **Reach** –providers initiate contact and undertake transformative accountability to create enabling conditions for youth agency; (2) **Engage** –co-creation begins as youth and adults establish partnerships terms, governance structures, and communication protocols, with youth leading with agenda setting and defining the engagement processes; (3) **Referral** –youth-led content creation (prosumerism) on health promotion directs peers to safe, inclusive, and affirming digital spaces, demonstrating a shift in the mindset of youth-adult partners and the community they exist on the possibilities of meaningful engagement; (4) **Uptake** –equitable access empowers youth to make informed decisions on the type of services (hybrid, on-site or online) to be sought and health information based on youth-led referrals; and (5) **Transformation** –sustained youth-adult partnerships generate relational accountability, collective responsibility and trust that drives systemic change. Movement through these phases is iterative, rather than sequential, with partnerships cycling through the phases as contexts and relationships evolve.

Across the co-design model, the text references youth-centred and youth-led processes. Often used interchangeably, but distinct in how they apply across levels of engagement, decision-making, and power distribution in initiatives, organisations, or policies that affect young people, these terms need clear definition. According to the WHO (2025), meaningful youth engagement is:

> *an inclusive, intentional, mutually-respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people’s ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organisations that affect their lives and their communities, countries, and world that affect their lives, communities and futures (WHO, 2025, p. 1).*

Rämmer et al. (2023) defined youth-centred approaches as “placing the development of young people’s personalities and well-being at the centre of the content, organisation, and

development of activities, services and programmes to achieve the best outcomes for young people" (p. 1005). Silva et al. (2002) described youth-led approaches as fundamentally about power sharing and democratising knowledge production and decision-making, building on young people's capacity as critical thinkers, effective leaders, and active change agents in their organisations and communities. For the current research, the definition of the youth-led approach by Silva et al. (2002) aligns with the third type in a 5-stage continuum of youth-adult relationships described by Jones and Perkins (2006), where young people lead a process for change collaboratively with adults, sharing equal chances of using their skills, decision-making, and mutual learning.

Understanding the theoretical 'meaning constructs' underpinning each phase is also needed to clarify how the model operationalises CPYD principles and ensures that power redistribution is structural rather than aspirational. Table 12 summarises the critical distinctions that apply to the conceptualisation of youth-centred and youth-led approaches within the context of this research. **Error! Reference source not found.** articulates the meaning construct for each domain of the 'Youth-Adult co-design model for digital YSRH promotion; that is, the conceptual reasoning that guides how youth and providers interact across the five phases.

Table 12.

Youth-centred and youth-led approaches

Dimensions	**Youth-centred approaches**	**Youth-led approaches**
Who initiates?	Often, adults with youth input	Young people themselves
Who decides?	Shared decision-making: young people and adults collaborate	Young people primarily hold the decision-making power
Where is power domiciled?	Power sharing through partnership models	Young people hold power while adults are in supportive roles (e.g., mentors, role models, professional knowledge sharing)
Who sets the agenda?	Co-created between youth and adults	Youth define the questions, priorities and goals
Where would the change be effected?	Within systems and services designed to be responsive to youth needs	Within institutions and systems that affect youth

Table 13.

An iterative framework for effective youth engagement in digital SRH promotion

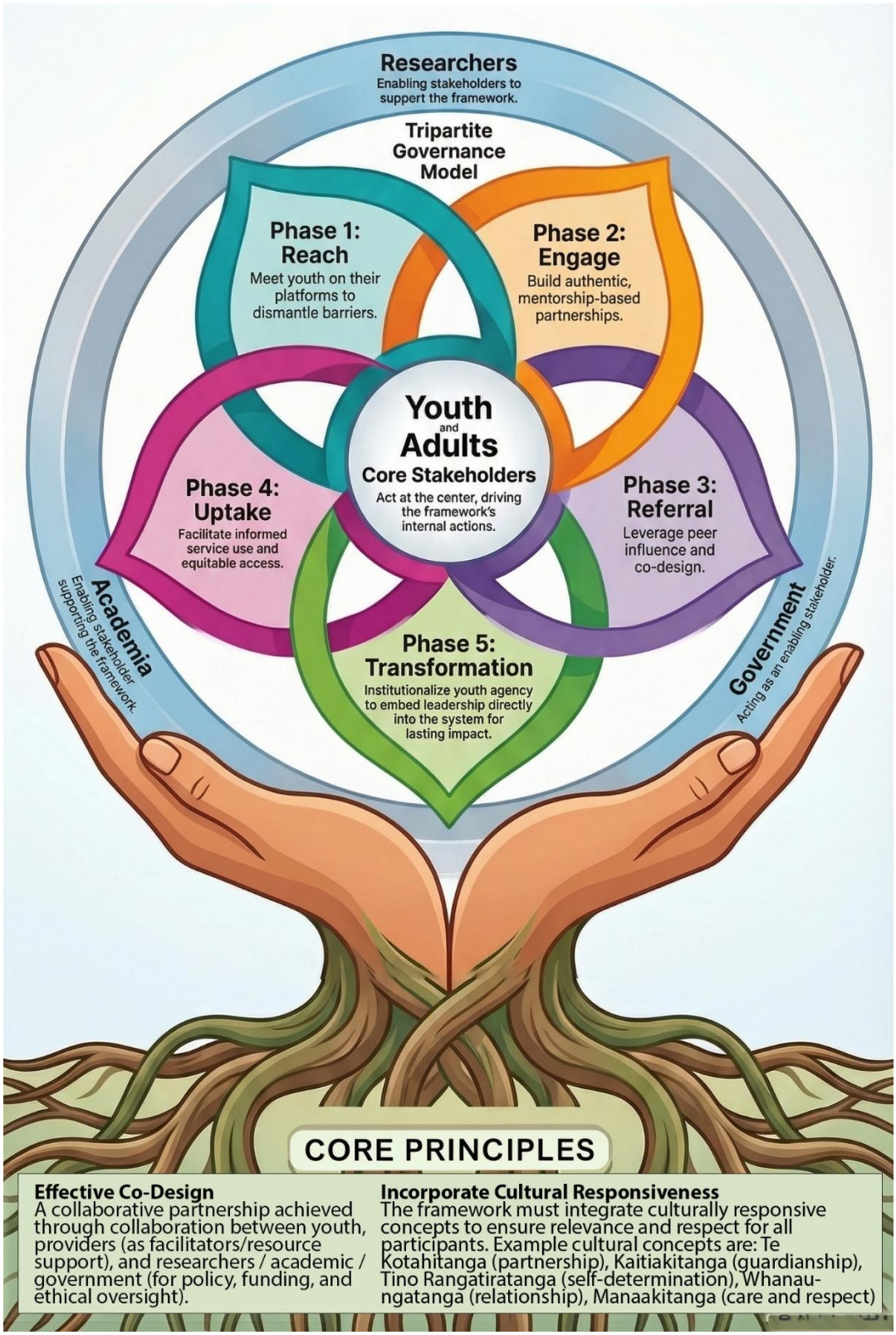
Framework components	**Relationship to research key themes**	**Meaning construct in the framework**
Reach	Theme 1: Social, but not socially connected	As the foundational concept, it underscores where and how adult providers meet and interact with young people. This is imagined as a social media or similar digital

Framework components	Relationship to research key themes	Meaning construct in the framework
		platform for health promotion communications. At this stage, adult providers undertake transformative accountability by dismantling barriers and ensuring an enabling environment for young people to lead. Conceptualised as youth-centred and gradually phased into youth-led. Providers operationalise this stage by ceding agenda-setting authority to youth to determine platform use, communication priorities, and engagement terms from the onset.
Engage	Theme 1: Social, but not socially connected Theme 2: Don't tell me what to do…	Interaction depends on the success of the 'Reach' phase; therefore, it is iterative until purposeful partnership and authentic connection are established. Rather than imposing authority, this phase relies on mentorship, role-modelling, and coaching strategies. Walking side by side and learning from one another, young people learn from the experiential and professional knowledge of adult providers, who, in turn, learn from young people what digital fluency and nativity involve, and adapt fluidly across their respective paradigms. Cultural reciprocity is grounded. Balance attained in youth-centredness and youth leadership.
Safe and self-referral	Theme 2: Don't tell me what to do… Theme 3: No one size fits all…	Youth leadership is concretised. Through authentic connection and meaningful engagement with adults in the co-creation process, young people can make informed decisions for and by themselves. Peer influence is a key strategy in this phase. Prosumerism—creating and consuming content—dictates the health promotion strategies and direction here.
Uptake	Theme 3: No one size fits all…	Young people make informed decisions and uptake their preferred service. Youth-led and critical to behavioural change and improved SRH outcomes. Supports the principle of having 'the right

Framework components	Relationship to research key themes	Meaning construct in the framework
		people' to lead the process of co-design, which is one of the nine lessons outlined by Goodwin and Boulton (2024). Equitable access and increased uptake are evidenced. Ethical standards are maintained. 'Measure what matters'.
Transformation (initially framed as Satisfaction & Trust)	Theme 1: Social, but not socially connected Theme 2: Don't tell me what to do… Theme 3: No one size fits all…	Culture and practice shift institutionalise youth agency. Youth and providers partner jointly to evaluate and address feedback. Throughout the engagement process, youth and SRH providers function as knowledge producers and researchers, with external academic support as needed, to serve youth-providers co-defined dissemination or methodological goals. The 'Youth-Adult co-design model for digital YSRH promotion' is refined to fit for purpose. The youth-led and youth-centred model fosters a purposeful partnership that authenticates a genuine connection between young people and adult providers. Sense of community and trust established.

Figure 21.

The 'Youth-Adult co-design model for digital YSRH promotion'



Note: Author-generated. This framework illustrates the iterative transformation from youth-centred to youth-led engagement in digital YSRH promotion. It is framed by shared governance, professional role-modelling and Indigenous principles to cultivate lasting partnerships. The image was created with the NotebookLM AI tool and edited with Adobe Photoshop.

Phase One: Reach

This foundational phase is conceptualised as youth-centred, with the framework designed to transition toward youth-led as the partnership with adult SRH providers matures. 'Reach' requires providers to take deliberate action by initiating contact in digital spaces where young people already function and thrive as digital natives, demonstrating their (providers') willingness to share power. Provider initiation here does not mean provider control because, from the first contact, young people determine the terms of engagement, including platform choice, communication preferences, and boundaries for adult involvement (Cahill, 2014; Gonzalez et al., 2020).

This phase demands transformative accountability from SRH providers, requiring them to deconstruct authoritative and hierarchical practices (Arnold & Silliman, 2017; Carter & Little, 2007; Freire, 1970) and embrace humility and equal partnership with youth (Goodwin & Boulton, 2024). This ensures providers critically examine their practice to prevent institutional gatekeeping, creating the conditions for young people's agentic capabilities as creators and knowledge experts, particularly in digital contexts (Cahill, 2014; Palacios & Allen, 2019). As Delgado (2006) noted, young people's willingness to initiate social change does not negate their need for support; however, this must be offered on youth terms, not imposed through professional authority. Providers are aware and consciously guard against opportunistic and tokenistic exploitation by enabling young people to self-identify as creators and knowledge experts (Cahill, 2014; Palacios & Allen, 2019). The Reach phase explicitly acknowledges that young people, as digital natives, hold expertise in communication practices and peer culture that providers, as digital immigrants, must learn (Stubbing & Gibson, 2021). Success in this phase is measured not by provider outreach alone, but by whether youth perceive genuine power sharing and whether the conditions for youth leadership are established (Gonzalez et al., 2020).

Phase Two: Engage

This second phase strongly reflects co-agency and co-governance. It is characterised by active learning and adaptations, where facilitative adult partnerships (Calder-Dawe & Gavey, 2019; Purcell et al., 2023) affirm youth agency grounded in mentorship, role modelling, and coaching strategies, showcasing the Tuakana-Teina model in practice through The Southern Initiative project (Te Taiwhanga Rangatahi, 2022). Navigating this phase jointly ensures cultural reciprocity and relational balance, which resonates with critical youth studies and Kaupapa Māori principles, whereby young people are not silenced or judged, nor is the provider's professional identity conflicted or threatened (Goodwin et al., 2025; Mark & Hagen, 2020; Te Morenga et al., 2018). Ethical standards and values are ingrained in the capacity-building experiences of both key stakeholders.

Emphasising the iterative nature of the 'Youth-Adult co-design model for digital YSRH promotion', providers and youth co-develop digital literacy and youth engagement strategies that centre youth agency and lived experience within digital environments. If the need to realign purpose

and partnership focus emerges, this phase facilitates refinement and iteration back to the 'Reach' phase, until clarity and intent are collectively achieved. Ultimately, youth champions and advocates emerge, foregrounding peer leadership and collective empowerment.

Phase Three: Referral

In this context, referral applies to youth-led navigation, where young people actively create digital health promotion content and direct peers to appropriate services and supportive spaces through trusted peer networks, rather than through professional healthcare referrals. Scholarly publications have shown that peer referrals are more effective than professional referrals, as peer relationships and trust minimise intimidation and feelings of being judged (Purcell et al., 2023; Rose et al., 2024; Rose et al., 2022; Stubbing & Gibson, 2021). With young people front-leading this third phase, prosumerism is demonstrated at its core, validating digital youth agency and participatory culture (Cahill, 2014; Conn et al., 2017; Deane et al., 2025).

Digitally curated social spaces are considered more youth-friendly, visually attractive, and smooth to navigate (Purcell et al., 2023). Young people can confidently and confidentially initiate direct messaging with peer advocates and champions, establishing private chat for support and information exchange. Adult providers support young people on the backend by maintaining ethical oversight and leveraging the empowerment from the 'Engage' phase, where youth were equipped to ensure privacy, confidentiality, and trust (Baraitser, 2025; Carter & Little, 2007; Kontak et al., 2025). This includes building their capacity to signpost peers towards the different types of services available. Peer referrals to safe, inclusive, and affirming spaces available online, on-site or via hybrid facilities are led by youth advocates (Guglielmi et al., 2024; Hémono et al., 2024; Phillips et al., 2024). Self- and peer-facilitated referrals (Stubbing & Gibson, 2021) result in a system that promotes equitable access to healthcare.

Phase Four: Uptake

Uptake is the fourth critical component of the 'Youth-Adult co-design model for digital YSRH promotion', and centres youth agency and autonomy, a clear reflection of legitimacy and trust among peers. Young people actively decide on the type of service they require and how they would like it to be delivered, whether digitally, in-person, or through hybrid models, continuing the participatory momentum initiated in the 'Referral' phase. This aligns with the thematic findings '*Don't tell me what to do*' and '*No one size fits all*'. As a result, equitable access to SRH services and increased uptake of telehealth consultations and in-person appointments are evidenced (Guglielmi et al., 2024; Phillips et al., 2024; Rose, Garrett, McKinlay, & Morgan, 2021). Aligning with Goodwin and Boulton (2024) regarding having 'the right people' to lead the co-design process, this phase reinforces the significance of equitable participation, such that young people are not just contributors but decision-makers in matters that affect their health and well-being. Fundamental to this phase are ethical standards—privacy, confidentiality, consent, and inclusivity (Baraitser, 2025; Kontak et al., 2025).

Additionally, this phase recognises the adaptive learning and flexibility essential for adult providers to effectively engage digitally fluent and culturally diverse youth. Such reflexive practice challenges hierarchical perspectives and positions and exemplifies how they are taking responsibility throughout the youth-centred and youth-led journey (Carter & Little, 2007; Palacios & Allen, 2019; Pang et al., 2023).

Phase Five: Transformation

Predominantly youth-led, this phase consolidates youth ownership and leadership within the co-design process. Young people drive the momentum for social change and action, building a sense of community and fortifying trust between peers and adult providers (Gonzalez et al., 2024; Stubbing & Gibson, 2021; Taba et al., 2025). Attaining this state marks a fundamental shift in the culture and practice of adult providers from tokenistic and opportunistic exploitations to institutionalised youth agency (Deane et al., 2025; Kontak et al., 2025; Purcell et al., 2023).

Another major aspect of this phase is that it enables evaluative collaboration between young people and SRH providers. As partners with equal stakes, they participate in reflective exercises to assess the effectiveness of the 'Youth-Adult co-design model for digital YSRH promotion', ensuring that it is adaptable, contextually relevant, and genuinely responsive to youths' needs in a rapidly evolving digital era (Goodwin & Boulton, 2024; Goodwin et al., 2025; Kontak et al., 2025). Thus, feedback and reflections are not just collected but acted upon meaningfully, emphasising the principle of shared accountability and continuous adaptations in co-design (Lerner et al., 2005; Lipton, Dickinson, et al., 2025; Nutbeam, 2021).

Ultimately, the youth-led and youth-centred model fosters purposeful partnership that authenticates genuine connection between young people and adult providers (Cahill, 2014; Mark & Hagen, 2020; Te Taiwhanga Rangatahi, 2022). As demonstrated in Chapter 6, SRH providers in this study identified power imbalances, communication challenges, stigma, and uncertainty about platform use as barriers to meaningful youth engagement. The 'Transformation' phase addresses these findings directly by institutionalising youth agency through sustained partnership, and youth become more trusting of their collaboration with SRH providers while providers develop the capacity to relinquish control and embrace supportive roles. This model reimagines positive collaboration as a relational and transformative journey where trust, inclusivity, and shared governance are the foundation for sustainable and equitable health promotion practice (Arnold & Silliman, 2017; Baraitser, 2025; Gonzalez et al., 2020; Goodwin et al., 2025).

7.6. Conclusion

This chapter has articulated the conceptual foundations and practical mechanics of the 'Youth-Adult co-design model for digital YSRH promotion', a practice-oriented framework developed to address the relational and systemic gaps identified in Chapter 6. The framework

represents a deliberate shift from a provider-centric approach that, while valuable for improving the engagement between providers and young people, cannot address the fundamental power asymmetries constraining youth agency within digital health promotion contexts. By grounding the framework in CPYD principles, constructionist epistemology, and culturally responsive Indigenous methodologies, this research offers a conceptual blueprint for transforming youth-adult relationships in New Zealand's SRH promotion landscape.

The framework's tripartite governance structure positioning youth, providers, and researchers as co-governors with distributed authority operationalises shared decision-making while ensuring youth hold genuine authority over agendas, resources, and evaluation. Critically, the 'researcher' function is fluid; youth and providers develop research literacies through co-design, functioning as knowledge producers with external academic support engaged only when serving partnership-defined goals. This prevents academic gatekeeping while enabling knowledge generation that serves youth and providers' collective priorities.

The five iterative phases provide practical scaffolding for implementing co-design within New Zealand's institutional SRH contexts. Each phase embeds power redistribution mechanisms, beginning with providers' transformative accountability (Reach), moving to youth-led agenda setting (Engage), youth-directed peer navigation (Referral), equitable access that enables informed youth decision-making (Uptake), and sustained relational and evaluative accountability (Transform). The framework shifts from youth-centred to youth-led as the partnership deepens, requiring deliberate cultivation and structural support through funding and policy frameworks that mandate youth leadership. Grounding the framework in culturally responsive methodologies and approaches ensures it resonates with youths' demand for representation and reciprocity, and counters Western models that risk imposing individualistic notions of empowerment.

In summary, the framework demonstrates how CPYD principles can be operationalised within institutional health promotion, offering New Zealand providers a pathway from consultative engagement toward genuine co-governance. Success will be measured not by improved service statistics, but by whether young people recognise it as enabling their leadership, honouring their authority, and creating conditions for them to thrive as agents of their own health and well-being.

Chapter 8. Conclusions and Recommendations

8.1. Introduction

The research examined power dynamics between SRH promotion providers and young people within digital SRH contexts in New Zealand. Guided by the CPYD framework, the study investigated how adult SRH providers conceptualise youth engagement on social media. The findings revealed that while providers recognise youth digital capabilities and express commitment to youth-centred practice, relational and structural barriers constrain them. Chapter 6 covered these barriers thematically, and Chapter 7 developed a practice-oriented framework to show how to operationalise a meaningful youth-adult partnership.

This chapter synthesises the empirical and scholarly evidence needed to inform meaningful youth-adult partnerships for digital SRH promotion in New Zealand. In the following sections, the research findings and theoretical contributions to the body of knowledge are summarised, highlighting critical aspects of centring youth voice. Next, the research contributions and recommendations for practice are discussed for each stakeholder identified in the tripartite governance model described in Chapter 7. Subsequently, the study discusses emerging challenges posed by social media bans, particularly in the Global South, and how they might affect the 'Youth-Adult co-design model for digital SRH promotion'. Finally, the study examines research limitations and future considerations for achieving genuine youth authority in SRH promotion.

8.2. Key Findings and Theoretical Contributions

Many current approaches to youth engagement in SRH promotion fail to embody genuinely youth-led or youth-centred practices. This study's findings revealed that tokenistic forms of engagement, such as one-off consultations, adult-led workshops where youth ideas are harvested but not acted upon, fall short of CPYD's vision for authentic youth leadership (Ginwright & Cammarota, 2002, 2007). Meaningful youth engagement requires creating space for young people to act as co-researchers, co-creators, and decision-makers on interventions that relate to them, not as beneficiaries of adult-controlled initiatives.

Interpreting findings through a CPYD lens prevents over-attribution of responsibility to individual young people and avoids deficit-based interpretations of health-related decision-making. Instead, this research situates findings within broader structural and relational contexts, acknowledging how institutional arrangements, social norms, and youth-adult power dynamics shape both opportunities for and constraints on agency. This analytical approach ensures that conclusions and recommendations emphasise system-level transformation alongside individual and community-level action, recognising that youth 'problems' often manifest as adult-controlled systems that undermine youth autonomy and agency.

Without this fundamental shift toward enabling youth agency, SRH interventions risk reproducing the very exclusions they aim to resolve. Moving toward genuine youth-provider co-design requires reimagining institutional cultures, flattening hierarchies, and enabling youth participation in governance structures (Cahill, 2016; Cahill & Dadvand, 2018; Palacios & Allen, 2019). These changes are vital to dismantling access barriers and ensuring SRH promotion and general health services meet the diverse needs of young people in New Zealand.

The study findings align with and extend Terry et al.'s (2012) observation that a substantial gap exists between 'best practice' rhetoric and actual practice in New Zealand's SRH provision. However, while Terry et al. framed it as a technical problem requiring innovative measures to close the gap, this research reveals the gap as fundamentally structural and relational, rooted in power asymmetries, institutional constraints, and competing knowledge frameworks rather than implementation deficits or resource limitations.

SRH providers' account demonstrated that even when they articulated commitment to youth-centred practices and recognised young people's digital capabilities, institutional structures, funding models, policy frameworks, and professional hierarchies constrained their ability to enact shared authority with young people. This suggests that addressing the gap between participatory rhetoric and practice goes beyond adopting 'innovative measures' such as social media platforms towards more redistribution of power over knowledge production, decision-making authority, and resource allocation within institutional YSRH promotion structures.

Similarly, while Henrickson et al. (2015) and Kanengoni et al. (2020) identified health inequities among marginalised young people in New Zealand, and proposed that access to SRH services be improved as a response, findings from the current study suggested that digital platforms alone will not bridge these inequities if their use remains structured within adult-controlled frameworks that position youth as passive recipients, rather than producers of SRH knowledge. The 'Youth-Adult co-design model for digital YSRH promotion', developed from this research, proposes that the meaningful reduction of inequities requires structural conditions that enable youth agency, especially those from marginalised communities, to exercise their voice, characterised by power, legitimacy and influence over how digital YSRH promotion is conceptualised, designed, and delivered. This approach moves beyond access-focused interventions toward transforming the power relations and epistemic hierarchies that reproduce health inequities in the first place.

8.2.1. Contributions to Knowledge and Practice

While digital technologies, particularly social media, have transformed how young people access and share health information, institutional health promotion practices have not adequately shifted to recognise young people as knowledge producers and capable agents within these digital spaces. Despite the rhetoric around youth participation, decisions regarding social media content creation, messaging priorities, and resource allocation in digital YSRH promotion remain solidly

within adult-dominated systems. The disconnect between young people's demonstrated digital capabilities and the hierarchical structures of institutional health promotion represents both a missed opportunity for effective YSRH outcomes and a continuation of adult-centric paradigms that marginalise youth voice. This research addresses this critical gap and makes several interconnected contributions to understanding youth voice in digital YSRH promotion in New Zealand.

Empirically, it shows that while SRH providers recognise youth digital capabilities and express commitment to youth-centred practice, this is insufficient because their conceptualisation of youth engagement is often constrained within participatory frameworks that do not extend to shared authority over agenda setting, knowledge production, or resource allocation. This empirical documentation of the gap between participatory rhetoric and actual practice in institutional settings provides specific evidence of where current approaches fall short.

Through critical analysis informed by the CPYD theoretical framework, the research reveals structural and epistemic hierarchies that operate as barriers within provider practice. The evidence unveiled this in the form of institutional requirements that privilege biomedical knowledge over youth experiential expertise (Martin, Alberti, et al., 2020), funding and accountability structures that constrain risk-taking and power-sharing (Came et al., 2018; Goodyear-Smith & Ashton, 2019), and professional norms that position SRH promotion providers as knowledge validators rather than co-producers of knowledge with young people. This finding extends CPYD scholarship by demonstrating how these barriers operate within the New Zealand digital health promotion and institutional SRH contexts, revealing that barriers to youth voice are not attitudinal deficits but structural features of how SRH promotion systems are organised.

Methodologically, the study contributes approaches for critically examining institutional discourse about youth through practice-based research that generates transformative artefacts rather than merely documenting problems. By engaging adult SRH providers to understand how power operates from their positional perspective, the research identified structural barriers that providers themselves encounter when attempting to share power with youth, necessitating the development of frameworks that are both youth-centred and implementable within institutional contexts. This methodological contribution demonstrates how research can serve practice transformation as well as academic documentation.

Young people are capable and have consistently sought to contribute meaningfully to matters affecting their present and future (Cahill, 2014; Ginwright & Cammarota, 2007). However, adult-led systems and structures governing societal affairs have not developed the requisite capacities to engage youth as partners with equal authority. Across generations, power asymmetries have been reproduced: the youth of yesterday become today's adults and perpetuate cycles of authoritative dominance over younger generations. This means transforming youth-adult relationships requires more than individual provider attitude changes. It demands disrupting intergenerational patterns of power hoarding that are deeply entrenched in institutional cultures and professional identities. Breaking this cycle necessitates

sustained critical reflexivity by SRH providers about their own socialisation into hierarchical relationships and their complicity in maintaining structures that marginalise youth authority.

To inform practice, the study contributes the 'Youth-Adult co-design model for digital YSRH promotion' as a practice-oriented framework, synthesising empirical findings with scholarly evidence on youth participation to propose conditions, processes, and power-sharing architectures essential to meaningful youth-adult partnerships in digital SRH promotion. This contribution lies not in prescribing standardised approaches but in articulating structural preconditions essential to meaningful youth voice and participation. This includes epistemic recognition of youth as capable knowledge producers; shared authority over problem definition and priorities; and the redistribution of decision-making power through institutional flexibility that enables youth agency. By explicitly surfacing these conditions, the model provides young people, SRH providers, policymakers, and research and academic stakeholders with a framework to interrogate their current positioning and where structural transformation is needed in institutional YSRH promotion, going beyond individualised capacity building.

While empirical findings and scholarly evidence (Hirvonen et al., 2021; Lim et al., 2022; Ludin et al., 2022) show that social media and digital platforms can be valuable tools for health promotion and communication, this research finds they do not automatically democratise health promotion or enable youth voice. Instead, power relations, epistemic hierarchies, and institutional structures mediate their effectiveness. The disconnect between young people's digital capabilities and institutional practice is both an equity and effectiveness issue: adult-centric approaches fail to leverage youth expertise and miss opportunities for better YSRH outcomes. Consequently, SRH providers must look beyond technical dimensions like platform selection and content design to interrogate underlying power dynamics that determine whose voice is legitimised, influences practice, and holds authority over digital health promotion agendas. The iterative nature of the co-design model developed in this study provides stakeholders with the framework to determine whether digital YSRH initiatives function as structural enablers for meaningful youth agency or inadvertently reproduce adult-centric paradigms within participatory spaces.

8.3. Practical Implications and Recommendations

This study offers perspectives unusual in traditional SRH provider discourse, challenging conventional assumptions about youth capabilities and SRH provider professional authority. Several practical implications emerge for different stakeholders.

8.3.1. Sexual and Reproductive Health Providers and Youth-serving Organisations

For SRH providers and youth-serving organisations, the research calls for a shift in communication strategies toward co-creation approaches when working with young people, moving

beyond one-off, tokenistic consultations or extractive relationships toward meaningful and authentic youth engagement. This requires recognising young people as experts of their own lived experiences and engaging them throughout the project lifecycle, from problem identification and planning to the implementation and evaluation of the co-designed health promotion initiatives.

Participatory strategies such as co-design and community-based participatory research offer progressive pathways to address health inequity in New Zealand (Goodwin & Boulton, 2024; Lipton, Dickinson, et al., 2025; Te Morenga et al., 2018). These approaches should position young people as co-researchers and co-producers of knowledge, supported to critically reflect on and shape their realities to inform intervention outcomes. Integrating digital platforms into participatory strategies offers a compelling way to advance positive youth engagement in YSRH promotion (Lim et al., 2022; Martin, Cousin, et al., 2020). From a CPYD perspective, adopting social media beyond one-way messaging fosters critical consciousness, youth agency, and equitable power-sharing, the core tenets that challenge traditional adult-dominated health systems (Gonzalez et al., 2020; Lerner et al., 2005). This also supports promoting Indigenous knowledge in the design, content creation, and governance of SRH messaging in digital environments (Garrett et al., 2020). In this context, social media can be conceptualised as a virtual space for dialogue, storytelling, and health promotion grounded in cultural identity and youth leadership. This approach fundamentally challenges the deficit framing of youth in public health, repositioning them as essential partners in shaping interventions that authentically reflect their lived realities (Decker et al., 2022; Rose, Dunlop, et al., 2024).

Purposefully recruiting young people, especially Māori and Pasifika youth, into roles such as advocacy, education, mobilisation, and health promotion can foster inclusion, build trust, and enable peer-to-peer learning (Collura et al., 2019). Such strategies must address intersectionality, ensuring marginalised groups, including takatāpui (LGBTQI+ Māori youth), disabled youth, and youth facing socio-economic marginalisation, are not doubly excluded from co-design and uptake of SRH interventions (Messenger et al., 2021; Rose, Garrett, McKinlay, & Morgan, 2021; Rose, Garrett, McKinlay, Morgan, et al., 2021).

8.3.2. Young People Themselves

While this framework was developed through engagement with adult SRH providers, its ultimate purpose is to create conditions for youth authority and leadership. The success of youth-adult partnership partly depends on young people's appreciation of these opportunities and on being given a chance for them to happen. Therefore, youth are encouraged to resist being positioned as passive beneficiaries or recipients of adult-designed interventions and assert their authority as co-researchers, co-designers, and decision-makers, transforming youth-centred practices into youth-led practices. Critical youth scholars refer to this as developing critical consciousness, where young people resist dominant narratives to build self- and social-awareness of their realities and capabilities (Akom et al., 2008; Gonzalez et al., 2020).

Additionally, young people must hold adult partners, that is, SRH providers, accountable by interrogating their willingness to yield authority over agenda and resources, ensuring that youth input is not merely performative and ultimately overridden by adult 'expertise' (Gonzalez et al., 2020). Working collaboratively to build social capital with SRH providers ensures young people can actively and meaningfully contribute to generating knowledge, documenting experiences and communicating findings on their own terms (Ginwright & Cammarota, 2007).

To ensure ideologies and worldviews are not misconstrued, young people should clearly define their core concepts and principles. For example, defining what 'safe' means to youth can help SRH providers and other adult gatekeepers (religious, family, community, government, and corporate institutions) better meet their needs, rather than exert authority over them under the guise of 'protection'. Leading the way in demonstrating what constitutes safe, inclusive, and affirming digital spaces for SRH promotion is better grounded in youths' lived experiences than in adult anxieties. Applying CPYD principles through personal storytelling and counternarratives that counter dominant narratives, as explained by Gonzalez et al. (2024), helps facilitate 'self- and social-awareness' of what the ideal world is for young people (Gonzalez et al., 2020). Cahill (2014) referred to this as 'Future Dreaming' (pp. 485-486).

Peer-to-peer recommendations, navigation, and support have proven effective strategies youth use to bypass professional gatekeeping and reduce stigma (Purcell et al., 2023). Youth-led referral systems and digital prosumerism ensure SRH information and services can reach those who need them most. Specific to marginalised youth, including takatāpui, disabled youth, Māori and Pasifika young people faced with socioeconomic barriers, it is critical that co-design processes do not reproduce exclusions within youth participation itself (Deane et al., 2023; Deane et al., 2025). This ensures that youth-adult partnerships address intersecting oppressions, not just age-based power imbalances.

8.3.3. Policymaking and Funding Institutions

Policy and regulatory institutions urgently need to develop guidance frameworks for social media health promotion messaging that address undue restrictions currently limiting how SRH providers and organisations share content. Such frameworks must balance human rights protection, youth safeguarding responsibilities and the imperative to enable youth to access accurate, affirming SRH information in digital spaces where they are native and fluent.

Recent policy developments in New Zealand, including the Women's Health Strategy, present opportunities to institutionalise youth-led approaches. However, to avoid replicating the pitfalls of traditional practice, it is essential to promote youth agency by facilitating opportunities for young people to shape their experiences and directly influence prevention, intervention, and service delivery strategies (Condran et al., 2017; Martin, Cousin, et al., 2020). As a pioneering initiative, the Women's

Health Strategy's success depends on genuine youth partnership, and not consultation, making it critical to embed structural mechanisms for meaningful youth participation from the outset.

The challenge of institutionalising youth participation is not unique to New Zealand. International comparisons reveal similar structural barriers. In the United States, co-design is often limited to community-based, grant-funded initiatives rather than embedded in national policy (Guttmacher Institute, 2023); while in New Zealand, frameworks like Kaupapa Māori, despite their conceptual strength, are inconsistently applied in practice (Garrett et al., 2020; Rose et al., 2024). This underscores the need for structural reforms that move beyond encouragement to mandating youth partnerships in national and local SRH policies, with accountability mechanisms to ensure implementation fidelity.

New Zealand initiatives such as Connect & Korero, Te Taiwhanga Rangatahi, and the Auckland Co-design Lab, supported by national and regional funding, exemplify the evolving dynamics of government and community organisations (Goodwin et al., 2025; Te Morenga et al., 2018; Te Taiwhanga Rangatahi, 2022). While they signal a move toward institutionalising co-design and participatory policy development with young people, a shift toward consistent investment beyond pilot or grant-funded initiatives is essential. Furthermore, achieving meaningful youth participation requires stronger advocacy for the formal recognition and compensation of youth expertise and labour.

8.3.4. For Researchers and Academia

Researchers and the academic community occupy a complex position within the youth-adult co-design framework, where they can either reinforce extractive knowledge production that benefits institutions and marginalise youth voice or function as enablers of youth voice, supporting youth-adult partnerships to generate, document, and mobilise knowledge based on their collective and youth-prioritised agenda (Dictus et al., 2025; Dixon et al., 2022). To achieve this, the terms of engagement must be negotiated and defined, ensuring that youth and SRH providers retain ownership over data, control dissemination strategies, and benefit directly from research outcomes, not as research subjects but co-investigators and knowledge authorities. This approach aligns with Indigenous data sovereignty (Calac & Mackey, 2025; Goodwin et al., 2025).

Another way that the research and academic community can support youth-adult partnerships is by providing methodological support, not methodological gatekeeping. Building the capacities of young people and SRH providers to design and implement rigorous evaluation, facilitating access to research infrastructure, and enabling dissemination to different audience types supports the recognition of youth and SRH providers as knowledge producers and practice change agents. Further, to ensure that evidence generated from youth and adult partnerships is recognised as credible by other practitioners and academic disciplines, partnering researchers should advocate for the formal

recognition of co-design frameworks, youth-led participatory research, and evaluation reports as legitimate forms of knowledge.

Integrating CPYD principles into research education and competency is essential to equip future scholars with the reflexive skills and participatory methodologies required to work with, rather than on, young people (Cahill, 2016; Cahill & Dadvand, 2018). This pedagogical shift ensures that research engaging Māori and other ethnic communities remains grounded in Indigenous methodologies, such as Kaupapa Māori and Talanoa, which prioritise self-determination, relational accountability, and cultural protocols (Goodwin et al., 2025; Kovach, 2021). Additionally, researchers and academia can support youth-adult partnerships by leveraging their networks, better access to policy-making spaces, and understanding of funding models to advocate for youth leadership in SRH promotion, and by strengthening accountability mechanisms that ensure co-design is genuine and not performative.

8.4. Social Media Ban – Implications for Youth-led Digital Sexual and Reproductive Health Promotion

8.4.1. Global and Contextual Overview

Social media censorship is accelerating globally, with individual nation-states attempting to regulate social media in the absence of coordinated international frameworks (Al-Zaman, 2025; Takhshid, 2021). Power asymmetries between social media companies concentrated in the Global North and users in the Global South deepen disinformation risks while leaving regulatory gaps that countries struggle to fill (Takhshid, 2021). Analysis of censorship patterns reveals that the most frequently targeted platforms—Facebook (22%), YouTube (~22%), Twitter (13%), TikTok (12%), Instagram (10%), WhatsApp (9%), Telegram (9%), and Reddit (3%)—are those with the largest global user base, suggesting that platform popularity correlates with regulatory attention (Al-Zaman, 2025, p. 409). Higher levels of government control reported in the Global South create particular vulnerabilities for youth in these contexts (Al-Zaman, 2025).

The rationales for social media bans vary significantly across jurisdictions, revealing different constructions of the problems platforms pose s such as state-imposed digital authoritarianism, manifesting in government suppression of social media platforms to control freedom of expression (Al-Zaman, 2025; Anthony et al., 2023); concerns about young people's protection and mental health as reported in Australia (Redlich et al., 2025; Wu, 2025); national security and data sovereignty (Khatiwada et al., 2025); and preventing specific harms like examination leakage (Al-Zaman, 2025). This variation matters because bans framed as youth protection operate under different logics than those driven by political control; yet both leave youth caught up between corporate policies, government restrictions, and their legitimate needs for health information and peer connection.

Redlich et al. (2025) warned that absolute bans can have intended and unintended consequences, denying young people the potential benefits of social media, placing an enforcement burden on parents, stressing parent-youth relationships, and making monitoring harmful behaviours more challenging once youth navigate past restrictions/bans. Critically, if the regulations and restrictions addressing harmful content design and algorithmic amplification are not in place, young people are still at risk by the time they come of age, meaning the problem was only delayed and not addressed (Fardouly, 2025). For marginalised youth, including LGBTQI+ young people, youth resident in rural or isolated areas, and those seeking sexual health information, restricted access can be particularly debilitating, increasing isolation and silencing voices (Redlich et al., 2025; Starrs et al., 2018; United Nations, 2025).

8.4.2. Critical Implications of Social Media Bans

Regulatory developments pose both challenges and opportunities for the practice-oriented artefact, the 'Youth-Adult co-design model for digital YSRH promotion' developed as a creative output of this research (Candy, 2006). This section examines these implications, alongside potential responses to manage this emerging issue.

Platform Access Restrictions Undermine Digital Co-design Foundations

If youth under 16 years are legally excluded from major social media platforms, the Reach and Engage phases of the co-design model, which assume youth and providers meet in digital spaces where young people already gather, become structurally impossible for younger adolescents. The Referral phase, premised on youth-led peer navigation through digital channels, is similarly constrained when the very platforms youth use to share health information are banned.

Measures to address this: The co-design model must diversify beyond age-restricted corporate platforms, leveraging alternative digital spaces that young people can easily access, and advocate for health information exemptions within ban policies that recognise SRH content as health promotion, not entertainment.

Epistemic Exclusion in Policy Development

Neither the Australian ban nor similar regulatory measures in other jurisdictions meaningfully involved youth in policy development. Young people were positioned as subjects of adult-led institutions, requiring protection from harm, and not recognised as experts on their information needs or rights-holders capable of contributing to solutions. This reproduces the same adult-centric paradigm the current research critiques, and raises questions about whose interests such policies best serve.

Measures to address this: The tripartite governance model informing the stakeholder functions within the 'Youth-Adult co-design model' must extend beyond health promotion practice to platform policy advocacy. Youth authority over digital YSRH promotion cannot be realised if youth are excluded from the policy processes that determine their access to digital spaces. Co-design

positions youth as experts on their information needs, and this must be structurally embedded in platform regulation development, not treated as tokenistic, post-hoc consultation.

False Dichotomy Between Protection and Autonomy

Current regulatory approaches assume youth safety and youth autonomy are opposed, implying that protection requires restriction. This framework rejects that binary perspective, showing that genuine safety emerges through meaningful youth-adult participation, not adult control. Young people need both protection from exploitation and autonomy to access health information, connect with peers, and navigate digital spaces.

Measures to address this: Effective regulation would address platform accountability without outright restricting youth access. The co-design model's emphasis on shared governance and accountability offers that alternative, enabling platforms, providers, policymakers, and youth to collaboratively develop approaches that enable youth agency while addressing legitimate harms.

8.4.3. Recommendations for Navigating Restricted Digital Environments

Accelerate Youth-Adult Partnerships

By turning adverse conditions into strategic opportunities, platforms' censorship may enable innovative approaches to youth-adult partnerships. As traditional digital channels become increasingly restrictive, providers must recognise youth expertise as essential for navigating evolving digital landscapes and identifying alternative pathways for youth engagement. This shift creates openings for the co-design model's tripartite governance structure to position youth not as mere audiences that need protection but as indispensable partners whose knowledge and digital capabilities are fundamental to effective SRH promotion (Cahill & Dadvand, 2018; Cahill, 2014).

Navigating Restrictive Regulatory Environments Through Stakeholder Collaboration

This action requires youth and providers to collaboratively challenge policies that conflate entertainment content with health information (Livingstone, 2026), and to advocate for healthcare exemptions that recognise SRH content as serving medical, not merely social, functions (Starrs et al., 2018). Policymakers must involve youth directly in platform regulation from inception, positioning them as self-experts rather than passive recipients of protection mandates (Baraitser, 2025), and distinguish between commercial platform use and healthcare information access when creating age-based restrictions. Platform companies need to centre youth voice in content moderation and develop youth-governed processes for health promotion content (Fardouly, 2025), recognising that while targeted moderation may address specific harms (Zhang et al., 2025), blanket age restrictions undermine youth rights to health information and autonomy (Redlich et al., 2025; United Nations, 2025). Therefore, regulatory approaches should focus on platform design and algorithmic amplification as sources of harm, rather than restricting youth access to social media (Al-Zaman, 2025; Wu, 2025).

While New Zealand has not implemented youth-focused social media bans comparable to Australia and other Global South countries, it operates within the same regional policy context and faces similar pressures. Given New Zealand's high youth suicide rates, compared to other OECD countries (Ministry of Health, 2024b; Ministry of Social Development, 2024), any regulatory approach must balance legitimate mental health concerns with the reality that marginalised youth, including takatāpui, rural youth, and those faced with socioeconomic barriers, rely on digital spaces for connection, identity affirmation, and health information (Rose et al., 2024). The 'Youth-Adult co-design model for digital YSRH promotion' emphasises shared governance and accountability, offering a pathway to address mental health risks without reproducing the epistemic exclusions and autonomy restrictions characteristic of ban approaches. Ultimately, youth must become central architects of policies shaping their digital futures, not an afterthought in adult-dominated protection paradigms (Cahill, 2014; United Nations, 2025).

8.5. Limitations and Future Research Considerations

This research makes important contributions to understanding youth-adult power dynamics in digital YSRH promotion, yet several limitations warrant acknowledgment and suggest directions for future inquiry.

Theoretical and Field-level

This research operates within a broader field-level limitation. Foundational frameworks, such as the 1986 Ottawa Charter and 1997 Jakarta Declaration, established participation and empowerment principles (WHO, 1986, 1997), but have not been translated into practice, particularly for digital contexts (Liu et al., 2024; World Bank, 2016). The 'Youth-Adult co-design model' from this research operationalises these principles within platform-mediated environments, but lacks updated theoretical guidance on how adult control and partnership function when power dynamics operate through government and corporate policies, including algorithms, rather than fostering meaningful and equitable engagement across communities. Future efforts should gear towards updating foundational health promotion frameworks to address how participation and empowerment operate within digital environments.

Methodological

First, this study engaged primarily with adult SRH promotion providers rather than young people directly. While this positioning enabled examination of how power operates from the provider perspective and identification of structural barriers providers encounter when attempting to share authority, it means the framework was developed through adult lenses interpreting youth needs rather than co-created with youth from inception (Cahill & Dadvand, 2018; Cahill, 2014). The framework's ultimate legitimacy, therefore, depends on youth adoption, contestation, and ongoing refinement. Future research must centre youth voices in evaluating the framework's relevance, utility, and

effectiveness, with particular attention to whether youth perceive it as enabling genuine authority or a refinement of adult-controlled youth-centred practices.

Second, research participants were geographically concentrated in specific areas of New Zealand and may not fully capture the diversity of provider contexts, organisational structures, or community relationships across the country. Urban providers in well-resourced organisations may face different constraints than their counterparts in rural or under-resourced settings (Gonzalez et al., 2020; Rose et al., 2022). Future research should examine how the co-design model functions across varied contexts, including smaller communities where provider-youth relationships may be more visible and subject to different social dynamics.

Third, the study provides a snapshot of provider perspectives at a particular moment rather than longitudinal data tracking how relationships and practices evolve (Hewitt-Stubbs et al., 2016; Logie et al., 2024). The framework proposes a progression from youth-centred toward youth-led practice (Gonzalez et al., 2020), but this research cannot demonstrate whether or how that transition occurs in practice. Longitudinal research tracking youth-adult partnerships (Zeldin et al., 2013) over multiple years would reveal whether the structural conditions the framework proposes enable the power redistribution it envisions, or whether adult-controlled systems reassert dominance despite initial shifts.

Framework

The framework's emphasis on digital platforms reflects contemporary realities of youth engagement but may not age well as technologies and communication practices evolve (Lim et al., 2022; Martin, Cousin, et al., 2020). What constitutes "digital space" in 2026 may differ substantially by 2030 or 25 years from now. Therefore, while the principles of power redistribution, youth authority, and tripartite governance remain constant, their operationalisation will require ongoing adaptation. Future research should explore how the model translates to emerging technologies such as virtual reality health promotion, AI-mediated peer support, decentralised platforms, and whether its core mechanisms remain relevant across technological shifts.

Additionally, the framework was developed within New Zealand's specific cultural and policy context, where Kaupapa Māori frameworks, Treaty obligations, and particular histories of colonisation shape youth-adult relationships and institutional structures (Public Health Advisory Committee, 2025; Terry et al., 2012). Specifically, Māori perspectives informed this work in two ways: through published, Māori-authored literature and frameworks, such as the Māori Sexual Health Framework and Te Tiriti o Waitangi commitments within national SRH policy, which shaped my ecosocial analysis of structural and institutional barriers in Chapter 2; and through provider accounts, some of whom work directly with Māori communities and reflected on cultural safety and institutional racism in their interviews. However, this is engagement with literature and provider perspectives about Māori contexts; it is not Kaupapa Māori research, and I have not sought or received Māori-led cultural review or validation of either the analysis or the resulting artefact.

Therefore, while the model integrates Indigenous and culturally grounded principles (Kaupapa Māori, Talanoa, Ubuntu, Kapwa), its validation and transferability to these varied contexts requires critical examination (Kovach, 2021). Future research should therefore explore how the framework might be adapted for these contexts while attending to local cultural epistemologies, political contexts, and youth-adult relationship norms, rather than imposing a New Zealand model universally.

Implementation Challenges

Implementation within resource-constrained contexts, characteristic of many community-based SRH organisations in New Zealand, will require creative approaches to sustaining tripartite governance without dependence on external funding or academic partnerships (Garrett et al., 2020; Sheridan et al., 2011). The framework assumes capacity for regular youth-provider engagement, compensation for youth expertise and labour, and institutional flexibility to accommodate youth-led innovation. Organisations funding precarity, high staff turnover, or rigid accountability requirements may fail to operationalise these conditions (Goodwin & Boulton, 2024). Future research should examine what minimum viable conditions enable meaningful co-design even in resource-scarce environments, and how organisations navigate tensions between funder requirements and youth-led practice.

The framework also does not consider power dynamics among youth peers (Cahill & Davdand, 2018; Ginwright & Cammarota, 2002). Co-design partnerships risk reproducing exclusions if the youth involved are primarily those already comfortable engaging with institutions, digitally confident, or from dominant cultural groups. Marginalised youth, including takatāpui, disabled youth, and those socioeconomically challenged, may be excluded from ostensibly youth-led processes (Messenger et al., 2021; Rose et al., 2024). Future research must examine how intersecting oppressions shape youth participation within co-design, and what mechanisms ensure power redistribution from adults does not privilege a subset of youth while marginalising others.

Emerging Policy Context

Finally, this research was conducted before the acceleration of social media bans targeting youth (Livingstone, 2026; Wu, 2025) (discussed in Section 8.4). The framework assumes youth have access to digital platforms where co-design can occur. As regulatory restrictions proliferate, future research must explore how youth-adult partnerships navigate increasingly constrained digital environments, whether alternative platforms enable the same forms of collaboration, and how the framework's principles apply when youth are legally excluded from major social media platforms (Redlich et al., 2025). Research examining youth experiences of platform restrictions and their strategies for maintaining peer networks and accessing health information despite bans would inform framework adaptation.

In summary, these limitations and future directions do not diminish the framework's contribution but must prioritise youth-led evaluation of the framework's capacity to enable genuine authority (Ginwright & Cammarota, 2002); implementation studies across diverse contexts

(organisational, cultural, economic); and longitudinal tracking of power redistribution over time (Zeldin et al., 2013). Additional critical directions include intersectional analysis of exclusions within youth partnerships, comparative cross-cultural adaptations studies, cost-effectiveness assessments, and examination of how regulatory frameworks shape possibilities for youth-adult collaboration (Wijamuni et al., 2025).

8.6. Concluding Remarks

Young people's capabilities remain undeniable (Cahill, 2014); however, each generation of adults, once empowered, reproduces the same power asymmetries that they experienced as youth. This intergenerational disregard for youths' authority operates through the normalisation of hierarchies that position adults as legitimate authorities and youth as subjects requiring guidance and protection. This research challenges that cycle, demonstrating that barriers to youth-centred and youth-led digital YSRH promotion are not technical or informational, but relational and structural. They are embedded in how power is distributed, whose knowledge is legitimised, and who holds the decision-making authority.

The 'Youth-Adult co-design model for digital YSRH promotion' offers one pathway, not as the ultimate solution but as an invitation for transformation. It requires New Zealand SRH providers to examine their power and dismantle gatekeeping practices; young people to claim the authority of their expertise within collaborative spaces; and institutions to restructure who holds legitimate voice in defining, designing, and leading digital SRH promotion. Youth autonomy is not achieved by improving the quality of services available to young people, but by fundamentally redistributing power across those services. Now, the question is not whether youth are ready to lead, but whether adults and institutions are ready and willing to follow.

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Appendix A. Introductory Letter

Appendix A. Introductory/Invitation letter

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Date: .....

Kia ora.

Research Introduction and Invitation to Participate

My name is Adetoun Nnabugwu. I am a doctoral research student at the Auckland University of Technology's School of Public Health and Interdisciplinary Studies. I am kindly requesting the participation of your organization in a doctoral research that I am conducting titled: "**Service providers perspectives of the use of Social Media as a tool for collaboration and engagement with young New Zealanders about their sexual and reproductive health.**" The aim is to explore how sexual and reproductive health (SRH) providers in New Zealand have engaged/or plan to engage with social media to collaborate with young people. At the end, a summary report presenting key ideas and suggestions for SRH promotion using social media in the form of a draft framework – would be developed for the use of SRH providers, young people in the space of sexual and reproductive health in Aotearoa and beyond.

The study will involve two (2) interview/group discussion sessions with one or up to three (3) of your staff(s) responsible for implementing SRH promotion activities with young people and/or has oversight function on the organization's social media strategy. The first session will be for introduction and data collection, exploring initial ideas and suggestions for social media based SRH promotion, while the second session will be for feedback of the main ideas gathered and further suggestions for a framework for SRH promotion and next steps. Voluntary consent to participate in this study is sought for members of your organisation. All data will be anonymised before it's shared publicly. Privacy and confidentiality of the participants (staff/organization) will also be maintained. Participant's right to withdraw will be upheld and this will have no implications on their employment status.

If your organization and one or more staff member(s) would like to participate in the study, kindly complete the '*Permission to access organization form*". Also, help to pass on the *participant information sheet* and the *consent form* attached to this letter to interested staff, and they in turn can reach out to me directly using the contact details outlined below and at the end of the participant information sheet.

Your participation will be of great importance to assist in the social change that ensures the voice of SRH providers and young New Zealanders are heard and reflected to achieve improved sexual and reproductive health outcomes in Aotearoa.

Thank you for your time.

Nga mihi.

Adetoun Nnabugwu
ghw8009@aut.ac.nz
0274205446
PhD Candidate
AUT School of Public Health and Interdisciplinary studies

Approved by the Auckland University of Technology Ethics Committee on 01 June 2022 AUTEC Reference number 20/368

Appendix B. Participant Information Sheet

Appendix B. Participant Information Sheet

Date Information Sheet Produced:

2 May 2022

Project Title

Service providers perspectives of the use of Social Media as a tool for collaboration and engagement with young New Zealanders about their sexual and reproductive health.

The Invitation

Kia ora!

My name is Adetoun Nnabugwu. I am a doctoral research student at the Auckland University of Technology's School of Public Health and Interdisciplinary Studies, hereafter referred to as 'researcher'. I am kindly requesting the participation of your organization in a research that I am conducting titled: "**Service providers perspectives of the use of Social Media as a tool for collaboration and engagement with young New Zealanders about their sexual and reproductive health.**" The rest of this information sheet will describe why I am doing this study and how it will be conducted.

What is the purpose of this research?

In Aotearoa, sexual and reproductive health (SRH) issues is a public health concern and lack of, or poor access to quality information has been one of the major culprits. Also, stigma and discrimination about sexually transmitted infections such as chlamydia, gonorrhoea, syphilis have persisted in our communities. To this end, this research aims to adopt a participatory approach to harness the views of SRH providers delivering services and making impact using the social media, specifically to target and engage young New Zealanders to attain improved SRH outcome.

The outcome of the research would give voice to the innovations of non-governmental organizations and their contribution towards improving young New Zealanders' health. Ultimately, a framework 'the artefact' that could be adopted as a tool of best practice would be drafted from the findings gathered during the research. The findings of the research would also be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

Your organization might have been identified and purposefully selected from an internet source[7] or you voluntarily reached out to me after receiving the brief about the research. In your organization, you are likely the staff member responsible for social media strategy and/or is involved in the execution of SRH promotion activities.

How do I agree to participate in this research?

To participate in the research, you must have read and understood the participant information sheet, then reached out to the researcher using the contact details at the end of this participant information sheet. You will also need to complete and send the consent form (per individual) attached herewith before any interview/discussion is held.

Please note that your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

I am inviting you to a one-on-one interview or group discussion with one or two of your colleagues. This will happen over two stages. The first interview, lasting approximately 60 minutes, is exploratory and focuses on how your organization uses social media as a tool to educate and empower young New Zealanders about their SRH. I am

[7] https://www.nzshs.org/health-promotion

interested in hearing about what you do, what works, and what challenges you face. Following my interviews with SRH NGOs in Auckland, I will go through the facts gathered and share some of the notable findings with you ahead of the second interview. When we meet for a second time, it will be an opportunity for us to discuss those preliminary findings, including how your organisation might use it, how it responds to the issues you raised in the first interview, and how it might be improved. This second session is also expected to last another 60 minutes. Please note that agreeing to participate in this first stage does not compel you to participate in the follow-up interview.

Face-to-face sessions will be scheduled at any of the AUT campus locations in Auckland depending on the one that is closer and more convenient for you. Alternatively, we can meet online using Microsoft Teams, Zoom or any virtual platform you prefer. The interview can be arranged depending on your availability and preference. Each session will be facilitated and audio-recorded by the researcher.

All data will be anonymised, and the privacy and confidentiality of the research participants will be upheld. It is important to note that the outputs from this research are solely for the purpose of research and would be the intellectual property of the student researcher with general acknowledgement referenced to all research participants whenever the findings are shared publicly, whilst maintaining your privacy and confidentiality.

What are the benefits?

You might find it rewarding and get some satisfaction from knowing you are contributing to knowledge and science as well as helping others (young people, other practitioners, the student researcher, etc.). As a practitioner, you would have the lead to suggest or recommend what the desirable artefact can be (Stage 2 of the study). Secondly, you get to give voice to young people and the challenges they face and what they are doing or could do to improve their sexual and reproductive health. Thirdly, the knowledge and experiences shared can better posit other practitioners and the community at large to support these young people using innovative approaches. Lastly, you support me to obtain my degree as I learn in the process.

What are the discomforts and risks?

Given that this research is within the domain of your professional practice, it is unlikely that you will experience any discomfort or risk as a result of your participation in this study. However, if you find any question to be uneasy, you are free not to answer it. Also, you are free to terminate your voluntary participation without recourse. All findings will be presented in a way that ensures your identity (personal and organization) and shared information are well protected. Lastly, as you know that I am interviewing you as a representative of your organization. If you have second thoughts about anything you have shared, you are welcome to contact me and I will address them in your interest.

How will these discomforts and risks be alleviated?

As a voluntary research participant, should you require some support, you can benefit from the AUT Health Counselling and Wellbeing. They are able to **offer three (3) free sessions** of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling

If any illegal or harmful information or behaviour is revealed in the course of the research activities, the student researcher is bound by law to report such to local authorities regardless of the confidentiality clause agreed upon at the inception of the research. Please note that this is important for the safety and protection of all research participants.

How will my privacy be protected?

Data handling and storage in this research will be in compliance with the Privacy Act 2020, AUTEC research data storage protocol and in accordance with your consent. This implies that your information will be used solely for the purpose of this research. Before sharing the findings of the research publicly, all identifiers (personal and organization) would be removed. Other documents produced in the course of the research like the signed consent form, audio transcripts will be stored securely on AUT premises, password protected and accessible only to the researcher and the academic supervisory team. All stored data will be destroyed after 6 years following the AUT protocol, that is, completely erase all electronic data and shred all paper documentation in an eco-friendly manner.

May I add that the SRH space is not a large field in Aotearoa and while I will not be naming any organization or interview or individuals, unless given the permission to do so (see the consent form), other people working in this field might recognize you or suspect they know the person participating in the study. Similarly, your manager and fellow workmates might know from within the firm who's agreed to take part. In light of this, I can only offer you limited confidentiality because other people might know that you have taken part.

What are the costs of participating in this research?

Without a doubt, your time is the most expensive contribution to this work, also your professional knowledge and experience which you are voluntarily sharing. Other than this, your participation would not place any financial burden on you. If you are within Auckland and travel to do the interview with me, you would be reimbursed to the tune of NZD50 in the form of supermarket voucher, petrol voucher or AT Hop card top-up. If driving to the campus (South/North), parking arrangements would be made available to you by the researcher.

What opportunity do I have to consider this invitation?

As a prospective participant, you will have up to 4 weeks to consider the invitation. If during this time you have questions or require some clarifications, please feel free to contact me at the email address below.

Will I receive feedback on the results of this research?

Yes, a 1 – 2 page summary of findings will be shared with your organization and you get the opportunity to provide some feedback. This is different from the data review after stage one. Any publication arising from this research will be shared with all the research participants for information purpose and finally, once the thesis is completed, you would have access to it via AUT's online depository.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Cath Conn, cath.conn@aut.ac.nz, +64 921 9999 ext. 7407.

Concerns regarding the conduct of the research should be notified to the Executive Manager of AUTEC via ethics@aut.ac.nz , +64 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

RESEARCHER CONTACT DETAILS:

Adetoun Nnabugwu
Email: ghw8009@aut.ac.nz
Ph: +64 (0) 27 420 5446
Auckland University of Technology (AUT)
School of Public Health and Interdisciplinary Studies
Faculty of Health & Environmental Sciences
Private Bag 92006
Auckland 1142
New Zealand

PROJECT SUPERVISOR CONTACT DETAILS:

Dr Cath Conn
Email: cath.conn@aut.ac.nz
Ph: +64 921 9999 x7407
Auckland University of Technology (AUT)
School of Public Health and Interdisciplinary Studies
Faculty of Health & Environmental Sciences
Private Bag 92006
Auckland 1142
New Zealand

Approved by the Auckland University of Technology Ethics Committee on 01 June 2022 AUTEC Reference number 20/368

Appendix C. Research Instruments

C1. Consent form seeking organisational approval

ORGANIZATION CONSENT FORM

Project title:	***Practitioners' use of social media as a tool for promoting the sexual and reproductive health of young people in New Zealand.***
Project Supervisor:	***Dr. Cath Conn***
Researcher:	***Adetoun Nnabugwu***

- I have read and understood the information provided about this research project in the letter of introduction/invitation.
- I have had an opportunity to ask questions and to have them answered.
- My organisation would like to be named in the Acknowledgements section of your PhD, and any subsequent publications. **(please tick one):** Yes ☐ No ☐
- On behalf of my organization, I give permission to access staff and data relevant to the aforementioned study **(please tick one):** Yes ☐ No ☐

Organization: .....

.....

Representative's name & signature: .....

Designation: .....

Date: .....

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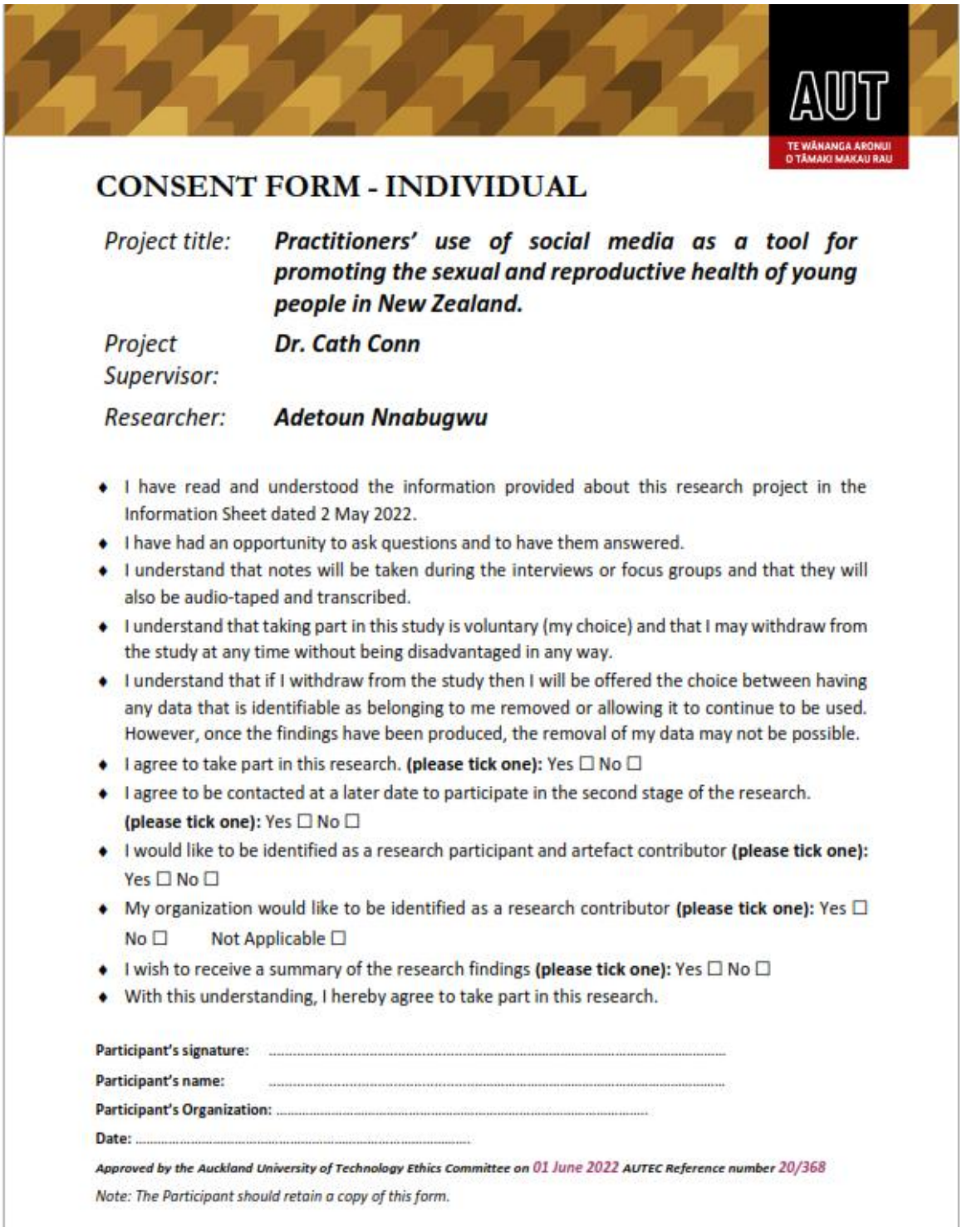
Note: Please retain a copy of this form.

C2. Consent form for individual participants



AUT
TE WĀNANGA ĀRONUI O TĀMAKI MAKAU RAU

CONSENT FORM - INDIVIDUAL

Project title: ***Practitioners' use of social media as a tool for promoting the sexual and reproductive health of young people in New Zealand.***

Project Supervisor: ***Dr. Cath Conn***

Researcher: ***Adetoun Nnabugwu***

- I have read and understood the information provided about this research project in the Information Sheet dated 2 May 2022.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews or focus groups and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, the removal of my data may not be possible.
- I agree to take part in this research. **(please tick one):** Yes ☐ No ☐
- I agree to be contacted at a later date to participate in the second stage of the research. **(please tick one):** Yes ☐ No ☐
- I would like to be identified as a research participant and artefact contributor **(please tick one):** Yes ☐ No ☐
- My organization would like to be identified as a research contributor **(please tick one):** Yes ☐ No ☐ Not Applicable ☐
- I wish to receive a summary of the research findings **(please tick one):** Yes ☐ No ☐
- With this understanding, I hereby agree to take part in this research.

Participant's signature: .....

Participant's name: .....

Participant's Organization: .....

Date: .....

Approved by the Auckland University of Technology Ethics Committee on 01 June 2022 AUTEC Reference number 20/368

Note: The Participant should retain a copy of this form.

C3. Research Interview/Focus Group Discussion Guide

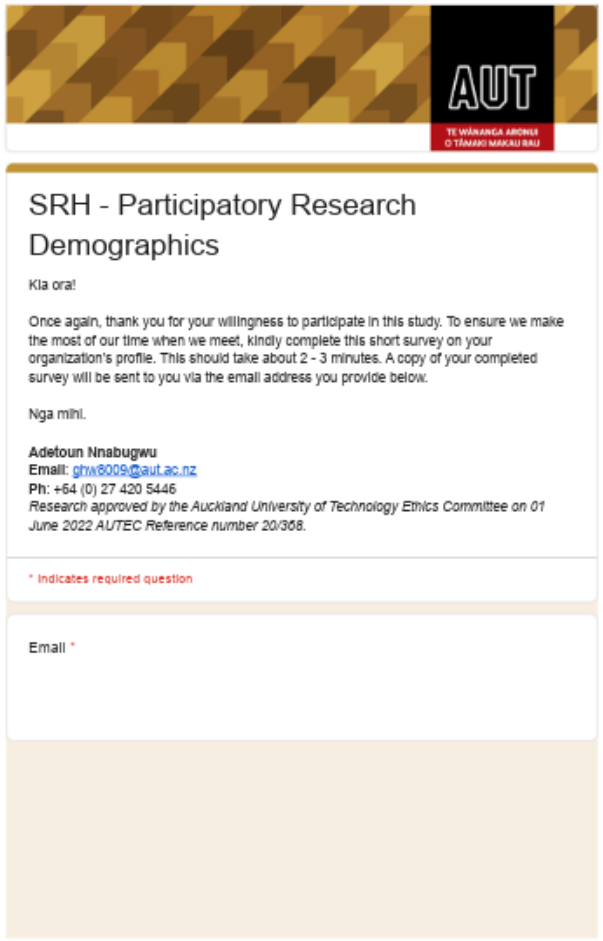
Session 1: Introduction and ideas/suggestions for youth SRH promotion and social media

1. How has your organization **used** social media to promote the sexual and reproductive health of young New Zealanders? What have you found to be useful in your social media engagement? Please provide examples.
2. What do you see as the **opportunities** faced concerning social media as a tool for SRH promotion with young people?
    a) How can this be delivered?
3. What do you see as the **challenges** faced concerning social media as a tool for health promotion?
    a) What are some of the challenges you see when delivering SRH promotion targeted at young people on social media? What is being / could be done about it?
    b) What could you or your organization achieve using social media but are limited in some way or the other? Time, resource constraints, etc.
4. How can SRH practitioners be **supported to effectively use** social media for SRH promotion among young people?
    a) In what ways can young people be co-opted further to enhance the use of social media for SRH promotion?

Session 2: Participants data validation

1. What stood out for you as you read the research notes/preliminary findings?
2. Were there expectations – are these met/unmet? Any surprises from the notes?
3. What actionable ideas did you get from the interview we had? How might the framework or guideline develop from this research be used? Any other suggestion or additional information you think may be relevant to the development of the artefact?
4. What suggestions do you have for its uptake/dissemination?

Appendix D. Participants Demographics Form Template



SRH - Participatory Research Demographics

Kia ora!

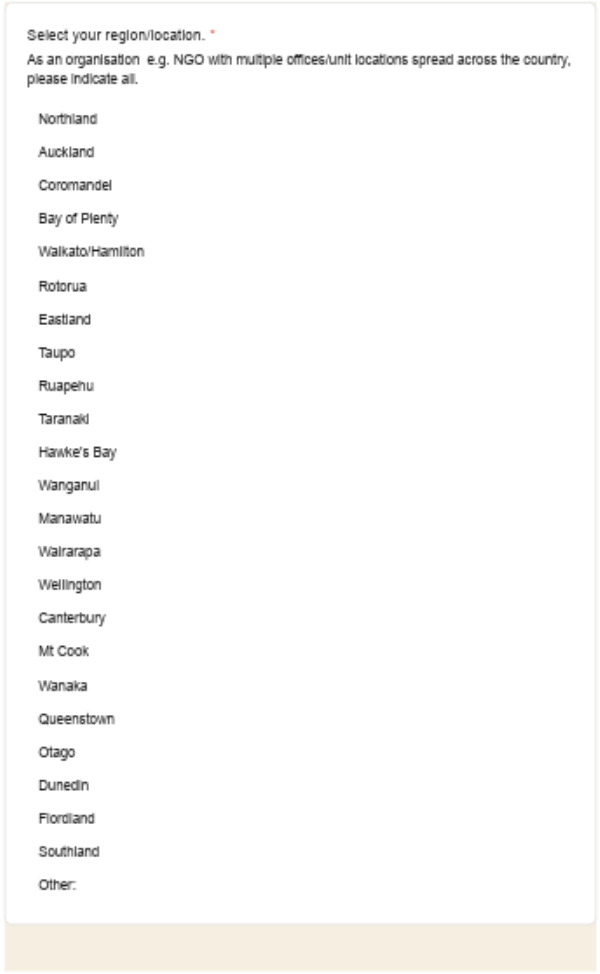
Once again, thank you for your willingness to participate in this study. To ensure we make the most of our time when we meet, kindly complete this short survey on your organization's profile. This should take about 2 - 3 minutes. A copy of your completed survey will be sent to you via the email address you provide below.

Nga mihi.

Adetoun Nnabugwu
Email: ghw8009@aut.ac.nz
Ph: +64 (0) 27 420 5446
Research approved by the Auckland University of Technology Ethics Committee on 01 June 2022 AUTEC Reference number 20/368.

* Indicates required question

Email *



Select your region/location. *

As an organisation e.g. NGO with multiple offices/unit locations spread across the country, please indicate all.

- Northland
- Auckland
- Coromandel
- Bay of Plenty
- Waikato/Hamilton
- Rotorua
- Eastland
- Taupo
- Ruapehu
- Taranaki
- Hawke's Bay
- Wanganui
- Manawatu
- Wairarapa
- Wellington
- Canterbury
- Mt Cook
- Wanaka
- Queenstown
- Otago
- Dunedin
- Fiordland
- Southland
- Other:

Gende *
r

- Woman
- Man
- Non-binary
- Prefer not to say

Name of organisation *

Position/Job title of participant. *
Here, indicate for the person completing the form. If other team members are participating, include in the 'additional information section' at the end of the survey.

- SRH Expert
- Social Media Strategist
- Youth Worker
- Other:

What category of young people does your organisation work with? *
Organisation's target audience i.e. young people.

- Adolescents/Teenagers (10 - 19 year olds)
- Young adults (16 - 24 year olds)
- Older youths (25 years and above)
- Women (16 years old or more)
- Men (16 years old or more)
- Transgender/LGBTQI+
- Other:

Which aspect of youth health does your organisation address? *
Note that the list of options is not exhaustive, so feel free to specify other areas of youth health that you/your organisation work on.

- Sexual health
- Reproductive health
- Mental health including alcohol and drugs use
- Physical health and wellbeing
- Other:

Which social media platform(s) does your organisation use for SRH promotion?

- Facebook
- Instagram
- Tiktok
- Twitter
- YouTube
- LinkedIn
- Reddit
- Tumblr
- Other:

Have you read the participant information sheet?

- Yes
- No

Have you read, signed and returned your individual consent form? *

- Yes
- No

Has your organisational consent/access form been signed and returned?

- Yes
- No

Number of participants from your organisation *

Please indicate depending on the number of research participants from your organization.

- 1
- 2
- 3 or more

Please add any other notable information considered essential.

Select date of completion. *

Date

A copy of your responses will be emailed to the address that you provided.

Appendix E. Categories developed post-NVivo coding

Category	Meaning construct	Example codes	Relevant research question
Use and user perspective	How practitioners currently use social media for YSRH promotion and their perspectives on its effectiveness	Benefits: Advocacy/awareness; Timely vs. traditional media. Downsides: Difficult to measure impact; Fast consumption limits engagement.	Sub-Q1
Social media restrictions	Regulations, filters, and limitations imposed by platforms or governments on health content targeting youth	Platform regulation varies; Ethnic targeting restricted	Sub-Q2
Technical capacity of practitioners	Skills, training, commitment, and time required to create and manage engaging social media content	Practitioners largely untrained; Role seen as extra unpaid work	Sub-Q2
Time, manpower and funding	Financial, human resource, and time constraints facing organisations using social media for YSRH promotion	Financial limitations; Government funding can restrict creativity	Sub-Q2
Cost	Financial implications and technical know-how required for meaningful youth content	Audiovisual content expensive; and Audiovisuals are technically demanding	Sub-Q2
SM content creation	What informs messaging and information sharing on social media from organisational and practitioner perspectives	Limited/exhausted ideas for specific niches; Audiovisuals get more engagement + costly + time-intensive;	Sub-Q1; Sub-Q2
Presentation	Creative and engaging approaches to social media content	Young people attracted to fun/comic content; Diversity and representation important	Sub-Q2
Topic-User Engagement	How young people engage with social media posts and how trending topics inform practitioner content	Youth engagement; trending topics = inform practitioner content	Sub-Q1
Alternative Platforms	Why practitioners choose other platforms (websites, on-site) over social media for certain purposes	more formal/lengthy content; due to audience/goals mismatch or topic sensitivity	Sub-Q1; Sub-Q3
Limitation of alternative platforms	Challenges with non-social media platforms like websites	Lengthy content, too technical; Boring and not engaging compared to social media	Sub-Q2

Category	Meaning construct	Example codes	Relevant research question
SRH communication barriers	Challenges of addressing youth SRH topics on social media, including educational gaps and stigma	Religious/cultural influences limit SRH education; Misinformation and mistrust result; Cybersecurity and privacy concerns	Sub-Q2
Community and trust building	Importance of fostering community and trust between practitioners and young people on social media	Young people easily connect/associate on social media; digital community fosters trust through sharing/learning	Sub-Q3
Language	Awareness and understanding of youth-oriented language in social media health promotion messaging	Youth slogans/terminologies are constantly changing; Managing diversity is challenging	Sub-Q2
Sense of responsibility	Empowering young people to feel ownership over their health decisions and messaging	Young people want decision-making power, not to be fed information; Builds trust and acceptance	Sub-Q3
Acceptance and relevance	Young people accepting health promotion messages and finding them relevant to their lives	Humans in content helps relatability; Representation, inclusivity, and collaboration	Sub-Q2
Ethnicity and cultural inclination	Social media health promotion as it relates to different ethnic groups—targeting, messaging, inclusion, representation	Targeting specific ethnic groups; Culturally appropriate messaging	Sub-Q2
Consultation as a strategy for managing diversity	Modes of engagement and collaboration with diverse communities within the NZ population	Practitioners engage diverse communities; Deliberate consultation	Sub-Q3
Relationship building with young people	Importance of building relationships, trust, and confidence with young people	Trust and confidence; Relationship building = effective engagement	Sub-Q3
Training	Capacity building opportunities for practitioners to effectively use social media for YSRH promotion	Too technical to navigate; Practitioners require capacity building;	Sub-Q3
Support needed by practitioners	Areas where practitioners require capacity building, funding, and training to improve delivery	More cultural capabilities needed e.g. Te Tiriti commitment; Verification/validation of professionals on platforms needed	Sub-Q3

Category	Meaning construct	Example codes	Relevant research question
Challenges hindering support	Setbacks practitioners encounter or are likely to encounter based on gaps and needs	Need for expert positioning and collaboration with youth; Dedicated staff rarely employed;	Sub-Q3
Collaboration and outsourcing	Opportunities for organisations, practitioners, and young people to work together	"With agencies: Inter-agency partnerships address weaknesses; Outsourcing to skilled professionals improves quality. With young people: Co-creation gives youth ownership; Communication gap evident	Sub-Q3
Mental health	Describes the link between or the impact of mental wellbeing on SRH wellbeing.	Central to psychosocial health and wellbeing; crucial to self-identity, sexual identify and acceptance; youth self-esteem affects sexual behaviours; influences ability to make informed decision	Sub-Q2
Impact of COVID-19 on SRH and social media messaging	Provides insights into how social media was used during the pandemic, exploring any differences in the before-and-after period.	Pivotal to digital uptake; hybrid work approach normalised; Practitioner uncertainty and forced adaptation; predisposed workforce to burnout, job loss, vulnerability; uptrends in risky sexual behaviours	Sub-Q1 & Sub-Q3

Appendix F. Themes, subthemes and categories alignment

Themes and subthemes	Description	Analytical patterns of categories	How categories connect
Social but not socially connected Organisational context and digital strategy implications Resource limitations	Examines the persistent gap between adult SRH providers and youth, and how organisational mission, size, and resources influence social media use for health promotion	Structural and resourcing constraints Time and manpower limitations Funding constraints and the cost of social media engagement Limited technical capacity of adult providers Policy and regulations constraints Platform and system limitations Social media restrictions and platform rules	These categories collectively reveal how provider perspectives, platform constraints, skills gap, and resource limitations create a disconnect between young people and adult SRH providers. Organisational capacity shapes what is possible, while provider sentiments about social media's effectiveness for behavioural change demonstrate adult-centric approaches.

Themes and subthemes	Description	Analytical patterns of categories	How categories connect
		Algorithms constraints and visibility issues Limited flexibility of alternative platforms Content and engagement challenges Social media content creation demands Presentation and format constraints Topic suitability and youth engagement fatigue	
Don't tell me what to do: The dilemma of language, community and trust Youth-Adult tensions in religious and cultural context Stigma and risk aversion	Examines how adult providers' own experiences and cultural sensitivities clash with youth perspectives, creating barriers to trust and community building within and outside of the digital spaces	Communication and messaging barriers SRH communication barriers Language choice and tone Sense of responsibility and risk awareness Trust, legitimacy and relevance Community and trust building Acceptance and relevance of message Ethnic and cultural inclination	The categories reveal how stigma, religious and cultural norms as well as provider perspectives and dispositions about youth sexuality create environments where young people feel judge, unsafe and unwilling to engage, fundamentally affecting their health-seeking behaviour and a resultant effect of lack of trust and authentic connection
No one size fits all: Engage, adapt and collaborate Platform differentiation and targeted content Targeting niche audience	This takes the analysis beyond identifying and discussing the problems to exploring pathways for solution through collaboration, co-design, and holistic engagement across stakeholders	Relational and participatory strategies Consultation as a strategy for managing diversity Relationship building with young people Negotiating authority and voice Capacity building and provider support Training needs Ongoing support for providers to improve skills Collaborative and adaptive approaches Collaboration with youth and agencies Outsourcing and partnership models Flexible, context-specific engagement strategies Structural and organisational barriers	These categories reflect how inter-agency partnerships, youth co-creation, peer-influence and trust-building strategies can address the barriers identified in themes 1 and 2, while centring youth voice and agency.

Themes and subthemes	Description	Analytical patterns of categories	How categories connect
		Institutional challenges hindering support Resource and policy constraints	

Appendix G. PR with SRH practitioners – Summary notes

The summary notes outline different categories and their description based on the series of quotes and codes.

Category	Description	Summary of data coded to the categories
Challenges of using social media	Describes the challenges that practitioners face when they use social media to target young people - informing, educating, and sensitising them about their SRH.	The algorithms are constantly changing, thus making it somewhat difficult to have a definitive and standard modus operandi for social media engagement. Some SRH [e.g., HIV] contents generate hateful feedback, but at times, it self-moderates. In such instances, the community learns, engagement is increased, and practitioners identify knowledge gaps and can create informative and educative content to address this. If the feedback is too toxic, such posts are removed.
Contextual challenges	Applies to challenges or limitations being faced by practitioners or young people because of their local environment.	As an ethnically diverse country with a significant migrant population, a gap appears to exist between medical practitioners and their ability to address the healthcare needs of migrant communities due to differences in cultural values and traditional practices. This has been a challenging gap to fill. Also, creating content that is responsive to the needs and language of young people and such that gets the approval of parents, guardians, school authorities and similar organisation is another hurdle. For instance, the National Sexual Health Curriculum approved for teaching in schools is subject to each school and its board. Some notes on funding were moved to their appropriate section.
Limitation as a tool	Describes how much can be done with SM applications as a tool - in the sense that it has its limits and at some point, it may no longer be useful or suitable, hence cause or intent would	Like everything else in life, social media has its limits. It can only do as much as it can. As a platform, everyone has the freedom to interpret information as they deem fit, and such can be detrimental. Easy to misconstrue. Diversity is more difficult to manage. It cannot filter down to ethnic identities even though contents that feature on individual accounts might be localised to the country or region level. This is most important when the post or information being shared does not apply to the general populace. Content creation and promotion are expensive.

Category	Description	Summary of data coded to the categories
	have to be transferred to another channel.	Health professionals and social media influencers are proving difficult to delineate because of the role that money plays, either for paid adverts or in influencer marketing. Those with deeper pockets lead while others are disenfranchised. Paid contents are expensive. Feedback is not easy to gather, and if at all, negative criticism outweighs the positives. Constantly changing algorithms make it difficult to track progress or impact. Followership gives credibility and not necessarily quality. Knowledge acquisition and the effectiveness of the information/education provided in driving behavioural change are difficult to measure. Designed for fast consumption – scrolling over several contents in very little time, hence no or limited chance to engage critically or in-depth with sexual health materials shared. The meaning and understanding gathered are subjective. Attention span is subject to the user and for most young people, that is very short. The amount of time spent on content shared is difficult to know. Non-verbal cues often noted in face-to-face interaction are lost when health promotion messaging happens and are limited to social media. The virality or speed at which information travels can sometimes be negative if such is misleading or misconstrued. Difficult, if not impossible to fact-check shared information because everyone assumes an expert status on social media, even when not qualified by training or experience. The amount of information that can be shared is controlled and sometimes limited to cover the topic at once.
Social media restrictions	In terms of the regulations within the industry or by the government, filters, and restrictions e.g., sensitive words and age restrictions that are placed on the app. Also, inability to target based on ethnicity in a multi-diverse country.	Regulations vary from one platform to another. For example, 'TikTok is less regulated and harder to use' whereas Instagram places restrictions on age- and sexually-sensitive content. Allows for a limited amount of information per time and how to fit so much within the little space or allowable time can be challenging. Targeting younger people, particularly those below 18 years old are not allowed. Sensitive contents even though valid and accurate are restricted. Such content is flagged and disapproved and can lead to banning social media accounts, challenging creativity, and information quality.

Category	Description	Summary of data coded to the categories
Technical capacity of practitioners	The technicality and commitment as well as time required to generate and post content on social media is quite a task and not many are skilled as much to produce an engaging post for young people.	Most practitioners alluded to being untrained and unskilled in the use of social media and content creation. Further to this, the job function is seen as an extra and unpaid job when there is no defined role and personnel assigned (manpower) to it. The fear and reality of running out of content affect the quality and consistency of health promotion messages shared on social media platforms. Post management requires technical capabilities, effectiveness, and efficiency, especially when posts go viral, are misunderstood or misleading or receive negative feedback. Audiovisual contents like videos and reels are expensive to curate and are tied to the skilled competence of the team or personnel in charge of content creation as well as the financial capacity and commitment of the organisation. Human resource management, specifically having a representative and inclusive identity on such messaging is another challenge.
Time, manpower and funding	Financial limitations remain a major barrier to the potential of organisations and individual practitioners using social media for SRH promotion.	Health promotion targeting young people on social media is time-demanding and requires dedicated personnel, but most organisations cannot afford to employ someone in a full-time, even part-time, paid role. Manpower asides from having dedicated staff, also speak to adequate representation (inclusion and diversity) of persons featured or engaged in social media messaging. The financial capability to cover all of these is most challenging with smaller, and non-funded organisations. Manpower also speaks to collaboration with young people. It applies to the fun creation of content, relevant to them in terms of language and presentation. To deliver effectively and optimally, the capacity of both the practitioners and the young people needs to be developed and that is not easily available. When government provides funding, it can limit or restrict how content is created by practitioners and where such funding is not available, practitioners are still limited especially if their organisation is not-for-profit. The funder dictates how the money is used. Paid advertisements, although expensive, reach more people and offer more engagements. However, the lack of appropriate funds for such activities in most organisations makes it far-fetched.
Impact of COVID-19 on SRH and social media messaging	Provides insights into how social media was used during the pandemic, exploring	Social media messaging became more needful and essential. It was the go-to for practitioners to share informational and educational resources and the place for young people to find comfort away from all the chaos going on.

Category	Description	Summary of data coded to the categories
	any difference in the before-and-after period.	Messaging at this time was mostly done with uncertainty. Most services were forced to switch to online service delivery mode, and this came with the challenge of not knowing what or how to deliver, both on the practitioners' end as well as their service users. Staff burnout, job losses due to team downsize and reduction in physical engagements were other forms of struggles encountered. Both sexual and mental health issues (abuse, assaults, etc.) seemingly skyrocketed because abusers and their victims were forced to cohabit due to lockdown restrictions nationwide. Albeit the chance to spend more time with family also allowed affected young people to speak up and share with trusted people, family members and practitioners alike. Post-COVID, activities are gradually returning to what they used to be, but most people are incorporating hybrid modes of service delivery, that is, both physical and virtual means of connecting and communicating.
Memorable Quotes	Contains interesting, must-use, need-to-refer quotes across the transcripts.	No summary is needed.
Recommendations and the way forward		Practitioners should not be afraid of outsourcing. Deploy social media health promotion messages as games, young people might find them quite engaging and interesting. (This can be an artefact, but I will need help). Why is reproductive health not as pronounced? What would a young person say or think in light of this? How to unpack cultural context? Workshop idea: What do you think the contribution to knowledge should be? Practitioners would like a platform where they can interact and seek technical support on how to create and deliver youth-centred information on social media. Example artefact: Online testing in Vancouver https://getcheckedonline.com/Pages/HowGetCheckWorks.aspx Suggestions or practicals during the workshop – ideate on the youth-centric app about SRH – how to create and what to create/topics to cover, regular updates. Needs to be short and engaging.
SRH issues identification	Describes the relationship between SRH and mental health among young	Refer to notes under child code – SRH communication barriers

Category	Description	Summary of data coded to the categories
	people and how social media helps.	
Mental health	Describes the link between or impact of mental wellbeing with SRH wellbeing.	Mental health is interwoven with sexual health. They are considered non-exclusive to one another and are considered to be in line with the Māori health models - Te Whare Tapa Wha and the Te Pae Mahutonga. The physical, mental, spiritual, and family wellbeing are all central to the health outcome of any individual. A lapse in one creates an imbalance in the overall wellbeing of the individual. It is therefore important to keep a healthy lifestyle. Sexual health is likened to building relationships with other people and to do so, one must be competent to make informed choices. In New Zealand, mental health is a critical public health issue and deserves to be given priority attention. Knowing who one is and being accepted for that plays a huge role in the mental health of young people. As growing youths who are in a stage of self-awareness and self-identity, it is important to respect and support young people as they evolve, otherwise, it can result in a mental breakdown. Self-esteem, poor body image and identity misrepresentation were some of the factors linked to poor mental health, and in turn, negative and risky sexual behaviours, and choices. Pornography is an issue among young people these days and it can be addictive, and in this state, they are predisposed to other mental health challenges like sleep depravity, depression, and anxiety. Sexual abuse has also led to PTSD, another form of mental health issue. Fear of contracting STIs like HIV also messes with young people's mental health, so they need counsel and support to make informed decisions including testing, diagnosis and treatment.
SRH communication barriers	Highlighting the SRH issues peculiar to the youth groups or specific population groups.	Lack of education and ease of mature communication about SRH in schools is one of the challenges facing young people and this is greatly influenced by religion. As a result, there is misinformation, miscommunication, and mistrust among peers and practitioners that engage with them. Cybersecurity and sexual nudity were other prevalent issues that face school-aged youths. Young people feel judged and unsafe when they want to talk about sex in schools, in church, meet with practitioners, or in some instances are prevented from accessing

Category	Description	Summary of data coded to the categories
		contraceptives by their parents. This affects the outcome of referrals and the uptake of support services.
HIV and other STIs	Lifestyle choices and behaviours because of fear of STIs.	HIV for one has not received much attention because the prevalence rate is low and therefore, it is not a critical public health issue in New Zealand. More older people live with HIV than young people so there is a limited form of experience or knowledge sharing between the age groups – there are fewer youth peer educators. In addition to the above, the national sexual health curriculum is subject to the approval of school boards i.e., parents before its content are taught to the children. Persons living with HIV are not easy to target using messaging or advertisements on social media but rather through infectious diseases clinics or person-to-person mode. This is because of stigma and discrimination. Other general population messages for raising awareness, and demystifying facts fit well on social media and facilitate engagement among people. Sexual health needs to be normalised, so people understand that it is part of their routine standard care. Fear of contracting STIs especially HIV has been a deterrent to young people who would like to have sex. The pressure of internalizing the health issue affects the mental health of young people negatively.
Stigma and discrimination		The fear of being stigmatised or discriminated against has kept young people away from offering themselves as peer educators. There is a need for an awareness campaign to provide support for people living with HIV rather than the transmission of the virus. Education is key to empowering people with the important details needed to make informed decisions. Also, the stigma and discrimination have stopped people from seeking professional care and support such as counsel, testing and diagnosis, however, they feel safer engaging with outreach persons set up on dating apps.
Support needed by practitioners	Describes the areas or ways that practitioners in the space of youth SRH require capacity building, funding, training, etc. to improve the delivery of work.	Organisations and practitioners need more cultural capabilities to deliver care and support to young people, especially a commitment to Te Tiriti Waitangi and the Māori ethnic group. There is a need for verification and validation of professionals on social media platforms to legitimize the information put up there. Organise community forums and panels for more engagement with young people so they can learn more about short-push information put on social media. Practitioners would like a platform where they can interact and seek technical support on how to create and deliver youth-centred information on social media.

Category	Description	Summary of data coded to the categories
Challenges hindering support	This describes some of the setbacks that practitioners encounter or are likely to encounter based on the prevalent gaps and their needs to function effectively as providers of care and support to young people.	Practitioners feel they do not have the technical capacity to deliver youth-centred messages on SRH. There is a need for expert positioning and collaboration with young people to deliver relevant and receptive information on SRH. Dedicated staff are hardly employed or assigned to manage SRH promotion on social media. Reciprocity and accountability to young people so they do not feel used or marginalised when engaged on social media. Finance is another challenge that has hindered practitioners from doing more than they are doing.
Collaboration and outsourcing	Opportunities for small agencies to come together and create social media contents to make up for their weaknesses or staff strength.	Collaboration supports the concept of representation, diversity and inclusion among young people and practitioners. Collaboration among team members in an organisation and with different communities are seen to be happening. This is helping practitioners to conceptualise how to support young people on social media with SRH promotion messages and other professional services. Collaboration is also happening between government agencies and NGOs as well as with communities to identify and address public health issues, particularly down to its roots. Practitioners are implored to work with service providers who are skilled in areas that they are lacking technical competence (and vice-versa) such as journalists, graphic designers, etc. It is believed that doing this will ensure that creative works are produced with more quality and credibility. To organisations and practitioners, funds can be a challenge on the periphery, but ground knowledge portends that it might be more affordable than thought.
With other agencies	Inter-agency partnership	Funding Skilled personnel and training others to improve their competence to deliver. Cross-organisation and cross-sector relationships: Working in concert with other organisations and practitioners to give a stronger voice to SRH promotion messages on social media.
With young people	Co-opting young people to own their message, and their	Some organisations have existing relationships and collaboration gigs with young people whereby they serve as peer educators to other young people content creators and designers for online and offline consumption e.g. websites, drama, newsletters, etc.

Category	Description	Summary of data coded to the categories
	story and giving them that sense of responsibility in the process of their SRH promotion.	Some other organisations do not engage with young people yet because the kind of audience they serve is not specific to youths or because they have not worked with youths enough to know what they are thinking or would be interested in. Practitioners can source ideas from young people by directly seeking their opinions using surveys, interviews, or group discussions. They can comment on what they think of the social media pages, what they want the practitioners to address on social media, and what they consider uninteresting so practitioners can change/improve. There is an evident communication gap between the youths and practitioners. More specifically, youth representation is minimal or lacking in some niches causing a disconnect between the older and younger generation. In addition, young people want to do their thing in their way but that may be lacking in professionalism, validity and accuracy of information shared. On the other hand, practitioners lack the youthful language and vibes that could ensure that the information they are sharing is well received because it is relevant and timely. This divide has made it more needful to collaborate so both parties can integrate and complement one another for a more robust engagement and health promotion success. Trust and community building are essential for the collaboration between young people and practitioners to work. Super-engaged youths could be considered members of the social media community because they are invested and committed to content put up by commenting, liking and/or sharing the posts. They can be converted into advisory groups to inform practitioners on areas of interest, provide constructive feedback and offer suggestions on how to improve their engagement with young people. Doing this is also a way to build their capacity. It is rewarding and empowering. Young people can be peer influencers to promote SRH messages among their friends and acquaintances. Trust and acceptance are stronger at that level than from an adult or expert source. Young people do not want to be told what to do so practitioners need to know how to adapt and engage with them innovatively.
Training	Capacity building opportunities	Social media can be technical to navigate, and practitioners require some capacity building to effectively use it as an SRH promotion tool so young people can get the best of it.
Use and user perspective	Describes how social media is being used and the practitioners'	Benefits: Useful for advocacy and mass media campaigns to create awareness. Information – sharing ideas and content.

Category	Description	Summary of data coded to the categories
	perspectives and experiences, that is, the factors they consider in this process.	Vast reach – viral messaging/posts. As a tool, useful to kick-start a process, raising awareness in the mind and real-life experience. Can be private when simply viewed without sharing. Viewing is the point of assimilation. However, sharing is equally important because that is how they engage and how their understanding can be assessed. Downside Not sustainable and effective towards long-term behavioural change. In other words, it is not easy to measure behavioural change via social media. It leaves a chance for untamed or uncontrolled interpretation – different interpretations are allowed. Designed for fast consumption – scrolling over several contents in very little time, hence no chance to engage critically or in-depth with sexual health materials shared. Using social media can serve as an informational, educational and health promotion platform for practitioners and young people. For some topics that are too sensitive for public context, facilitating this in a closed and moderated group is encouraged. In the current digital age, social media is considered timely and relevant to youth engagement compared to other traditional media. Working with young people to co-create social media messages seemed like uncharted waters but a promising endeavour if rightly done. Commitment to sexual health is weak unlike how COVID was dealt with. Storytelling is considered quite effective because it is relatable, especially lived experiences. Across the platforms, reels on Instagram and TikTok sound bites are considered to have more views and engagement. Audio-visuals appeal more to the target audience especially if it is short and fun.
Alternative platforms e.g., website or on-site	Practitioners explain why the choice of other platforms other than social media is preferred, for example, the sensitivity of the topic, the kind of	Aside social media, websites were suggested to be a common alternative, and in some cases, a preferred medium for sharing information and educating the masses, not just young people. However, websites do not have the interactive feature that social media platforms have, making it difficult to provide immediate feedback on shared content. Also, it is somewhat formal, sometimes lengthy, boring, and not as interactive and fun compared to social media. During the interviews, some organisations reported not using social media as a health promotion tool – an interesting perspective to come across despite the prevalence and influence of social media in the present day. One of the reasons provided is that their

Category	Description	Summary of data coded to the categories
	audience being targeted, etc.	overall goal and target audience do not align with the demands and etiquette of social media. Secondly, some organisations serve young people by proxy (other service providers) and hence do not feel obligated to reach them through a medium like social media. Other fundamental issues why websites and similar platforms are used instead of social media are differences in culture and the sensitive nature of SRH issues. For those without social media accounts but websites and private dating apps, a closed and highly moderated platform on Facebook, WhatsApp, Signal, and Telegram may be considered, if it becomes a must. Offline activities such as print media, and community campaigns are also not well received because they can open the group of young people to external criticisms and incendiary comments that are more damaging than constructive and supportive. In-person and on-site engagements foster familiarity, bond, and acceptance. It also encourages youth and peer-to-peer leadership; whereby young people can organise group discussions and team bonding exercises that help them to learn and share among themselves. It helps to build trust and bolsters a sense of community. Secondly, with practitioners, non-verbal cues are as important as verbal feedback during live discussions with young people. It adds to the context and value of information gathered during counselling sessions and helps with the diagnosis and treatment process. For organisations that conduct training for other practitioners, a face-to-face meeting is preferred, although this was tested during COVID and other adaptive ways were embraced. Resources are uploaded on organisational websites and interested persons can access them in a self-paced training mode. This has been practised before, during and post-COVID pandemic. Online training just like virtual counselling supports privacy and confidentiality. It can be cost and time effective too, in terms of professional consultation and referral time that is cut off in the case of medical or clinical issues. Website is considered safer and more private, unlike social media. While the latter could be a kickstarter, the former serves as a base for information storage/archive and can take so much more than any social media platform can at any point in time. For instance, the preview of a topic can be shared as a reel, post, or short video content on social media, and then at the end, a link redirecting to a more detailed website is included for people who want more information or service. Websites can hold longer videos that fit for storytelling, a medium of expression that some young people have begun to explore i.e., the Tapu Va project. You can also create a frequently asked questions and answers

Category	Description	Summary of data coded to the categories
		section on the website because it has more storage capacity, unlike social media. It is good to note that most social media platforms allow the use of link trees to external sources and this can be indicated in stories or the bio section of a page.
Limitation of alternative platforms e.g., website	The limitations and challenges that practitioners and their target audience may encounter while engaging with these platforms and the resources shared therein.	Website resources may be lengthy, too technical, and not easy to consume especially for young people who get bored easily and would rather have fun or be engaged in creative ways.
Diversity and its management	Diverse communities require diverse engagement platforms. This explains the multi-ethnic population, multiple social media platforms, as well as other facilities in place for young people to access SRH care and services.	Cultural and religious sensitivity, including parental approval, is a barrier to interacting with young people about their SRH issues. Consultation (FGDs, IDIs, transect walks, etc.) with the target population in their respective communities has yielded positive outcomes as they are more receptive and open about their needs as well as solutions that they consider to be effective. In addition, storytelling by the community members about their experiences, challenges, and ways they addressed them has encouraged others to also open up and seek help.
Ethnicity and cultural inclination	Social media health promotion as it relates to different ethnic groups - targeting, messaging, inclusion, representation with youth SRH. Also covers some social	Refer to notes under parent code [Diversity and its management]

Category	Description	Summary of data coded to the categories
	and cultural influences on SRH education and service uptake.	
Consultation as a strategy for managing diversity	Describing the modes of engagement and collaboration with diverse communities within the larger context of the NZ population	
Retargeting population groups		
Reproductive health		Very few codes (<5), hence collapsed into SRH issues identification.
Strategies for managing diversity in reproductive health		
Relationship building with young people	In the use of social media, the importance of building relationships, trust, and confidence in working with young people is described.	Social media and influencers have an impact on the reasoning and expectation of young people about sex.
Acceptance and relevance		This is about young people accepting the health promotion messages they see on social media and their relevance to them. Seeing humans in the content also helps them to relate to the message better because they can see themselves in it. In addition, young people want to feel accepted about their sexual orientation and practices, not to be judged, so language and presentation are key. If they perceive the message to be imposing or manipulative, they will be repulsive, so it is important to speak in their language. Also, providing the information in form of empowerment so they can influence themselves positively, sharing and learning from one another facilitates acceptance and

Category	Description	Summary of data coded to the categories
		relevance. Representation, inclusivity, and collaboration are also important to young people in social media health promotion. For some topics that could be controversial or stigmatizing, while the viewership may be high, comments are often limited because young people don't want to identify or be identified with such, for example, alcohol and drug issues, mental health issues, or with STIs, etc.
Community and trust building		Young people are eager to connect and associate on social media as in real life. This power of association fosters a sense of community within the group and with externals when collaborating. With community building also comes trust as they share and learn. Community building and trust take time and the establishment of rapport. Consistency is equally important. To gain young people's trust and access their community, practitioners need to learn how to approach without appearing nosy or judgemental. Practitioners can facilitate mentorship or collaborative programs with youth leaders who can in turn promote their learning among peers as this approach can be more receptive by young people unlike when practitioners share with them directly. Dating sites, although not conventional social media platform is also another form of community where target groups can be engaged and influenced for healthy sexual behaviour and practices. Instagram is perceived to support community building. There you are likely to have a community of super users, highly invested followers that engage with your content from time to time especially when it is one that they can relate to – representative and inclusive, language. Storytelling (sharing) supports community building e.g., the Tapu Va project. Other forms of sharing can be through film, photography, interviews and focus group discussions.
Language	Awareness and understanding of youth-oriented language in social media health promotion messaging.	Young people have their slogans, terminologies and relational signs that are constantly changing. This can be hard to keep up with as practitioners, therefore, working together collaboratively is one way to effectively communicate with them as well as build their capacity to deliver the message in their language. It is important to realise that within the youth population, there are different subgroups and identities. Managing this diversity can be challenging but it needs to be acknowledged and served, each in its uniqueness, otherwise, understanding might be lost or the message could be rejected.

Category	Description	Summary of data coded to the categories
		More positivity needs to be embraced when talking about sex. Sex positivity can alleviate the barrier to testing, for instance. Because people feel judged or could be stigmatised, they would rather not get tested and then be at risk of life-threatening infections that are treatable if detected early.
Sense of responsibility		Young people need to feel and know that they have the power to decide for themselves. They do not want to be fed with information, rather, they want to forge their path. Considering this, practitioners need to adopt the youth-led approach (peer-to-peer) by devolving power, stepping in only when requested or when it is highly necessary, otherwise, the goal of promoting healthy behaviours might be defeated. Also, to make young people feel more responsible, practitioners can purposefully engage them by seeking their opinion or feedback on the health promotion content put on social media and similar platforms (websites, dating apps, etc.) where they are being targeted. Workshops and advisory groups can be formed to serve this purpose as well. Another way is by working with a local to lead the process rather than the organisation or a government agency fronting the messaging. This also speaks to building trust and community as well as accepting them for who they are. 'Maybe we just need some young people on board who tell us how to do it, and then it would work.'
SM content creation	Describes what informs messaging and information sharing on social media from an organisation and individual practitioners' perspective.	Of great importance is the quality of the content that is being produced as well as its consistency. It remains a challenge to keep up with content creation due to limited or exhausted ideas, especially for those whose niches are too specific. Audio-visuals get more engagement, but it is costly, require technical competence and is time intensive. Representation and inclusivity are threatened when faced with such challenges in an ethno-diverse context like NZ. Opportunities abound for collaboration and partnerships with young people and communities to address the challenges noted above.
Cost	The huge financial implication in addition to the technical know-how of meaningful	It is cheaper to run adverts on socials compared to other traditional forms of media or dating apps.

Category	Description	Summary of data coded to the categories
	content for young people.	
Presentation	Creative and fun.	Audiovisuals get more engagement than text-based posts. It is a lot easier to disseminate compared to traditional media and prints. It can be cost-effective rather than engaging people to man campaign booths or distribute newsletters. Young people are more attracted to fun and comic content, and this demands lots of time, and technicality and can be costly. Boring is a turn-off. Using young people themselves to deliver this message helps to keep up with trends that are constantly evolving. In social media messaging, diversity and representation are very important and these are featured in the use of language, photos, and video content. Get external eyes to evaluate or critique social media health promotion messages before releasing them. Doing this helps to eliminate the risk of tunnel vision and improve the quality of production. Social media influencers come in handy towards achieving viral messages. Having huge followers gives credibility. Constant and consistent posting also fosters engagement. In a bid to be cautious, sometimes social media content is over-edited so much that upon release, they are no longer topical or timely.
Topics-User engagement	Describes how young people (users) engage with social media posts and topics. Highlights how trending topics, commentaries and enquiries from users inform posts made by practitioners.	At an organisational level, team members meet to discuss contents that would be posted on social media. This is often informed by their subject interest as an organisation, topics that are trending, emerging issues from fieldwork, upcoming local events as well as major public health issues that need to be communicated consistently. Young people can be reached easily on social media unlike via traditional media and prints. This is because social media messages are quite short and snappy, and roll by fast as they scroll. Also, because their attention span is short, engaging with them on such platforms works better for practitioners. Stories have been found to encourage interaction – young people learn and in turn share their own stories and experience, thereby fostering a community of like people. Messages directed at a specific population group also gain traction especially if are considered marginalised people. For example, more Māori and Pacifica people are on TikTok in New Zealand, hence it is a good catchment area to engage with them without stigmatizing or marginalising them. Also, to boost engagement, influencers are good agents that practitioners partner with to make social media health promotion messages go viral.

Category	Description	Summary of data coded to the categories
		Instagram and TikTok are considered to be more youth-friendly but not Facebook, which is said to be better at paid promotion. Specially dedicated platforms e.g., after-dark Twitter, and Grindr are used to further engage with vulnerable groups like highly sexualised MSM. Positivity promotes healthy behaviour. When public health messages are constructed positively, it is more likely to be accepted than when it is shared as such with negative consequences. Further engagement can be done by embedding links so interested youths can access external resources that can substantiate the preliminary information obtained via social media.

Appendix H. Examples of Youth-led Initiatives

Case studies are considered descriptive accounts of knowledge and experiences situated within specific contexts (Cleland et al., 2021). The two cases illustrated below exemplify the shift from traditional, adult-controlled health promotion initiatives to those that recognised youth agency, fostered shared learning, and reflexivity, and can be applied within the New Zealand context.

Case Study 1: UK-based Peer-led Social Media Sexual Health Promotion

Adoption of a peer-led approach situated within a co-design model

The Sexually Transmitted Infections and Sexual Health (STASH) programme was designed to address the inadequacy of school-based sex-ed curriculum by providing a complementary intervention that is youth-led and youth-centred. This intervention combined a peer-led approach with social media for health promotion purposes to improve knowledge and mitigate the spread of sexually transmitted infections (STIs) among young people. It is grounded in Diffusion Innovation Theory and adapted from the 'A Stop Smoking in Schools Trial (ASSIST). Conceptualising the intervention and applying the provisional design through the Six Steps Quality Intervention Development (6SQuiD) framework, several iterations, including evidence review, consultations, a co-designed website and pilot testing, were undertaken.
Adolescents aged 14 - 16 years old were identified by peers based on their perceived influence and recruited as 'Peer Supporters'. In addition to engaging these young people, several other stakeholders, such as peer education and youth workers, children protection officers in local council areas, school management, health promotion specialists, and academia, were consulted to inform the programme design.
Following the multi-stakeholder consultations and reviews, young people were brought together in a collaborative and innovative workshop, similar to what Stubbing and Gibson (2021), Deanne and colleagues (2023; 2025) and Calder-Dawe and Gavey (2019) described in their publications. To foster authentic participation and connections within this youth-adult collaboration, young people, website development experts, trainers from Youth Service Organisations (YSOs), and a sexuality and relationship expert collectively developed a mobile-friendly website dedicated to STASH content.
To assess its effectiveness and usability, the draft website was piloted among young people within a school setting. Deploying the procedural outline of the conceptual STASH programme, peer supporters were trained, and feedback was obtained from the student participants, trainers and teachers. This was assessed against the theoretical framework for commonalities and differences, and another workshop was organised with the same participants from the first workshop to inform the tool refinement. In particular, several iterative sessions were held with young people to reflect their preferred content (relevance, relatability and credibility) and delivery mode.
By deploying a co-design model, knowledge gaps among young people such as, communication, consent, sex-ed digital literacy, contraceptives knowledge and use, were identified. Among care providers, use of outdated SRE packages and traditional delivery mechanisms was also highlighted. Working with professionals on website content emphasised the importance of 'less is more', and the need to ensure inclusive, gender- and sexual-diversity content.
This afforded the experts a real-life shift experience from a prescriptive, adult-driven programme implementation to a more youth-centred and youth-led health promotion model. Providers functioned as facilitators and resource mobilisers, building young people's technical and essential life skills to be better equipped to conceptualise and inform the design and content of the website. As a country, New Zealand can adapt the STASH programme to its context, incorporating relevant indigenous principles and frameworks to deliver a youth-centred and youth-led digitally informed SRH solution that thrives in equity, reflexivity and shared agency.

Hirvonen et al. (2021); Purcell et al. (2023)

Case Study 2: Baltimore City Youth Data Hub

Youth-led integrated data system for improved data governance

In Baltimore, the Data Youth Hub was legislated by the state general assembly in 2022, meaning they are formally recognised and institutionally secured. Informally launched with ground works as far back as 2016, it has since evolved into a youth-centred initiative responsible for facilitating an integrated data system that securely links data across several youth-serving organisations and the community, maintaining data integrity and ethical standards. Young people drive the process of making the shift from fragmented silos to integrated systems. They are involved in identifying social problems, generating evidence to inform youth-specific innovations and solutions that are contextual and relevant to Baltimore's youth. This, I believe, could offer a crucial learning approach for the New Zealand health system to build and strengthen the fragmented digital health systems reflected in the Chapter 2 findings.

The Data Hub is similar to the 'Connect & Korero' social innovation that resulted in the 'Framework for Ethnic Youth Participation in Policymaking' in New Zealand, although its success can only be assessed further down the line, being quite recent (Deane et al., 2023; Deane et al., 2025). The Data Hub membership in the Community Research and Action Committee is open to members from as young as 16 years old and upwards. As youth members, they are empowered to make decisions that directly involve and affect them, while collaborating with policymakers and older community members allows for the interactions and negotiations necessary to achieve the Data Hub's meaningful outcomes. Participation in policymaking is crucial to the authenticity of youth voice and in the change-making process, a challenge noted by Te Taiwhanga Rangatahi, and needs collaboration with adults to achieve (p. 39).

Young people also get compensated for their time and work, showing that they are valued and not simply being used in a tokenistic or opportunistic manner. This is a shift from tokenism to empowering youth and enabling youth agency. A similar approach is reported as one of the success factors in the Te Taiwhanga Rangatahi project, a prototype of the foundational co-design lab in South Auckland, New Zealand (Te Taiwhanga Rangatahi, 2022). When young people are involved in the collection and use of data, more so in higher capacities as organisation staff members, youth programme evaluators, board and advisory team members, it shapes their interaction with the process and the outcomes achieved (Fink & Velure Roholt, 2022).

Heavy reliance on government funding, however, for any youth-led and youth-centred initiative can compromise the potential of empowering young people, contrasting with the nature of flexibility and creativity (Came et al., 2018; Diepeveen & Phiona, 2021; Goodwin et al., 2025). Therefore, multiple and alternative sources of funding should be encouraged; doing so also helps to manage top-down power dynamics encountered in the government-provider funding relationship (Came et al., 2018).

More information available at the Baltimore City Data Youth Hub website (2023a, 2023b)