

“She’ll be right”? National identity explanations for poor sexual health statistics in Aotearoa/New Zealand

The sexual health statistics around sexually transmitted infections (STIs) in Aotearoa (New Zealand) suggest two things: many STIs are increasing, and our STI rates are high compared to other ‘similar’ countries. What sense do ordinary New Zealanders make of these figures? Focusing on heterosexual sex, this paper discusses lay accounts that sought to make sense of Aotearoa’s STI statistics. In total, 58 participants (38 women, 20 men) aged 16-36 (mean age 25) took part in 15 focus group discussions related to sexual health. Participants were mostly Pākehā and heterosexual. Data were analysed thematically. The predominant category of explanation was national ‘identity’ accounts. National ‘identity’ explanations invoked a particular New Zealand persona to explain our sexual health statistics. New Zealanders were characterised, sometimes contradictorily, as: binge drinkers; poor communicators; self-sufficient and stoic; conservative yet highly and complacently sexual; and ‘laid back’, which was associated with a lack of *personal* concern about sexual health risk. The emphasis on national identity shifts responsibility for sexual health from the individual, and suggests agency lies beyond the individual, who is fully embedded in their culture and acts according to its dictates. In terms of sexual health, this suggests a need to consider whether, and if so how, national ‘identity’ might be meaningfully invoked and deployed in sexual health promotion initiatives.

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Aotearoaⁱ has recently been claimed to be “the chlamydia capital of the world” (Weatherall, 2005) - a somewhat dubious area of world leadership. With the exception of HIV, Aotearoa appears to fare poorly overall compared to other Western/’developed’ countries on STI incidence - although international comparisons do need to be interpreted with caution. Regional laboratory-identified STI rates are consistently higher than national rates in Australia, the UK and the USA. Rates of chlamydia, the most common STI, in 2006 were 722/100,000 in Auckland, compared to 282/100,000 in Australia (STI Surveillance Team, 2007). Data generally show high and increasing rates of STIs like chlamydia and gonorrhoea, and increases in far less common STIs like HIV and syphilis (STI Surveillance Team, 2006, 2007). Between 2002 and 2006, sexual health clinic diagnosed chlamydia increased 27.7% and gonorrhoea 52.1%; between 2005 and 2006, syphilis increased 44.7% (STI Surveillance Team, 2007). This pattern mirrors international trends (e.g., Parratt, 2003; Power, 2004; Ross, 2002). Such sexual health statistics have raised concerns about the sexual health of our population, but the issue has not been one of significant national public debate.

In this paper, I explore lay accounts of ‘cause’ around Aotearoa’s sexual health status, as indicated by such STI statistics. Within health psychology, attention has for some time been given to lay explanations around health and illness (Hughner & Kleine, 2004), including sexual health (e.g., Manhart, Dialmy, Ryan, & Mahjour, 2000; Nicoll, Laukammjosten, Mwizarubi, Mayala, Mkuye, Nyembela et al., 1993; Pawluch, Cain, & Gillett, 2000). Various referred to as lay beliefs, knowledge or epidemiology (Prior, 2003), the overall premise is that people’s constructions affect their health-related choices and practices (Hughner & Kleine, 2004). Employing different theoretical frameworks, critical and discursive qualitative research has pervasively demonstrated (often gendered) constructions and discourses related to sexual health which act as impediments to sexual health (e.g., Gavey & McPhillips, 1999; Hillier, Harrison, & Warr, 1998; Waldby, Kippax, & Crawford, 1993; Willig, 1995). I use the term lay accounts to signal a discursive orientation, which recognises

that these explanations are not simply neutral transmissions of knowledge (Blaxter, 1997; Radley & Billig, 1996).

Both literatures have illustrated the complexity and variety of lay explanations, their often patterned nature but simultaneous lack of fixity, and the way they relate to sociocultural contexts (Pawluch et al., 2000). Lay accounts “result from the complex interaction of individual, cultural, social and political factors” (Hughner & Kleine, 2004, p. 396), and often differ remarkably from those accounts provided by experts. However, it is not simply a dichotomy: lay accounts often echo expert discourse (Shaw, 2002); individuals can also be theorised as ‘talking back’ at or ‘against’ expert discourse (Hodgetts, Bolam, & Stephens, 2005).

Most research has focused on explanations for individual health or illness, rather than for populations (although see Blaxter, 1997). In this paper, I focus on lay accounts of population level indicators of sexual health. I am interested in lay accounts not from a ‘fact’ based perspective (are they ‘right’ or ‘wrong’?) but for what they can tell us about our topic of interest, including: the ways these issues are constructed; the ways in which blame and accountability are attributed and managed; the ways in which the topic is contextualised within individual’s accounts of their broader lives; and the discursive resources available at a particular time for that topic, including expert accounts, and how these are, or are not, taken up (although see Radley & Billig, 1996).

Expert discourse (e.g., published research, analysis, policy) offers the authoritative account of sexual health. With increasing recognition of the socio-structural basis of ‘risky’ sexual behaviours (Chan & Reidpath, 2003), various personal, social and structural factors have been identified as affecting (Westerners’) sexual health, mostly in terms of whether individuals practice ‘safe sex’ or engage in risky practices. Personal factors include drug and alcohol use (Boyer, Tschann, & Shafer, 1999; Millstein & Moscicki, 1995; Roberts & Kennedy, 2006; although see Weinhardt & Carey, 2000), self-efficacy (Boyer et al., 1999) and assertiveness (Roberts & Kennedy, 2006), perceived susceptibility (Roberts & Kennedy, 2006), number of partners and age at first intercourse (Williams & Davidson, 2004), pleasure as a reason for sex (Hoffman & Bolton, 1997), and lack of, or inconsistent, condom-use (e.g., Roberts & Kennedy, 2006). An avalanche of research has identified diverse dislikes of, and

reasons for not using, condoms among heterosexuals (e.g., Flood, 2003; Hillier et al., 1998; Khan, Hudson-Rodd, Saggars, Bhuiyan, & Bhuiya, 2004; Willig, 1995). Social and interpersonal factors include parental and other social support (Boyer et al., 1999; Millstein & Moscicki, 1995; Roberts & Kennedy, 2006; Williams & Davidson, 2004), parent-child sexual communication (Hutchinson, 2002; also Williams & Davidson, 2004), peer norms, behaviours and affiliation (Boyer et al., 1999; Millstein & Moscicki, 1995), including gendered roles and expectations (e.g., see Wight, Abraham, & Scott, 1998), and the experience of partner violence (Silverman, Raj, & Clements, 2004) or sexual abuse (Upchurch & Kusunoki, 2004). Structurally, school sexuality education has been associated with reduced risk (Wellings, Nanchahal, Macdowall, McManus, Erens, Mercer et al., 2001; see also Williams & Davidson, 2004), but it can be contentious, politically charged practice (e.g., Irvine, 2002). Socioeconomic factors and sexual health service access and provision may also be influential (Williams & Davidson, 2004).

Method

This paper analyses focus group discussions from 'young' lay New Zealanders, collected as part of a broader qualitative project on discourses of sexual health. Participants in the research were asked for their views on why Aotearoa's sexual health statistics are (comparatively) poor. The primary focus was heterosexual sex, and STIs other than HIV, as (a) the incidence and prevalence of HIV in Aotearoa is relatively low, and, until recently, had primarily remained among men who have sex with men ("HIV and AIDS in New Zealand - 2006," 2007), and (b) many other STIs are far more common. Many of these, especially if untreated, have potentially significant personal and population health impacts, mostly for women, including infertility, pelvic inflammatory disease, cancer, and ectopic pregnancy ("Sexually Transmitted Diseases & Women's Health," 2002; Williams & Davidson, 2004). Fertility has been recently characterised as a 'third' protection that practices of safer sex can offer (alongside preventing STIs and unwanted pregnancy) (Brady, 2003).

As the primary interest was in local discourses of sexual health and risk, the project recruited anyone aged 17 to 35 who had experience of heterosexual sex, spoke English and had lived in Aotearoa for some time. Participants under 35 were targeted as, although older populations are increasingly seen as 'at

risk' for STIs (Shepherd, 2007a), those under 30 have far higher rates (STI Surveillance Team, 2007). In total, 58 participants (65% [38] female) aged between 16 and 36 (mean age 25) took part in 15 group discussions. Participants were recruited through advertising, word of mouth, and snowballing. Two individuals were hired specifically to recruit participants from their broad social networks. This was the most successful recruitment strategy; advertising the least. Participants chose whether they wished to be in single or mixed sex groups, and with friends/acquaintances or strangers. Six groups were female only, three were male only, and the remaining six were mixed; approximately half were friends/acquaintances. Participants in almost all groups (14) resided in the Auckland region (Aotearoa's largest city); the others resided in Hamilton (Auckland's closest city) (see Table 1).

Demographic information was collected by individual questionnaire at the end of each group. The majority identified currently as heterosexual, and all had experiences of heterosexual sex. Their average number of sexual relationships (self-defined) was six; the average number of sexual partners was over 12. Seventy-five percent reported that they had engaged in casual sex at least once. Virtually all talked about engaging in unsafe sexual practices (e.g., intercourse without a condom, not knowing STI status of partner or self) at some point, and 73% reported at least one sexual health 'check'. Twenty-five percent reported at least one known STI, and of these, 27% (4 participants) reported more than one. This figure for STIs is slightly higher than that reported in a large-scale Australian survey, where 20% of men and 17% of women reported ever having had an STI (Richters & Rissel, 2005). Almost all (89%) participants identified as Pākehāⁱⁱ/European, and most had lived in Aotearoa for the majority of their lives. The ethnicity of participants does not match the ethnic diversity of Aotearoa (Spoonley, Macpherson, & Pearson, 2004); most were members of the ethnic group that is politically, socially, economically and numerically dominant. Most were working.

[INSERT TABLE 1 ABOUT HERE]

Focus groups were moderated by the author, and took place either at the University, or in participants' homes, and lasted from approximately 1 hour to over 2 hours. Discussion covered a range of topics, including: ideas and meanings around having sex, what sexual health is, knowledge of STIs and STI prevention, factors associated with unsafe sex, Aotearoa's STI statistics, and ideas

about sexual health promotion. All discussions were audio-taped and transcribed orthographically. Thematic analysis within a constructionist framework (see Braun & Clarke, 2006) was employed to analyse talk pertaining to why Aotearoa's STI rates are so high. The analysis was influenced both dominant traditions of discourse analysis within psychology (Wetherell, 1998). Relevant sections of data were collated and coded and re-coded into themes. Names and other identifying features were changed; in most cases, participants chose their own pseudonyms. Quotes have been edited to facilitate reading ease; emphasis is the participants own, unless indicated otherwise.

Results

Participants were presented with a range of statistics about Aotearoa's STI and sexual health status, in comparison to our past, and to other countries, and asked to discuss their perceptions on why Aotearoa might have such (comparatively) poor/high statistics. In some groups, responses were quick and rapid; in others, they struggled to explain our sexual health statistics. The majority of participants engaged in detailed discussion of possible explanations. As the question focused at the population level, responses also tended to focus on the national level factors, rather than on individual factors. Explanations were coded into two main, but overlapping, themes: national socio-structural explanations (which encompassed factors including sexuality education, health service provision and general national safety issues), and national 'identity' explanations. The latter offer a comparatively unique account in sexual health discourse, and as this theme they predominated, *and* space excludes a detailed analysis of both, national 'identity' explanations are focused on here. The in-depth analysis of one particular theme within a dataset is one approach within thematic analysis (Braun & Clarke, 2006).

'National identity' explanations - "it is just like a cultural thing?"

The explanations categorised as national 'identity' related to dimensions of the purported cultural *character*, and associated behaviours, of New Zealanders. They spoke to who 'we' are, as a people. The sub-themes identified were: Aotearoa's drinking culture; New Zealanders as poor communicators; New Zealanders as conservative but highly sexual; and the "laid back" Kiwi persona

(Kiwi is a colloquial term for New Zealander) with a “she’ll be right” (‘everything will be ok’) attitude, meaning we do not worry about things that can or do go wrong. In some instances, the identification of a unique and specific ‘cultural character’ was straightforward; in others, the participants struggled to see what made NZ *different* to other places, most notably Australia.

“We’re such a huge drinking culture”

Alcohol (and drugs) was the first reason virtually all members of all groups gave for why people might engage in unsafe sex, and frequently came up in explanations of our sexual health statistics.

Aotearoa was characterised as having a binge-drinking culture, with New Zealanders characterised culturally as heavy drinkers. While this could be framed as a socio-structural account, heavy drinking tended to be framed as part of our ‘culture’, and who we *are* as New Zealanders.

Francesca: like New Zealand in- maybe a cultural thing like, we have quite a binge drinking culture, specially in the teenage population. That may have something to do with it like every weekend getting smashed.

Mike: well there’s a lot of binge drinking going on in most cultures I think (laughing)

Francesca: well I think particularl- oh yeah in a lot of cultures but I think New Zealand definitely, than say like France who you know have a, you know, red wine at dinner and sort of spread it out more than binge drinking (FG11)

Francesca constructed a particular cultural practice, binge drinking, and when Mike disputed the *particular* unique status of Aotearoa as a binge drinking culture, the status was reasserted, through reference to France, and a construction of ‘spread out’ drinking. Aotearoa was often contrasted to European countries, or even North America, in accounts of a binge drinking culture. In the following quote, the link with sexual risk is made explicit:

Diana: New Zealand has quite a high, I mean again if you compare us with European countries, where people don’t drink to excess, as it’s not part of their culture as it is in New Zealand, and I mean, yeah okay who hasn’t had, you know, had a few and then gone home and just like screw it whatever let’s just go for it, you know (FG14)

These accounts situate drinking with a particular cultural context, as something unique to New Zealanders (or certainly not universal), and often invoked, if not actual pride, then a lack of concern about this identity and practice. Participants' accounts of New Zealanders as binge drinkers maps onto drinking pattern data: binge-drinking has been identified as a key problematic pattern of drinking (www.alac.org.nz), and 'hazardous' drinking is prevalent among New Zealand youth (Kypri, Langley, McGee, Saunders, & Williams, 2002). The nature of drinking in Aotearoa has been targeted in the last few years in a nationwide public health campaign: "it's not the drinking. It's how we drink" (<http://www.alac.org.nz/CampaignItsNotTheDrinking.aspx>).

In terms of sexual health, the enculturated New Zealander here is one who drinks heavily, and with that drinking, loses the ability to make 'responsible' sexual choices, resulting in high rates of STIs. The implication is that without alcohol, we would be sexually 'responsible,' although this idea is challenged by other accounts of the Kiwi character. The normative nature of this behaviour in Aotearoa is articulated in the last lines of Diana's extract above. Diana constructs this as the sort of behaviour that anyone drunk would do at some point: since New Zealanders are, through our culture, *naturally* positioned as binge drinkers, this behaviour is framed as normative and understandable.

New Zealanders are poor communicators

Another claimed aspect of the New Zealand 'character' was a lack of communication about personal matters like sex. In various ways, New Zealanders were constructed as having no desire and no ability to talk about "hard issues":

François: maybe that's why New Zealand does have a higher rate because New Zealanders have been notoriously closed people at like discussing hard issues like that I think we're not very up front

Oliver: good point

Jay: it's not that we don't carry through and act on our impulses around that, like we'd still have sex but, for some reason we find it difficult

Oliver: to discuss intimate things like that I don't know if other cultures are better at that but

Jay: between the boys it's all good you know

Voight: yeah yeah

Oliver: but ah, maybe not so comfortable with the girls

Voight: yeah that's a good point (FG5)

While these close friends invoked a gendered 'mateship' where communication was possible about sex, cross-gender communication - with a real or potential sexual partner - was framed as more complicated. The idea of the difficulty of sexual communication is not new (e.g., Pliskin, 1997); here it is framed not as an individual character, but a national one, and not just limited to sex:

Sandra: definitely I think that's a factor that we, that there is this kind of 'head in the sand she'll be right mate' and also, other qualities of the Kiwi persona like, still a lot of people are unwilling to discuss private matters or, you know, personal things, and there's kinda this stoicism too, that you gotta be tough to tough it out (FG10)

Sandra disputes the idea that it is simply our laid-back identity (discussed later) that results in poor sexual health statistics. Instead, she offers a range of other personality aspects, including a lack of communication about personal matters. She also alludes to a type of national character, characterised by stoicism and unemotional toughness, which contrasts with communication and help-seeking behaviour. It invokes what is colloquially often identified as 'man alone' (C. Bell, 1996b), in reference to a seminal piece of New Zealand fiction (Mulgan, 1949), a character with a long history within New Zealand's (Pākehā) cultural imagination. While strongly gendered 'masculine', this personality is not limited to men (see Bannister, 2005), and is, in these accounts, applied to all.

This account of the (strong, silent) poor communicator suggests that the opposite - open and honest communication - is necessary for sexual health, and communication is espoused within sexual health promotion. However, at the same time, it demonstrates the complexity and difficulty of communicating about sex *with a sexual partner*.

New Zealanders as conservative (but sexually 'extreme')

Participants frequently produced an account of Aotearoa as a conservative country with conservative social values, but at the same time, its inhabitants as somewhat sexually active, or 'extreme'. This

was best captured in the following long quote, which also nicely demonstrates the co-construction of accounts and meanings, a feature and strength of focus group research (Wilkinson, 1998):

Brandon: the only perception I have with New Zealand, sexually, and just comparing it to, you know, what you see overseas, it's going back to what I said before, we just seem very conservative about it so you know when something like that does happen, you know, it's not really something you like talking about, you know, and that may be why the abortion rate's so high [...] it's almost the shame factor behind it, or I'm not too sure but it just. I know we are a very conserva- we seem like a very conservative country like that (sex) is not something that people-

Jason: my impression is that although there's a sort of conservative, ah, attitude, when it comes to broadcasts like TV, and print, and the media, that like in actual fact people generally are extremely sexually active and

James: and laid back about it

Jason: and really laidback about it like it's just no big deal it's just, you know, meet someone you go home with them you have sex it's just normal, like everyday, the majority of people are doing it, and it's

Brandon: shaking hands

Jason: yeah it's like, it's really not much beyond shaking hands or, you know

Brandon: mmm, as trivial as that

Jason: yeah, it's just like, like casual sex it's just, that's it, it's casual, it's just no big deal and (pause) so kind of the opposite of conservative, like just, really, really I don't know if you'd call it liberal but really laid back about it and 'she'll be right', you know, it's like a New Zealand kind of thing, it's like 'oh whatever', you know, it's no big deal, it's just

Dylan: my opinion on New Zealand is from just from what I've seen in travelling a little and stuff in general I think we seem, we come across quite conservative but I actually think we're quite extreme in a lot of ways, in sex, in a lot of things, it's just not really talked about **(FG7)**

Here, we find an account of New Zealanders as conservative, but at the same time, treating sex as an extremely casual event, as “no big deal” (lack of communication and ‘laidbackness’, discussed next, are also evident). These contradictions are framed as existing simultaneously, so the account becomes one of cultural opposition and extremes - at both ends of the spectrum. This construction of New Zealanders as both conservative and sexually ‘extreme’ matches (or reflects) the findings from the 1996 NZ partner relations survey which found ‘a dominant pattern of sexual conservatism’ (more so than UK or USA) although there was “clear evidence of a trend towards greater diversity and experimentation in personal sexual choices” particularly among the young (P. Davis & Yee, 1996, p. 57). Sexual conservatism was evidenced by factors such as numbers of sexual partners, rates of intercourse before marriage and age of first intercourse, and increased sexual liberalism by reported levels of engagement in ‘non-standard’ sexual practices such as oral sex. Recent media coverage reporting on the sexual practices of youth headlines them as “young, promiscuous and unsafe” (Shepherd, 2007b, p. 25).

This ‘casual’ Kiwi attitude to sex was further articulated later:

James: I’ve got a friend living in the States and they say that dating is really big over there, and you get to the second or third date or you kind of expect to have sex [...] they’re really big on going out on dates with lots of different people, but whereas in New Zealand there’s just no such thing as dating really, you go to a party and

Jason: you go to a party and you get laid (laughter) or you go to a club and get laid, or you go to a bar and get laid, there’s no

Dylan: it’s usually, and first dates you usually get laid (laughter) [...] it depends on the girl, but it’s not (slow)

James: but it’s not unusual though-

Dylan: it’s not unusual no

James: to meet someone and go to bed you know it’s that’s kind of accepted. And I think also the university scene really helps that a lot, ‘specially if you’re living away from home, say you go

to Otago [university] you know, that's what they do down there, you know, they get drunk and they get laid, that's (laughs) that's what they do (FG7)

This culturally-located approach to sex, often particularly associated with younger generations, encompassed a casual attitude to sex, and willingness to engage in sex very early on in a 'relationship', particularly on the part of men (women are the ones who decide when sex happens in this account - they remain the gendered gatekeeper's of [male] sexuality). Casualness is further emphasised by reference to an easily culturally recognised 'extreme' case - students at the University of Otago, who have a reputation for heavy drinking and irresponsible behaviour (so much so that the university recently adopted a controversial code of conduct which applied to both on- and off-campus behaviour; http://www.otago.ac.nz/news/news/2006/12-09-06_press_release.html). This 'casual' approach to sex fits within a wider cultural casualness associated with social interactions in Aotearoa (e.g., a visitor may arrive at a house without prior warning, and be genuinely welcomed).

It also encompassed high levels of sexual activity and desire:

Hermione: [...] I'm not sure I don't really have any idea why we have [STIs] so high

Gertrude: neither

Bob: just the way the cookie crumbles [...]

Hermione: we're just so damn horny (laughter)

[...]

Gertrude: we're just young hippies (laughter) free love (FG12)

Although Bob, Gertrude and Hermione suggest they have 'no idea', they offer an explanation based around an idea of acted-on high levels of sexual desire and sexual 'promiscuity'. Based on accounts such as these, sexual practice in Aotearoa operates within two competing pressures: on the one hand, a cultural conservatism around sex (possibly linked to 'poor communication'); on the other, a norm of sexual 'freedom', in which sexual activity is mundane and common-place. The national character of youth, within these accounts, is predominantly the latter, but infused with the former.

The implication for sexual health promotion is that people will be having sex, frequently (and casually), but not necessarily openly, and not necessarily communicating with their sexual partner(s).

'We're very laid back people'

The final national identity explanation - invoked spontaneously in a number of groups, and discussed in a number of others - revolved around what can be characterised as a core element in the "Kiwi persona" (Sandra, FG10): a laid-back, "she'll be right and no worries" (BK, FG2) attitude. The following two extracts illustrate this point:

Researcher: what I'm interested in is kind of why you think it might be, why do you think it's so bad here?
Any ideas?

Mandy: the whole 'she'll be right' attitude. It won't happen to me

Jenna: yeah everyone thinks that the grass is always greener in New Zealand, and so it's like

Pierre: yeah, kiwi people are sooo laid back compared to other countries, we're just like 'oh yeah you'll be sweet mate' (Jenna: (laughs)) get out of it eh [...]

Jenna: [...] everyone's just like 'nah it doesn't matter'

Pierre: (I won't) get chlamydia (FG6)

In one group, this was explicitly framed around the concept of a national sexual identity:

Melanie: ['double Dutching's'ⁱⁱⁱ] an awesome trend [...] so maybe that does go some way to supporting (like the idea of a) national sexual identity, and I think if you were gonna summarise New Zealand's, then I think that's probably quite apt [...] 'she'll be right', 'fix it later' (FG15)

The articulation of this particular national (sexual) character was strong in the groups, and seemed to exist as an easily-available resource participants could draw on to explain poor sexual health statistics. This account of New Zealanders does seem to operate as a (Pākehā) cultural truism: The editor of the national weekly magazine *The New Zealand Listener* identified that "New Zealanders might be characterised as having a laid-back national psyche" (Stirling, 2005, p. 5, although she then disputed it). As befitting something identified as a *national* psyche, differences in ethnicity, class, and gender, were erased in such accounts.

While participants invoked this identity to account for our poor STI statistics, the identity itself was explicitly framed positively by a number of participants (and was subtly constructed as positive in other ways, as was binge drinking - for instance, the account of such 'risky' behaviours as 'laid back', rather than 'irresponsible'). For instance:

BK: 'she'll be right' and 'no worries' is pretty much a New Zealand motto

Kimberly: it is yeah

Sam: it's great though, it's so good

BK: and that could just be it, you know what I'm saying

Kimberly: it's good yeah it's really good in most senses, but it does I mean the other side of that coin is complacency and, you know, I mean it's great to be positive and, you know, optimistic, but you can't sort of- (FG2)

This 'positive' identity was thus constructed as a mixed blessing by some, and needing to be tempered with 'realism' about sexual risk.

I wish to draw attention to two inter-related aspects associated with this account of a laid-back sexual identity. First, there was the construction of the self as implicitly *safe* through this identity. This safety was evoked in the idea that "oh it won't happen to me" (Jay, FG5).

Researcher: it seems [...] that you guys [...] generally not that concerned about STIs as something you could catch would catch

Pierre: nah

Researcher: umm

Jenna: oh well they say it's like [...] New Zealand is one of the most like, popular place for chlamydia or something but you know you just don't believe it it's just like 'nah I'm not gonna get it' (FG6)

In that account, whatever sexual risk exists might happen to others, but the individual does not need to worry about him/herself. Second, at a cultural level, there was an idea also evident in the above quote that STIs are not seen as something to particularly worry about. Participants referred to "such

easy cures” (Hermione, FG12) for STIs, and the perception that “you can go and get antibiotics and boom it’s gone” (Arnold, FG2), suggesting that (most) STIs are not seen as seriously impacting health and wellbeing. As one participant suggested, they are not something to be even *complacent* about:

Brandon: I don’t think it’s even complacency I mean complacency is knowing that there’s a risk and not really caring it’s almost [...] we tolerate it because it’s common, it’s trivial, it’s just, it’s not even something you need to be complacent about I think that seems to be a lot of the attitude with people it’s just not even something that’s, you know. It’s like getting a cut

James: like it doesn’t even register (FG7)

This national identity explanation for Aotearoa’s poor sexual health statistics invokes a national character at odds with the dominant framework of public health promotion messages in the last decades, which have tended to be about the identification of risk on an individual level, and the alteration of individual behaviour to protect the self from that risk (e.g., www.hubba.co.nz).

These accounts which construct a national (sexual) *identity* to explain New Zealand’s poor sexual health statistics invoke sexual subjects as enculturated subjects, making ‘choices’ and ‘decisions’ on the basis of their cultural practices and identities, rather than an independent rational agent (who is the assumed subject of much HIV/STI prevention work, Chan & Reidpath, 2003; M. Davis, 2002). They present a picture of ‘Kiwi culture’ and the ‘Kiwi character’ - both around sexual health, and in general - that informs these choices, and which works against sexual health (promotion) as it has been traditionally conceptualised. They construct us as sexually ‘irresponsible’ citizens, unable to communicate, but more than willing to ‘fornicate’. In such a ‘laid back’ culture, responsibility and concern are potentially constructed as overcautious and the behaviour of someone ‘uptight’. The important consideration for sexual health promotion is the way in which they work to situate this lack of ‘responsibility’ around sexual safety as just part of our ‘nature’, as Kiwis. In these accounts, the New Zealand sexual subject is not fully a sexual *subject*, he or she is without *full* agency of his or her own practice, because culture precludes this.

Discussion & Conclusions

When asked to account for Aotearoa’s sexual health statistics, participants in this research provide explanations that tended to fall within two main categories: socio-structural, and national identity or

character ones, discussed here. The accounts echoed Singer et al.'s (2006) identification of a "cultural logic" (p. 2017) of sexual risk assessment among a specific US population, which made sense of patterned sexual practices that resulted in higher levels of STIs in their particular population and context. The cultural logic was produced by the interpersonal and socio-political life histories of their participants, and they argued for the need to recognise 'ecosocial' and psychosocial factors, and move away from primarily considering factors like 'individual irresponsibility', in STI prevention campaigns. My participants similarly invoked a (different) cultural logic around sexual risk and safety, located within recognisable (Pākehā) cultural identity narratives. It is positive that socio-cultural explanations tended to be offered; they recognise that sexual health occurs, for individuals, embedded within social contexts, both broad and narrow (Shoveller, Johnson, Langille, & Mitchell, 2004; Singer et al., 2006); meaning-making and practices around sex are always going to be culturally-specific (Schalet, 2004), affected by cultural, social, and structural factors (Chan & Reidpath, 2003; Williams & Davidson, 2004).

Before considering the meaning and implications of these accounts, it is worth noting 'absences'. First, an explanation that 'people are not having safe sex' was typically not provided. This seemed to be taken-for-granted, and a 'deeper' level explanation for why safer sex is not happening was required. Second, *individualised* explanations tended not to be given. Participants did not construct an aggregate of *individuals* engaging in risky sexual behaviour as responsible for the STI statistics. This contrasts with much lay accounting around health, where individual responsibility is a pervasive feature, and socio-structural accounts tend to be neglected (Blaxter, 1997). Instead, in focusing on the national level, with *group* identity, behaviour, and socio-structural factors, the locus of blame and responsibility was moved from a few (or many) irresponsible individuals, and became constructed as a problem for the nation as a whole, and for us as members of that. This may in part reflect the question - participants were asked to explain national-level statistics and theorise international comparisons. This draws attention to the need for researchers to think carefully about the questions we ask, for the response possibilities they open up and/or close down (see Blaxter, 1997; Radley & Billig, 1996, on the importance of questions and context). Regardless of the influence of the

question, if these national identity explanations exist as apparently readily available discursive resources for understanding sexual health statistics, they presumably also exist as readily available discursive resources for understanding, and for shaping, *individual* ideas and practices (Gavey, 1992; Wetherell, 1998) - the things that produce *national* statistics. Therefore, it is worth considering whether, and how, they may be useful for sexual health promotion.

The third notable absence was that these identity explanations tended to be gender-neutral. The accounts were overwhelmingly of *New Zealanders*, not of New Zealand men or women. By its absence, gender was framed as irrelevant; it is how we *all* are, in this nation. This contrasts strongly with research which continues to demonstrate that sex and sexual health remain strongly gendered domains (e.g., Holland, Ramazanoglu, Sharpe, & Thomson, 1998; Shoveller et al., 2004; Woollett, Marshall, & Stenner, 1998). Although there was some associating of sexual risk with particular (ethnic or socioeconomic) groups, for the most part this account of 'our' national identity tended to be un-raced, and un-classed, as well as un-gendered, although it actually reflects a predominantly *Pākehā* national identity.

Finally, these accounts around sexual health tended not to be about blaming others, but accounts of inclusion - the national identity participants constructed was something they situated themselves within. The accounts were typically of 'we', not 'them'. They did not locate themselves outside the causes, or the 'blame', that implicitly goes along with the explanation; they were implicitly situated as as personally culpable as anyone else; they situated themselves as part of the problem. This is perhaps not surprising, as the majority identified as *Pākehā*. However, national-level accounts also work to displace, and even remove, *individual* responsibility and blame because we, as individuals, simply act according to the dictates of our culture (and the resources it provides). It is not really a choice, it is just who we are, and we are all doing it. Indeed, engaging in 'unsafe' sexual practices is constructed as a normative, and thus not a blameworthy, event. It could be theorised as a process of resisting the moral imperative around health (Blaxter, 1997), through framing this as impossible. Perhaps this also has something to do with the almost 'positive' aspects of these accounts (as noted earlier) - that this particular national identity carries a sense of pride.

I theorise that participants drew on culturally available resources for making sense of these statistics (Wetherell, 1998), and the stories told were both similar and different to the explanations offered in expert discourse. The accounts provided fit most clearly within three categories identified in expert discourse: knowledge/sexuality education (not discussed in this paper), risk associated with alcohol and other drug consumption, and 'cultural attitudes', which seems to map onto the idea of national identity explanations. However, they do not appear to be *quite* the same thing as cultural attitudes; instead, 'national identities' are embodied, lived and experienced to the extent that individuals cannot easily act outside them - they are *who they are*.

What are the possible implications of these constructions for sexual health promotion? National identity accounts can be examined in terms of the positives and negatives they potentially offer, through the identities and responsibilities available to the individual within this account. These explanations offer a potential lack of individual culpability, and potentially responsibility, for sexual health practices, as we are the products of our culture. These accounts effectively construct sexual safety as 'un-Kiwi': in these accounts, to be a 'Kiwi' is to be laid back, to like having (lots of) casual sex, but not feel comfortable talking about it, and to have little concern for STIs. If we consider the way language and discourse can work as regulatory ideals which construct norms and practices, and produce subjects and their desires (Gavey, 1992), then the pervasive discourse of the laid back Kiwi potentially works strongly against individuals constructing identities in which sexual responsibility and safety is a valued priority (particularly in the face of others who might embody desires and practices more in line with this seemingly dominant account).

This account constructs Aotearoa's sexual health statistics as unlikely to improve: if New Zealanders are too 'laid back' to care about safer sex, particularly if we are drinking, individual campaigns to promote such behaviour is framed as somewhat futile. Of course, this is only one narrative, and national individually-oriented behaviour change interventions continue to be implemented (e.g., www.hubba.co.nz). Given the risks associated with STIs (Williams & Davidson, 2004), and the fact that in other countries, rates are far lower, the question becomes how the knowledge gathered here can be mobilised productively in work towards sexual health. Can we use such interventions to

develop a different practice (and, perhaps, identity) to shift towards a position where New Zealanders would make comments similar to a Dutch man who observed that ‘having sex without a condom seems as wrong as driving through a red light’ (cited in Williams & Davidson, 2004, p. 99)? At the present time, such sentiment seems almost unthinkable in Aotearoa.

What these national identity accounts suggest is that (hetero)sexual health change will require national identity change, or engagement with the national identity meanings invoked here. It is not simply a matter of putting resources in to individually-focused campaigns; to get our STI rates down, we need to address the “cultural dimensions of behavioural experience” (Pliskin, 1997, p. 102) - in this case, the heart of the ‘Kiwi character’, and (Pākehā - and potentially other) New Zealanders’ investment in that identity. This is an extension of the recognition and incorporation of social norms and contexts into sexual health promotion campaigns (Wight et al., 1998), but goes beyond the idea of health promotion that includes or is oriented to specific ethnic groups (although this is very important too, in a country with an ethnically diverse population). It forces us to ask questions about the way our national identity is constructed (and reconstructed) and, indeed, to unpick the ‘truth(s)’ of our nation/nationhood, itself imagined, created and continually reiterated (e.g., Anderson, 1991; Billig, 1995), and intimately reciprocally linked to constructions of national *identity*.

Given that the task of reconstructing a national character around sexual ‘safety’ and responsibility is an enormous and potentially difficult one, how might we engage with, and use, these meanings within this framework for sexual health promotion? Aotearoa has a precedent in public campaigns which have invoked national-identity to promote individual change, in an anti-littering campaign from the 1970s, which centred around the phrase ‘be a tidy Kiwi’. This campaign was recently re-invigorated as “Come on: be a tidy Kiwi” (http://www.beatidykiwi.org.nz/tidy_kiwi_campaign.html) for a 3-year Auckland-region campaign. It invokes a community-orientation to an individual practice, situating ‘good’ practice (tidiness) as about more than the individual.

The results from my research suggest that considering such an approach could be worthwhile for sexual health promotion, invoking positive national identities to encourage individual (safer sex) practices which are located as consequential for communities as well as individuals. However,

further research exploring the intersection of national identity, other cultural-contextual factors, and sexual practices and desires, would clearly be necessary. My study is limited by a relatively small, largely ethnically homogenous, convenience sample, and so cannot be generalised to all New Zealanders. It also specifically targeted a younger population, as they predominate in both STI statistics (STI Surveillance Team, 2007) and sexual health campaigns (although see Shephard, 2007a). Therefore research with a broader, more diverse sample is necessary. Another interesting factor to explore is if, and how, national identity explanations appear when individual practices, rather than national statistics, are in question.

Notes

ⁱ Reflecting socio-political changes in the last few decades which have seen increased recognition and rights for Māori (the indigenous population) within New Zealand's social and political environment, as well as the status of te reo Māori (the Māori language) as an official language, Aotearoa is now commonly used as a Māori term to refer to New Zealand.

ⁱⁱ Pākehā is a Māori term used to refer to New Zealanders of European ancestry (in contrast to Māori, and New Zealanders of other ancestries [e.g., Pacific, Asian]), and more specifically those born/raised in Aotearoa. Somewhat contested, not all Pākehā choose to use this ethnic identifier; when used, it signals an ethnicity specific to this socio-political and geographic location (see A. Bell, 1996a; Fleras & Spoonley, 1999).

ⁱⁱⁱ Double Dutching refers to the safer sexual practice of using a condom *and* the contraceptive pill to reduce risk of pregnancy and STI transmission (Williams & Davidson, 2004).

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Table 1: Focus group details

Group	Number in group	Age range	Sex	Status	Location
FG1	3	26-27	Mixed	Friends	Auckland
FG2	5	22-28	Mixed	Friends	Auckland
FG3	3	24-33	Female	Strangers	Auckland
FG4	4	22-29	Female	Strangers	Auckland
FG5	4	24-25	Male	Friends	Auckland
FG6	3	17-32	Mixed	Friends/strangers	Auckland
FG7	4	25-29	Male	Friends	Auckland
FG8	4	26-32	Mixed	Strangers/acquaintances	Auckland
FG9	5	16-20	Female	Acquaintances	Auckland
FG10	3	23-30	Female	Strangers	Auckland
FG11	6	22-36	Mixed	Friends/strangers	Auckland
FG12	3	19	Mixed	Friends	Hamilton
FG13	3	22-23	Male	Friends	Auckland
FG14	4	30-36	Female	Friends/acquaintances	Auckland
FG15	4	22-23	Female	Friends	Auckland