Social Science & Medicine 67 (2008) 1817–1825

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

"She'll be right"? National identity explanations for poor sexual health statistics in Aotearoa/New Zealand

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ARTICLE INFO

Article history:
Available online 10 October 2008

Keywords:
Aotearoa/New Zealand
Sexually transmitted infections (STIs)
Sexual health
National identity
Lay accounts

ABSTRACT

The sexual health statistics around sexually transmitted infections (STIs) in Aotearoa (New Zealand) suggest two things: many STIs are increasing, and the 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 years (mean age 25) took part in 15 focus group discussions related to sexual health. Participants were mostly Pākehā (of European ancestry) 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 the 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.

Aotearoa[1] 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 sexually transmitted infection (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 & Hay, 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 et al., 1993; Pawluch, Cain, & Gillett, 2000). Variously referred to

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[1] 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.

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doi:10.1016/j.socscimed.2008.09.022

as lay beliefs, lay knowledge or lay 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, Saggers, 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 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 17–35 years who had experience of heterosex, spoke English and had lived in Aotearoa for some time. Participants under 35 years were targeted as, although older populations are increasingly seen as 'at risk' for STIs (Shepheard, 2007a), those under 30 years have far higher rates (STI Surveillance Team, 2007). In total, 58 participants (65% [38] female) aged between 16 and 36 years (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