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# Structural Impediments to Sexual Health in New Zealand: Key Informant Perspectives

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**Abstract** New Zealand's bacterial sexually transmitted infection (STI) rates are considered the worst in the OECD. Policy within New Zealand (NZ), as in many Western countries, often takes a particularly individualistic approach to reducing STI rates, but this has proved unsuccessful. This paper presents a thematic analysis of interview data from 32 key informants working in sexual health in NZ, talking about sexual health problems and solutions. Focusing typically on structural explanations, informants identified a large gap between 'best practice' and actual practice in NZ. They referred to the interaction between a lack of government prioritisation and a 'sexually conservative' culture in New Zealand as lying at the heart of this. Informants advocated for a long-term programme of government leadership and a cultural 'shift' in approaches to, and research on, sexual health. To do so, key informants consistently constructed an account of 'competing rationalities'—or the notion that policy makers, and those that work in the 'frontline' of sexual health are operating within two opposing paradigms, and that the 'culture of conservatism' they described was limiting dialogue between the two 'sides'.

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## Sexual Health as a Public Health Issue in New Zealand

New Zealand's (NZ's) statistics for rates of sexually transmitted infections (STIs) are not good. Despite limits in the statistical data (Baker et al. 2005a; STI Surveillance Team 2011), primarily as a result of STIs, other than HIV, not being notifiable in NZ (Johnston et al. 2005; STI Surveillance Team 2011), it has been claimed that NZ has one of the highest rates of chlamydia worldwide. The available statistics indicate that rates of chlamydia trebled between 1998 and 2008 (Morgan et al. 2011), and at 782 per 100,000 population, are currently the highest recorded in the OECD (STI Surveillance Team 2011). The NZ incidence is four times that in Australia or in the UK, twice that in the USA (Morgan et al. 2010a; STI Surveillance Team 2011). Another bacterial infection, gonorrhoea, shows a somewhat similar pattern—roughly twice the national rates observed in Australia but lower than US rates (STI Surveillance Team 2011). Rates for viral STIs like the human papilloma virus, and genital herpes, are also high, and show an upward 5-year trend (STI Surveillance Team 2011).

The consequences of STI infections compound the health significance of infections like chlamydia. Bacterial STIs are often asymptomatic, yet can have long-term, and sometimes permanent, impacts on reproductive health (Williams and Davidson 2004). Alongside increased antibiotic resistance (Azarish and Perkins 2007), these impacts beyond the sexual locate sexual health as an important public health concern. These, overall high rates of STIs, and the trend of increasing incidence, have led for calls for sexual health to

be a higher priority for national health services and policy making (Baker et al. 2005a; Braun 2008; Morgan et al. 2011; Perkins 2004; STI Surveillance Team 2011). Yet the general trend of increasing STIs do not seem to have been met with any significant public health policy or practice shifts to prioritise sexual health in the New Zealand context (Morgan et al. 2011; STI Surveillance Team 2011).

National guidelines for chlamydia screening (Morgan et al. 2010b) have been produced as a model of 'best practice' in diagnosis and treatment within primary care settings. These guidelines include: identification of candidates, cost–benefits of testing, treatment of various forms of infection and partner management. However, significant gaps remain between the model and current practice in the New Zealand context (Morgan et al. 2010b), and there is no organised screening programmes for chlamydia, nor any other STI (Morgan et al. 2011; Paul et al. 2009). This contrasts with the UK, Australia and the USA, where notification and reporting of STIs became part of bacterial STI surveillance (Baker et al. 2005b; Christophers et al. 2008; Johnson et al. 2005). More generally, the UK government's funding, prioritisation and long-term sexual health strategy have led to optimism among policy makers about STI rate reduction (Christophers et al. 2008). Although the NZ government allocated NZ$7.3 million in 2011 for new sexual health initiatives, including sexuality education evaluation, condom promotion initiatives and community health projects (NZPA 2011), STI reduction and sexual health more generally do not seem to be a government priority. Haphazard and non-continued funding of initiatives also suggests a lack of overarching vision for sexual health. In New Zealand, these have included: a regional programme to allow free youth GP consultations for sexual health and a national condom-use campaign, both of which did not receive ongoing funding, despite showing 'success' (Ministry of Health 2010; TNS Global Market Research 2005).

## Health Policy, 'Risk' and Competing Rationalities

This story of poor sexual health statistics hides the fact that STIs do not affect everyone in the NZ population equally. People from certain sociocultural groupings (e.g. young people, Māori, Pasifika) appear 'overrepresented' in STI statistics (Morgan et al. 2011; STI Surveillance Team 2011). For example, chlamydia and gonorrhoea are highest among youth (i.e. those 15–25), with males most likely to present at 20–24, and females at 15–19 (STI Surveillance Team 2011). As male to female transmission of a number of STIs typically exceeds that of female to male (Price and Hyde 2009), this gendered age imbalance raises questions. Assuming similar ages of first intercourse (Dickson et al. 1998) and primarily heterosexual transmission, it appears that younger women contract STIs from older male partners. Power imbalances, such as those produced by age, experience and resources, as well as gender, can have marked effects on condom usage (Gavey and McPhillips 1999; Gavey et al. 2001; Jackson 2004; Roberts and Kennedy 2006). As such, younger women with older male sexual partners may be particularly vulnerable to contracting STIs.

Despite a recognition of increased risk of STIs within different social groupings, especially at the intersections of race, gender and age, contemporary research and policy focus has continued to focus on individual risk explanations to the exclusion of deeper sociocultural explanations (Braun 2008; Chan and Reidpath 2003; Jackson 2004; Roberts and Kennedy 2006; Williams and Davidson 2004). Not making significant changes to address reasons for increased vulnerability among certain social groupings does little except ratify certain groups as 'problematic' (Hodgetts et al. 2004), which potentially further increases their vulnerability (Chan and Reidpath 2003).

In a climate where reduction in health priorities and funding cuts in the health sector predominate (Prince et al. 2006), the key framework for addressing sexual health is a model of individualised risk and responsibility. Individualised health rhetoric is predicated on social psychological models of reasoned action, planned behaviour or health belief (Downing-Matibag and Geisinger 2009; Gough and Robertson 2010; Sloan et al. 2010), with an implicit model of the person as an agent who is sexually 'empowered' by the provision of sexuality information, or disempowered by its lack. The concept of a 'health consumer-citizen' still predominates in NZ's health institutions (Prince et al. 2006): the model 'consumer' is a rational, self-maximising, responsible individual who will look after their health (Hodgetts et al. 2004; Prince et al. 2006). Despite theorising that information, provision will lead to self and other protection from risk, this approach has so far not proved effective; individuals with high levels of knowledge about STI transmission may not always avoid 'risky' practices (Allen 2001; Braun 2008; Jackson 2004; Roberts and Kennedy 2006). Moreover, it risks marginalising those affected through an implicit blame model. Individualised risk formulations focus on citizens taking responsibility for the consequences of their choices.

An individualised risk and responsibility focus in sexual health policy can be seen as a 'rationality' or 'logic' that results from both conceptual and structural factors (Colebatch 2002; Coveney 2010). This is, of course, not the only way of conceptualising issues of health and 'risk', and often is not the framework espoused by many stakeholders and researchers in the sexual health field, nor in many cases the citizens subject to it. Public health orientations toward improving sexual health and the ways in which lay people can conceptualise sex, and risk do not always match up (Braun 2008; Corbett et al. 2009; Jackson 2004). The idea of providing sociocultural

scaffolding (Gavey 2005) to *support* individuals' knowledge, and therefore sexual health, might be considered a competing rationality to the model that structures governmental health services. Proponents argue this broader scaffolding disrupts the potential disconnections between public health structures and lay experiences and understandings (Braun 2008; Santelli and Schalet 2009; Swartzendruber and Zenilman 2010).

In this paper, we explore the ways key informants (KIs) discussed sexual health, sexual health problems, and sexual health solutions in NZ. In particular, we focus on their identification of the 'barriers' to improving sexual health as primarily structural and consider the implications for sexual health promotion in New Zealand.

## Method

This analysis is part of a broader project exploring lay and professional views on STIs in New Zealand (e.g., Braun 2008). The current paper analyses qualitative data from semi-structured interviews with 32 KIs working in the area of sexual health and/or education. KIs can provide in-depth knowledge in areas that remain under-researched, offering insights not often obtained through lay accounts (e.g. Braun et al. 2009; Jackson 2004). The data were collected following implementation of NZ's first national sexual health campaign in 10 years, during 2004–2005 (TNS Global Market Research 2005). As there have been no subsequent national sexual health campaigns in NZ, or radical shifts in sexual health policy from government, the data remain relevant to the current context.

The KIs' occupations broadly grouped into: sexual health educators/promoters (eight), sexual health physicians (eight), specialist community/youth workers (five), sexual health nurses (four), management in sexual health (four), researchers (three). The KIs' experience in the area of sexual health ranged between 2 and 40 years, with an average of 12.5 years. All except one (a school peer educator) had tertiary qualifications, which ranged from diploma to doctoral level. The KIs' ethnicities varied: Pākehā/NZ European (20), Māori (six), Pasifika (four), Chinese (two), and all had experience working in their respective ethnic communities. The participants were purposively recruited with the aim to cover a diversity of perspectives through VB's networks, snowballing from participants and approaching organisations associated with sexual health. Almost everyone approached agreed to participate.

Interviews were semi-structured, lasted between 45 min and an hour and a half; all were conducted by VB. The interviews were audio-taped and transcribed verbatim by a hired transcriber to include hesitations, speech repetitions and overlapping talk. In presenting the analysis, extracts have been edited slightly to ease reading, without altering meaning or inference. The annotation […] indicates that part of the transcript not relevant to the analysis has been omitted.

The interviews produced rich data due to the KIs' insight and expertise. We applied thematic analysis to the data, from a critical realist perspective, which assumes a socially influenced reality (Willig 2001). The thematic analysis process followed Braun and Clarke's (2006) stages, from coding to theme refinement. It was initially inductive and data driven, but later focused on more latent aspects of the data. Although sexual health and 'threats' to sexual health in NZ were explicitly discussed, our analysis went "beyond the semantic content of the data" and started "to identify the underlying ideas, assumptions and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data" (Braun and Clarke 2006, p. 84). Data were initially subject to multiple readings by PF and coded to identify broad themes in the KIs' descriptions of threats to sexual health in NZ. From this first thematic mapping, the data were recoded, and themes identified by examining codes and coded data, to identify broader patterns of shared meaning relevant to the research question by GT in collaboration with VB. The purpose of this analysis was to map out the concerns and issues expressed by the KIs in relation to NZ's sexual health statistics. Despite the diversity of KI backgrounds and perspectives, themes were consistent across the entire data corpus, suggesting that the ideas the KIs expressly articulated or drew on are prevalent among those who work in the sexual health field.

This project was approved by the The University of Auckland Human Participants Ethics Committee. In order to protect the KIs' privacy, significant identifying features were replaced in the transcripts, and each informant chose a preferred professional identifier, which we use in conjunction with their data extracts.

## Results

Despite the diversity of KIs' roles and communities, an overarching theme across the dataset was KIs depicting a clash between 'best practice' within sexual health, and the current practices and policies in place in New Zealand. This clash was regarded as having a direct impact on the lives of young people in particular; young people tended to be positioned within a Western liberal–humanist model of sexual self-actualisation as ideal and as needing information to lead to this point of empowerment. Under this overarching theme, two key themes were identifiable in the ways KIs explained NZs poor sexual health statistics. The themes identified were: (a) best practice needs to be less individualised, with comprehensive sexuality education and (b) impediments to best practice are structural. This second theme contained two subthemes: STI rates not being seen as a national priority

and a sexual conservatism in NZ. The two primary themes were represented by the KIs as combining to create a climate where negative sexual health statistics could 'thrive'.

## Long-Term, Integrated Sexuality Education and Policy as the Ideal

The majority of the KIs spoke of good sexual health being a product of lifelong access to education about sex, sexuality, relationships and health, a perspective in line with WHO guidelines on sexual health (WHO 2011). They argued that comprehensive, 'holistic' sexuality education for youth was lacking in New Zealand and had been for some time. Both parents and teachers were presented as being 'out of their depth' by the vast majority of the KIs and often deferring responsibility to provide sexuality education to someone else. The complexity of different positions around sexuality education, in schools, in the home as well as in sexual communication, is captured in the following quote:

> Some parents will actually say well that's just the school's job you know so they don't even take it on that there actually could be responsibility of the parent to be discussing these things with their kids, and then you also get the ones that don't want teachers to deliver it at all because they don't feel it's the right place, but then they're also not delivering it at home so you know we're going to end up with a population that possibly haven't even got their awareness education so don't even know how to keep themselves safe when it comes to a whole lot of things. And the communication, there's not a lot of education around how to communicate with others about issues when it comes to sexual health. (KI22, Sexual Health Promoter)

KIs consistently argued that a lack of strong consensus on best practice throughout the entire community, combined with other factors, meant sexuality education was typically winnowed down to a bare minimum of information dissemination, delivered in an uneven way. This identified practice was in contrast to the rhetoric of the Education Standards Act (Ministry of Education 2010), which outlines a need for consistent, *quality* sexuality education. One informant, representative of almost all of the sexuality educators, talked about the limited quantity of information delivered:

> The research tells us that you're supposed to provide fourteen hours [per year] comprehensive sexuality education to young people to make a difference and I don't think there's anyone we offer fourteen hours to. (KI6)

The limited time spent on school-based education meant limited scope to approach the issue in the *holistic* manner the KIs seemed to prefer. This meant 'more important' skills, such as broad communication and relationship negotiation training, were often left out of programmes on offer. Their views on this cohere with other research on the provision of sexuality education in the New Zealand context (Allen 2001, 2003a, 2003b, 2008; Jackson 2004). Where information was given, KIs argued that it was often decontextualised and certainly far from the models advocated by researchers like Kirby and colleagues (see Kirby 2008; Kirby and Laris 2009; Kirby et al. 2007), which were often referred to (by name) as 'best practice' by the KIs. Informants argued that many schools' defined provision of information about 'simple' sexual and reproductive 'plumbing' as 'education' despite its distance from the best practice models they subscribed to. Those that were engaged in sexuality education identified funding and schools being overly cautious with regard to parents' expectations as the primary reasons such simplistic models were favoured.

The KIs argued that young people needed far more than these short, simple information sessions. They argued 'real' education should provide greater contextualisation of sexual behaviour within what they often referred to as a 'holistic' understanding of the self and others. They argued that important to this change in perspective was more funding and more access to schools by sexuality educators for longer periods of time. Rather than treating sexuality education as a small part of the health curriculum, it needed to be seen as an investment in the 'whole person'.

This call for a perspective shift to a more *holistic* framework was frequently referred to by the majority of the KIs, irrespective of their professional experience or ethnicity. There seemed to be a standard definition that was drawn on, which informed their responses to questions of what this broader education programme would look like. For instance, when asked what sexual health meant for them, one sexual health promoter commented:

> It's the full realisation of people's sexuality and their ability to express their sexuality in a way without harm to others, but enabling them to reach their full potential sexually. So it's not just the absence of pathology, but also including concepts such as pleasure and being able to maintain healthy sexual adult relationships. (KI2)

This holistic view of young people would often simultaneously draw on several ideas of personhood at once. However, the dominant perspective was primarily a Western liberal humanist understanding of a self-actualising individual who simply needs to right tools and a positive framing of their sexuality to enable their sexual health. In most cases, tools were still defined as information, but provided in the 'right way'. For instance:

> Sexual health is I guess acknowledging that sexuality is an absolutely fundamental part of being human and it's a life-long part of being human and so sexual health is so

> much broader than reproductive health I guess in terms of it's not just about being free of infection and having healthy pregnancies it's about how you feel about your body, how you interact with your body, how you develop relationships, how you develop intimacy, your sense of yourself your sense of how much power you think you have in terms of being able to effect positive outcomes in relationships and interactions with other people. (KI6, Sexuality Educator)

Good education was thus often connected with 'empowerment' by the KIs, and fundamental to individuals making the right choices within relationships, and with regard to their bodies. All of the KIs spoke of a need to shift the focus of education from negative, pathology-based information about sexual health *problems* to a more *positive* framing. For instance, a sexual health physician suggested the aim of sexual health education should be:

> To provide them with best care so that they can have overall positive ideas and positive connections with sexual health, so that sexual health to them is a good thing, a positive thing, and doesn't just mean illness and infection and dysfunction. (KI11)

These KI accounts seem to have much in common with Carmody's (2005) notion of ethical erotics and sexual consent. Carmody has suggested that within a societal context where care *for the self* is emphasised, care *for others'* health and well-being occurs more frequently and 'naturally'. When relationship and negotiation skills are taught to both sexes, the benefits in reducing (hetero)sexual assault have been evidenced as invaluable (Albury et al. 2011; Carmody 2005). By extension, principles emphasising ethical sexual behaviour were seen by the informants to have greater impact on sexual health outcomes than the current models, which KIs deemed largely ineffective. KIs argued that they were trying to decentre the notion of 'vulnerable individual' or the 'risky individual' that they suggested dominates current sexual health policy (Braun et al. 2009) and instead emphasised an understanding of sexual health that fosters communication and self-efficacy. It is worth noting a caution around endorsing any gender-neutral approach to empowerment, as power differences, and even the structuring of 'normal' conversation (see Frith and Kitzinger 2001) can ensure gendered, and other, power dynamics continue to influence practice (Gavey and McPhillips 1999; Gavey et al. 2001). Almost all informants identified that an approach aimed towards training to 'police' individualised practices (i.e. use of condoms, abuse of alcohol) was prioritised over teaching broader relationship and communication skills. They also consistently commented that rising STI rates and other negative statistics demonstrated the lack of efficacy of this individualised focus. Although not denying the importance of programmes designed to reduce abuse of alcohol and increase condom usage, most suggested more was needed. Alongside information, skills to use that information were considered essential. For instance:

> It's more than just telling kids to you know use a condom, 'cause that's not going to change behaviour, and it never has, and it never will. So sexual health is, I think, about empowerment and having the right information for when you need it and the skills to be able to use that information. (KI7, Sexuality Educator)

As well as closely aligning with the definition of sexual health provided by the WHO (2011), these ideas resonate with the broader understanding of sexual health that Schalet (2000, 2004, 2009, 2010) advocated following research comparing Dutch and US sexual health practices and policy. She concluded that good sexual health and sexual decision making must be viewed as a product long-term investment in young people's wider health, identities and self-esteem (Schalet 2010). In contrast, KIs made reference to the 'failures' of New Zealand education and programmes, often comparing this failure to the 'successes' of Dutch, Norwegian and Swedish sexual health programmes. However, this tendency to compare with contexts that seemed to be 'doing it well' consistently neglected the sociocultural differences that made these success stories possible, such as much more homogenous populations and longer histories of liberal policy making. Schalet (2010) has noted, within the Netherlands at least, this has been the product of at least two to three decades of consistent public health focus, and an emphasis on young people's sexual identities as to be valued and encouraged (Schalet 2004, 2010). It should be noted that KIs identified certain cultural values as potentially clashing with their visions for sexuality education. How this might be understood in ways appropriate to the formations of New Zealand's particular diverse cultural landscape would need to be addressed alongside any programming in this regard.

Within the UK, where a comprehensive shift in policy direction has been implemented, it has taken close to a decade to see significant improvement. STI rates that were steadily rising, as they are in New Zealand, have now slowed and almost levelled out (Christophers et al. 2008). One informant noted the UK approach involved co-ordination of different ministries and NGOs:

> So what seems to be working [in the UK] is a much more integrated plan, which is I understand based nationally, but also locally that these groups work together. So you've got your housing education towards employment, and then you've got your sexuality education and your health services somewhat integrated, and the fact that we are so

separate I think works against it. (KI27, Family Planning Physician)

Lacking the explicit structural focus of the Netherlands, or the integration of the UK, New Zealand was seen to be failing in providing education and support for young people's sexual health. A broad approach to STI prevention that deals with sociocultural aetiologies rather than individual vulnerabilities, risks or symptoms, and focuses on harm reduction as well as providing better sexual health services was viewed as essential to changing the negative state of sexual health in New Zealand.

An important ingredient for success was the suggestion that parents should be informed enough and encouraged to play a key part in sexuality education:

I think it would be recognised as something that needs to start very early in life. I think parents would be encouraged and supported to be able to talk about bodies and touch, and teach their kids right from day one the basic facts about their bodies and their reproductive bodies. (KI6, Sexuality Educator)

KIs argued that if such a sociocultural shift occurred, then sexual health clinics and services would not be seen as the front line of improving sexual health, as they identified them as currently operating, but rather one component in a successful overarching framework.

To shift the focus away from the typical focus on risk and individual vulnerabilities, the majority of the informants argued for a more *structural* approach to produce positive change. This, however, was seen to not fit comfortably with what some informants described as the current 'neoliberal framework' in New Zealand health policy, which locates responsibility within individuals rather than society (see also, Jackson and Weatherall 2010). One informant spoke of the struggle to even raise the issue of structural change and the short-term focus of many current approaches:

What happens in health and certainly what happens in my experience in the sexual health sector is that people start to yawn, get very sort of bored at the idea of looking at structural stuff or a structural analysis because it all seems too big and too hard and what do we do now just with what's in front of us. (KI28, Researcher)

The KIs identified a number of impediments to improving sexual health in New Zealand that arose out of this aversion to deeper structural analysis, which we will discuss in the next section.

## There are Significant Structural Impediments to Improving New Zealand's Sexual Health

The second theme focuses on the reasons sexual health policy and practice were seen to fall short of the ideals identified. Across the data, difference between the ideals KIs articulated and the sexual health practices seen within New Zealand were attributed to two key impediments: (1) STI rates not being considered a national health priority in New Zealand and so not receiving the necessary funding or strategy to improve the current situation, (2) a 'conservative' culture, which has resulted in little public debate or even awareness about New Zealand's sexual health problems, and thus no push for change.

### *A Lack of Priority*

It's not a priority for the Government […] it's always gonna be at the bottom really. (KI9, Sexual Health Management)

All of the KIs referred to a lack of prioritising STI reduction at government level: This was often expressed around of a lack of funding, a key issue for organisations largely reliant on government spending in their area. However, the primary concern of the KIs seemed to be a lack of *strategy* or even *interest* in the issue. A sexual health physician put this eloquently: "Sexual health and mental health are the Cinderellas of our health system" (KI4). All of the KIs described a need for a shift in this regard:

If things are as bad as we're all saying they are surely we would be putting sexual and reproductive health in one of the priority areas, and if we were doing that then we would have, as we have with healthy eating healthy action, the whole strategy, the whole framework for managing that … Anything that's not one of the health priorities is struggling to get air space. (KI17, Sexuality Educator)

Government expenditure in the area of STI-related health problems has the potential for significant impact but is often overlooked (Waetford 2008). Often the government was seen by KIs as needing convincing that a strategic focus would produce saving in the long-term, and efforts were instead described as moving in the opposite direction: cutting costs, reducing government priorities. This was seen as particularly short-sighted by the KIs:

If only we could convince policy makers of the importance of investing in this area of health, then they would find that the longer term savings both in terms of individual well-being, and in terms of cervical cancer, infertility and fertility treatment, ectopic pregnancy, increases in HIV AIDS would certainly be greatly reduced. (KI9, Service Provider Manager)

A lack of New Zealand research was emphasised by some, and many spoke of a lack of statistical data that left no question that there was a problem. The double bind was

that, in order for these data to be generated, funding and strategy were needed. For instance:

> It's a bit of a catch twenty two, 'cause you need all the evidence to be able to get the resourcing and you need the resourcing to be able to get the evidence. (KI22, Sexual Health Promoter)

Many of the KIs felt that this circular dynamic had stalled forward momentum and government needed to be 'woken up':

> One of the reasons why I want to see more reporting and a more accurate picture of the true pool that we've got is that it is the only way that I know of to generate the funding to increase the services from central government […] It's reasonable that you need that hard data to convince treasury that you've really got a problem. (KI14, Sexual Health Nurse)

All of the KIs argued that government leadership was the only way out of this pattern of underfunding, lack of education and poor sexual health. However, there seemed to be little optimism that any potential government had the capacity to take leadership and plan for consistency over the long-term. The overarching argument appeared to be one of successive governments' investments in maintaining the status quo (which they critiqued, as already discussed).

Evidence for this pessimism was given in more recent efforts to address sexual health, which KIs suggested has been characterised by a 'fits and bursts' approach. As an example many of the KI's referred to the *Hubba Hubba* national advertising campaign promoting condom use which ran from November 2004 to June 2005 (TNS Global Market Research 2005). Although the vast majority of those who referred to it recognised its quality and value, they suggested it did not go far enough:

> I think the No Rubba, No Hubba Hubba campaign was really successful in promoting that [using condoms] is the only way to go. But we've got a long way to go in that kind of campaign. So I think we need the No Rubba, No Hubba Hubba campaign multiplied by a factor of several to have some impact, but that was a that was a very good move and it was a good step in the right direction. (KI14, Sexual Health Nurse)

The campaign's isolation from a broader government strategy to reduce STIs and improve sexual health was seen to limit long-term impact.

### *A Sexual Conservatism*

Some KIs situated this lack of government vision and leadership within a context of a sexual conservatism they claimed for New Zealand, where sexuality is not something to be discussed, despite sexuality pervading the media:

> It's very hard to have sexual health as a priority when society doesn't really want to talk about it (KI18, Sexual Health Nurse/Manager).

Despite noting that New Zealand does not have the same political climate as the USA, with its powerful religious conservative base (Scheepers et al. 2002), they suggested 'New Zealanders' struggled with talk about sex and sexual problems (see also Braun 2008). This was not simply about sexual communication between sexual partners; it was also identified with regard to a 'societal debate' about sexual health:

> I think in lots of ways in New Zealand we like to think that we're quite liberal and there's lots of healthy discussion about most things, but when it comes to stuff around sexuality, sexual health we're actually really quite conservative in a lot of ways, particularly around talking openly about specific stuff. (KI1, Sexual Health Educator)

This unwillingness to enter into a broad discussion about New Zealand's STI problems was identified as particularly evident in relation to young people's sexuality:

> Our society, it's kind of "discomforted" with the whole thing of pleasure and positive aspects of sexuality, particularly with teenagers and younger […] I don't think we are entirely comfortable with teenagers having sex. (KI3, Sexuality Educator)

The portrayal of a particular 'New Zealand identity' (Braun 2008) was important to understanding this conservatism. References to "our society" and "in New Zealand" gave some coherence to their account of 'how' and 'why' sexual health is the way it is, in New Zealand, providing a useful rhetorical base from which the KIs could explain the resistances to change that they identified. Williams and Davidson (2004) portrayed a similar reluctance to discuss adolescent sexual health issue within the Australian context, also constructing this as a nationwide issue.

As evidence of this 'national identity' characteristic of conservatism, KIs would often speak of parents as being part of the problem. As noted briefly above, the value of parental relationships and family discussion for improved and positive sexual health was often emphasised by KIs (see also Gavin et al. 2010; Kirby 2002; Schalet 2000, 2010), but portrayed as lacking. Adults were therefore often framed both as products of this sexually conservative environment, but also as *reproducers* of it, unable to 'handle' the asking and answering of sexual health questions:

> Especially as adults, I think we still struggle talking to our children about it. I still don't think they're being raised where this is just a natural thing where you can ask questions and it's okay, and that it's an integral

> part of the curriculum at school that young people have enough information that they can make informed choices about what they're doing. (KI6, Sexuality Educator)

The majority of KIs argued that because of this pattern of many parents and children not talking about sex and sexual matters, compounded by limited exposure to high quality, consistent sexuality education at schools, the state needed to lead:

> My hunch would be that the great majority of New Zealanders are actually be fine with it but need to be lead there, they're not fervent anti-sex people, it's just that we're not used to talking about this stuff and these problems, and yet most people would agree with the approach of we just sat down and we entered into a public debate and awareness campaigns around it. There'll always be high profile, loud objections to it, so you've got to have the political will to carry through with it. (KI26, Youth Health Specialist)

Many of the KIs situated government intervention as necessary to forward momentum of sexual health promotion and STI prevention, but identified a reticence on the part of successive governments to do so, thus leaving many of the structural impediments they discussed in place. Informants identified this lack of political will to give momentum to sexual health changes within New Zealand as having perpetuated the problem, both through ongoing lack of debate and unwillingness to prioritise sexual health. These features were seen to feed into one another, limiting strategy and funding to a sector that was often spoken about by KIs as increasingly fragmented and competing for what little funding does exist.

## Discussion and Conclusions

KIs argued that there was a culture of silence and lack of government prioritisation around sexual health in New Zealand, and these acted as substantial barriers to improving the country's poor STI rates. KIs further argued that there was an ongoing acceptance of neoliberal governmentality as compatible with, or even essential to, health policy and practice (see Prince et al. 2006 for further discussion). This was at the expense of providing better sociocultural scaffolding, which meant that young people in New Zealand were not benefitting from what is considered 'best practice' internationally. The government's 'rationality' within this construction was seen to be defined primarily by economic considerations, in which rhetoric of 'individual responsibility' and a shift to primary health settings might be seen as much as a cost-cutting measure as an ideological framework.

There was strong consensus among the KIs' accounts, effectively arguing for a 'competing rationality' to that of the governments' framework for approaching the issue—one where the focus would be on the support structures that enable the wellbeing and 'holistic' education of young people. This rationality seemed both coherent and easily drawn on by KIs. Yet they argued that the differences between the two rationalities, and the dominance of the 'government model', created an environment that continued to marginalise the perspectives of those arguing for 'holistic', structural framework for sexual health. Informants argued that in contrast to the government's approach, the internationally recognised 'best practice' approach they advocated was informed by an investment in the health and well-being of young people's immediate health needs.

Perhaps as a consequence, KIs accounts were consistently marked by a sense that they were working in an almost adversarial relationship with a distant and disinterested government. KIs seemed strongly invested in explaining the 'problem' in these terms, with the government 'setting the conditions' or having the power in this exchange. This may have a lot to do with the environment these accounts are built within. As New Zealand central government is the primary source of funding for sexual health initiatives, often KIs were working within organisations that directly relied on this funding. As such, it is completely understandable that an 'us versus them' discourse pervaded the data.

The KIs seemed to be arguing that the 'horizonal dimension' of policy formation, which Colebatch (2002) has described, was difficult to access. Colebatch (2002) has argued that policy formation is not as simple as top-down (or vertical) decision making, but is rather a product of wider cultural and institutional forces, and stakeholder voices, which constrain and enable certain policy choices. However, the KIs' construction of a 'culture of conservatism' seemed to be providing limitations, or justification, for the value of their alternative rationality remaining unheard. Thus, according to the KIs, the horizontal dimension was limited in its capacity to shape policy formation.

To take this idea of a 'culture of conservatism' seriously would mean that specific steps would be needed to reduce these limitations. An important step would be an increasing number of strategically focused conversations about the sexual health of New Zealanders. These Kis' accounts are only one description of the state of sexual health within New Zealand, and many of the other 'voices' that might contribute to dialogue seem to be missing from research in the area. The key to the shape of these conversations is the pressing need for more research, both in terms of quantity and in diversity. This is not a new argument, Jackson (2004), for instance, has noted a number of areas requiring some attention that continue to be neglected 8 years on.

Although there is an increasingly sophisticated picture of New Zealand sexuality education programmes emerging (e.g.

Allen 2007, 2008; Jackson and Weatherall 2010), further evaluative work into its utility and value for target groups is needed. In addition to a re-examination of Jackson's (2004) suggestions, we would also suggest that accounts from within the 'vertical' dimension of policy development (officials, ministers) are missing from the picture, except through carefully managed media releases. In order to facilitate a broader understanding of the societal conversation about STIs, such accounts must also be considered. The health sector's shift toward primary health settings in the last two decades has meant that GPs are often the first port of call for those dealing with STIs (Morgan and Haar 2009). Understanding the experiences and training needs of this group would also prove a valuable part of any conversation.

Identification of the particular factors that impact on some groups such as Māori and Pasifika youth, and young women, and then making change that reflects the special needs and cultural frameworks of these groups would also be necessary. Often KIs would construct New Zealand culture as single and cleanly defined, with a dominant 'national identity' (Braun 2008), which they repeatedly articulated. Although acknowledgement of the impact of understandings of national identities on health practices may provide a useful direction for campaigns and programmes, recognising the multiplicity of cultural frameworks and values that exist in New Zealand would be important to successful policy and programme development. This is another clear direction for future research, as often STI research is defined by the 'national problem', or an implicit focus on the majority (Pākehā) culture. Issues of colonisation and its on-going impacts (Tobias et al. 2009), the protective features of various cultural frameworks specific to New Zealand, and a querying of the place of dominant Western liberal humanist views of 'empowerment' and its potential assumptions of gender neutrality would need to be addressed for any shift in rationalities to have long term value.

This analysis of how key informants in the sexual health field 'make sense' of sexual health and STI rates in New Zealand, identified a lack of dialogue about the problem as a key structural barrier to changing its direction. Although these data are now a number of years old, the observations and recommendations of these key informants are still pertinent to analysing the current sexual health climate in New Zealand.

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