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The role of a sexual health promotion leaflet for 15—18 year olds in catalysing conversations: A constructivist grounded theory

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Summary Following the summer holidays of 2011, twelve girls returned to school pregnant in one high school in Auckland New Zealand (NZ). A health promotion leaflet that folded into a small square containing a condom and was dubbed the 'teabag' was distributed to 15—18 year olds prior to the summer holiday of 2012, in order to increase their sexual health knowledge. This paper reports on the evaluation of the teabag from the students' perspective. During the first term of 2013, seventeen students from two high schools who had received the teabag were interviewed. Five were male and twelve female. Most (16) were of Pacific Island or Māori (indigenous New Zealanders) descent. Interviews were digitally recorded, transcribed, coded and categorised concurrently, in accordance with grounded theory methods. Theoretical sampling was employed and students who had perceptions of the teabag, that were consistent with evolving constructions from data, were invited by school nurses to be interviewed by the researchers. Interviews were coded line by line by two researchers and these codes collapsed into seven focussed codes. Further analysis resulted in the codes being subsumed into three main categories. These categories revealed that the teabag was, helpful, appropriate and became a talking point. The grounded theory and basic social process the researchers constructed from data were that the teabag catalysed conversations about sexual health. The teabag was an acceptable and appropriate sexual health promotion tool to disseminate information about sexual health.

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1. Introduction

New Zealand fares badly for the health and well-being of young people (defined by WHO as those between 10 and 24 years) when compared to 35 developed world countries. In 2002, teen pregnancy rates (live births and abortions) in New Zealand were the third highest in the OECD with rates of 52 per 1000. Among Pacific teens the rate in 2002 was 74 per 1000 (48 live births and 26 abortions per 1000 girls) and even higher for Māori (indigenous New Zealanders) at 100 per 1000 (70 live births and 30 abortions) compared to New Zealand European girls who have a rate of 43 per 1000 (22 live births and 21 abortions (2012)). The latest statistics indicate no reduction in the rate of teenage births nearly a decade later (see Table 1) (UNICEF, 2013). When compared to similar OECD (developed world) countries, New Zealand's rates are third highest, being only marginally better than Britain and the USA. There has been no recent (in the last 13 years) Government strategy to address these high rates. Teen pregnancies often interrupt the education of the teen mother, reducing her future employment opportunities and earning potential. The incidence of pre-term births and low gestational weight is higher amongst teen mothers. Teen pregnancies are also associated with an increased risk of poverty, lower health outcomes, particularly for the baby, and teen pregnancies in the next generation. Teen pregnancies are more likely to lead to solo parenting and benefit dependency. Teen mothers are also often emotionally unprepared for parenting (UNICEF, 2001).

Young people who are exposed to the risks of pregnancy are also subject to acquiring sexually transmitted infections (STIs), the most common being chlamydia. Few individuals infected with chlamydia are symptomatic and an estimated 80—95% have no symptoms at all. This silent disease has major implications for the long term fertility of an individual and the attendant societal costs of fertility treatment (McIsaac, Kellner, Aufricht, Vanjaka, & Low, 2004). In 2009 NZ's rate of chlamydia infection was estimated at 809 per 100,000 population from selected diagnostic laboratories. Unlike Australia, chlamydia is not a notifiable disease in New Zealand, so reported rates in Australia are likely to be more accurate. Australian chlamydia rates were reported as 285 per 100,000 population and the UK's rate was 349 per 100,000 for the same year (NICE, 2008). An audit conducted in 2013 at one general (family) practice whose staff work with school nurses in three high schools in one area of Auckland, illustrated that over an 18 month period, 75 out of 246 (36%) young people who presented to school nurses for sexual health care, tested positive for chlamydia (unpublished data).

Table 1 Comparable countries to New Zealand teen birth rates (aged 15—19 years per 1000 females) data from 2010.

Japan	5
Italy	5
France	7
Germany	8
Australia	15
New Zealand	26
United Kingdom	30
United States	36

Source: UNICEF (2013).

Children and young people aged 0—18 years are a defined cultural group whose rights in New Zealand are protected under the United Nations Convention on the Rights of the Child (UNCRC) (Lundy, 2007). Yet despite ratification of the UNCRC in 1993, young peoples' opinions are rarely sought in the provision of sexual health information due to the belief that young people are irrational and unstable (Leahy & Harrison, 2004). Additionally sexual health education in schools is an issue teachers approach with trepidation, due to their desire to avoid controversy. Longstanding debates have focused upon what sex education should be taught where and by whom, with critics posing that discussing sex in schools will encourage experimentation and promiscuity (Coleman, Kearns, & Collins, 2010). Young people are not included in debates around school curriculum content generally and their voice is absent where sex education is concerned (Coleman et al., 2010; Collins & Coleman, 2008). Yet article 12 of the UNCRC states children and young people's opinions should be included in all matters affecting them. Internationally authors' have noted that not having a say in decisions made about them was the single most important issue children reported in a study conducted in Northern Ireland that examined how well the UNCRC had been implemented in society (Kilkelly et al., 2004). The *1999 Health and Physical Education Curriculum* and *2001 Sexual and Reproductive Health Strategy* are two documents cited as providing the foundation for sexual health education in schools throughout New Zealand. Neither of these references include any consultation with young people (Coleman et al., 2010), an omission that contravenes the UNCRC.

During the first term of 2012 at one high school in Auckland, school nurses reported that twelve girls had become pregnant over the summer break. Part of the curriculum for third year Bachelor of Nursing students at the University of Auckland is to undertake a community project examining a public health issue. Three student nurses (all aged less than 22 years) were given the remit of finding a solution to unintentional pregnancy in high school students. After the three week project, during which time the student nurses consulted with health professionals, teachers and school students at the school with the high pregnancy rate, they produced a sexual health promotion leaflet that folded into a 6.5 cm square and concealed a condom (unpublished report). The leaflet was dubbed the 'teabag' (Fig. 1) and was reviewed by a young PhD candidate (aged 26 years) at the University of Auckland who was of Māori descent. The teabag was distributed by either school nurses or the students involved in leading the peer sexuality support programme, to students at two high schools in Auckland prior to exam and summer leave in November 2012. The Principals at both schools approved distribution of the teabag. The schools were chosen due to their known high pregnancy rates and also because KH (first author) works as a nurse practitioner, providing a weekly health clinic to one of the schools and telephone support and advice to the school nurses at the other school. The Principals and school nurses of both schools were very keen to distribute the teabag.