

DRAFT

Sexual & Reproductive Health Issues, Programmes and Services in Counties Manukau: A Profile and Proposed Action Plan

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1 Executive Summary

Sexual and reproductive health is a priority area for action identified in the *Counties Manukau District Health Board Strategic Plan* and *District Annual Plans* for 2003//04 and 2004/05.

The local prioritisation of sexual and reproductive health is backed by a series of national policy documents on the subject; the *Sexual and Reproductive Health Strategy (1996)*, *Sexual and Reproductive Health Strategy – Phase One (2001)* and *Sexual and Reproductive Health: A resource book for New Zealand health care organisations (2003)*. Furthermore national statistics indicate rising numbers of bacterial sexually transmitted infections (STIs) diagnosed at sexual health clinics over recent years and annual increases in the numbers of abortions being performed.

Counties Manukau figures indicate sexual and reproductive health issues are particularly pertinent in this area. About half South Auckland secondary school students who are sexually active don't consistently use contraception. Gonorrhoea is more commonly diagnosed locally than elsewhere in New Zealand. Pelvic inflammatory disease and ectopic pregnancy admissions have increased in Counties Manukau over recent years. Local teenage pregnancy rates continue to exceed those of neighbouring DHBs. Furthermore several sexual and reproductive health issues are of particular relevance for Maori, Pacific and/or Asian communities, with substantial representation of these groups existing within Counties Manukau.

Currently a range of providers deliver sexual and reproductive health programmes and services within Counties Manukau. For this reason one of the objectives for sexual and reproductive health in the *2003/04 District Annual Plan* is to improve coordination between services. Other objectives include improving access to services, the acceptability of services and the provision of effective health education and promotion.

These issues were investigated in a series of key informant interviews by the author, in a planning workshop session with some of these participants, with a focus group of Counties Manukau general practitioners and by exploring the local data on these issues and directions from international literature and practice.

The international literature suggests that societal attitudes and socio-economic factors play an important part in sexual and reproductive health outcomes. In terms of service provision, however, and for young people in particular, comprehensive sexuality education, clear messages about risks, youth-focused primary health care and ready access to condoms and contraceptives are thought to be necessary components for successful services. Other areas for improvement locally, and in some cases nationally, appear to be increased use of public education campaigns, the development of sexually transmitted infection contact tracing services, increasing the practice-level availability

of single dose antibiotic treatments for Chlamydia and the use of opportunistic screening for Chlamydia amongst at-risk populations.

Given the variety of issues discussed above, a sexual and reproductive health action plan that acts at a number of levels is most likely to be effective for Counties Manukau.

This plan proposes that measures be taken to:

- Improve access to services by
 - A local public awareness campaign to inform people about the often free but somewhat fragmented sexual and reproductive health services already provided
 - Developing sexually transmitted infection contact tracing capabilities
 - Providing further sexual health services to southern South Auckland
 - Funding a number of vasectomies for provision to ‘higher need’ individuals
 - Seeking a deprivation-weighted funding formula for Family Planning with a higher number of capped visits locally, so this (often free) service can seek to reach and provide to ‘harder to reach’ groups
 - Reviewing local termination of pregnancy capacities

- Enable workforce development and training by
 - Facilitating primary care workforce capacity development and training, such as in the areas of
 - Screening for youth health issues in routine consultations, such as unmet contraceptive needs or for undiagnosed Chlamydia
 - ECP prescription capacity for nurses
 - Contact tracing skills for health workers
 - Possibly IUCD insertion skills for GPs
 - Facilitating the development and distribution of best practice guidelines for use in the community, in particular for STI management
 - Considering scholarships to allow Maori and Pacific members of the health workforce to upskill in community sexual and reproductive health provision

- Improve the quality of services by
 - Advocating for azithromycin to be made available on a practitioner’s supply order for single dose treatment of Chlamydia in the community
 - Encouraging providers to ensure the acceptability of their services is maximised for young people, Maori and Pacific and Asian peoples

- Facilitate the prevention of adverse health outcomes by
 - Increasing the use of opportunistic screening within primary care consultations and uptake of the national cervical screening programme
 - Reducing the cost of the emergency contraceptive pill and condoms obtained without prescription
 - Exploring further development of sexual and reproductive health promotion and education in schools and other community settings

- Exploring further development of sexual and reproductive health service provision in schools
- Wrapping preventative/health initiatives around the proposed school-based Pacific Teen Parent Unit by
 - Making funds available for the extension of services
- Improve local governance of sexual health services by
 - Exploring the establishment of a steering group(s) for regional services with Counties Manukau representation

This plan has been identified through the above consultation, discussion, data review and literature exploration processes and is outlined in more detail within the body of this document. It seeks to provide a positive, proactive and multi-faceted response to the significant sexual and reproductive health issues that exist in Counties Manukau.

2 Introduction

The Counties Manukau District Health Board's *2003/04 District Annual Plan* highlights several sexual and reproductive health issues that require addressing.

These include:

- High teenage pregnancy rates
- High sexually transmitted infection (STI) rates
- Perceived high termination of pregnancy rates
- A history of limited access to some specialist services
- Limited available information on some of these issues for the CMDHB area

Although these issues are of particular local relevance, they also largely concur with those identified in the Ministry of Health's *Sexual and Reproductive Health Strategy – Phase One*, as key issues that need to be addressed.ⁱ

With regards to potential ways to progress sexual and reproductive health for the region, several factors have been highlighted in the *District Plan*.

These issues are addressed in this document and include:

- Improving access to sexual and reproductive health services
- Improving the acceptability of these services
- Better coordinating service provision
- Providing effective health education and promotion

This document has evolved, with the help of a planning workshop on sexual and reproductive health issues and other feedback from key informants, from a discussion document to a proposed action plan for the DHB.

The structure of this document is to first profile key sexual and reproductive health issues, in particular those of STIs, teenage pregnancies and termination of pregnancies for the DHB and then profile local service and programme provision relevant to these issues. The information used to develop these profiles has been obtained from a

combination of hospital, ESR and service-specific data and a series of key-informant interviews. Some key findings from relevant policy documents and the published literature are then discussed, followed by recommendations for sexual and reproductive health progress in the CMDHB area. These issues and recommendations have been discussed and worked upon in the setting of a key-informant workshop. The recommendations at the conclusion of the document reflect the outcome this process.

3 A profile of key issues for the Counties Manukau region

3.1 Introduction

The key sexual and reproductive health issues for the Counties Manukau region profiled in this section are those of sexually transmitted infections (STIs), teenage pregnancies/motherhood and terminations of pregnancies (TOPs). As previously mentioned, these specific issues closely concur with those identified in the Ministry of Health's *Sexual and Reproductive Health Strategy* as being of importance. Other issues that are briefly discussed in this section, but are not the main focus of this action plan, include those of cervical cancer, hepatitis, HIV/AIDs and prostitution.

3.2 Initiation of sexual activity and contraceptive use statistics

It is estimated from recent research that about one third of secondary school aged young people in South Auckland are likely to have had sexual intercourse.ⁱⁱ Previous New Zealand research has demonstrated that the majority of young people become sexually active before they turn 18 years of age.ⁱⁱⁱ To further elaborate on this statistic, a national study in 1995 found that 46% of a 20-24 year old sample had first had sexual intercourse by the age of 16 years, whilst 31% had first had sexual intercourse between the ages of 17 and 19 years of age.^{iv} The value of timing robust sexual health education to occur at least by the early secondary school years is therefore apparent.

Data on contraceptive usage finds that about half of South Auckland secondary school students surveyed report using some form of contraception to prevent pregnancy every time they have sexual intercourse.^v Similar proportions reported using a condom as protection against sexually transmitted infections last time they had sexual intercourse.

National data has found that women who first have sex at a relatively younger age are more likely to do so without using any form of contraception, than women who first have sex at a slightly older age.^{vi} For example, 39% of those who first had sex at 16 years of age or less did not use any form of contraception on this occasion, compared with a lesser 27% of those who first had sex at 17-19 years of age.

These figures indicate there is substantial room for improvement in the proportion of sexually active young people who use contraception to prevent pregnancy, and more specifically, use barrier contraception to prevent STIs.

National data also finds an apparent difference in the preferred methods of contraception used by women of different ages. Use of the oral contraceptive pill (or this pill combined with another form of contraception) appears to be most popular amongst women in their younger reproductive years. Of women in their twenties, 44% reported using the oral contraceptive pill as their method of contraception, compared with 27% of women 30-34 years, 17% of women 35-39 years and 10% of women 40-44 years.^{vii} Condoms (or condoms and another form of contraception) appear to be used as the main form of contraception by a smaller but more stable proportion of sexually active women. Nineteen percent of sexually active women in each of the 20-24 year old, 25-29 year old and 30-34 year old age groups reported using this method of contraception, with slightly lesser percentages of older women doing so.

Consideration of these figures may indicate that a lower proportion of sexually active young people are using condoms for barrier contraception than is desirable. In line with current best practice, as discussed later in this document, unless individuals are in a stable, faithful relationship (and in many cases both parties have been tested for STIs), the use of barrier contraception and another form of contraception, such as the oral contraceptive pill, is often promoted.

In 1995, between 11% and 16% of sexually active, non-pregnant New Zealand women between 20 and 44 years of age reported using no method of contraception. In *New Zealand Women: Family, Employment and Education Survey (WFEE)* it was concluded, therefore, that the level of unmet contraceptive need amongst New Zealand women was relatively low at the time. Nonetheless, STI and termination of pregnancy statistics suggest that whilst this level of unmet need may be internationally “relatively low”, it still exists. Furthermore, contraception use in many cases appears to be intermittent and harmful consequences are resulting.

To this end the Ministry has since developed a sexual and reproductive health resource book for New Zealand health care organisations, to assist DHBs and PHOs in addressing these issues. Whilst this is a national document, the issues raised appear to be of potentially greater concern for the CMDHB population than the general population. This is due to higher local rates of the some of the aforementioned consequences of a lack of contraception use, as well as the socio-economic and ethnic composition of the DHB’s population.

Furthermore, since the *WFEE* survey, changes in contraceptive usage patterns, at least amongst abortion clinic attendees, have been highlighted in a recent New Zealand Medical Journal article.^{viii} This article found that a lack of contraceptive use preceding presentation for termination of pregnancy was much more common in 2002 than it had been in 1995 and 1999. The percentage of attendees who reported using no contraception was a staggering 70% in the 2002 survey. It was also notable in this paper's findings that the percentage of women on the oral contraceptive pill had substantially decreased from 23% of attendees in 1999 to just 8% in 2002. This may reflect in part a 'back lash' against the oral contraceptive pill, due to the recent media publicity given to third generation oral contraceptive pill risks.

The authors also note that a substantial and increasing percentage of attendees were of Asian and more specifically ethnic Chinese backgrounds. In 2002, 55% of attendees were Asian. The authors of this article highlight specific issues relating to the way many Chinese patients view and use contraceptive and abortion services, which they feel need to be addressed with appropriate public health education. Given the substantial Asian population in the eastern parts of the Counties Manukau area, this may need to be an issue that is addressed by the DHB.

The evidence that has been discussed in this section suggests there is considerable scope for addressing contraceptive, disease prevention and health promotion initiatives, which could well be part of the solution to the issues of high teenage pregnancy, termination and STI-related condition rates for this area.

3.2.1.1 In summary

- Most New Zealand young people become sexually active prior to 18 years of age
- About half of sexually active South Auckland secondary school students don't consistently use contraception when having sex
- Substantial proportions of young people use oral contraceptives as their form of contraception, but may not be using barrier contraception

3.3 Sexually Transmitted Infections (STIs)

3.3.1 Introduction

Sexually transmitted infections (STIs) are infections that can be acquired through sexual contact. The common STIs in New Zealand are chlamydia, genital warts, gonorrhoea, genital herpes and, in males, non-specific urethritis (NSU).^{ix} These infections have been identified as one of the main preventable causes of ill health for young people in this country; they have also been identified as a particular issue for Maori rangatahi.^x

3.3.2 Data limitations

Existing data on sexually transmitted infection (STI) rates is notably incomplete in this country. This is the case both nationally and with respect to South Auckland. Data on the number of confirmed laboratory diagnoses as a percentage of the number of clients seen at specialist sexual health clinics is collected and collated by the Institute of Environmental Science and Research (ESR). This is likely to represent only a limited portion of the actual number of STIs with laboratory diagnoses however, as patients also seek treatment for these infections at a range of other providers including general practitioners, family planning clinics, school health clinics and other hospital services. Data from these services is captured more incompletely by ESR. Furthermore, some STIs may be treated without a confirmed laboratory diagnosis and undiagnosed infections are also likely to exist in the community. Therefore the true prevalence and incidence of STIs in the South Auckland community is unknown. Consideration of trends in the STI data collected is, however, of importance.

3.3.3 New Zealand STI statistical trends

The numbers of confirmed bacterial STI cases seen at sexual health clinics in New Zealand has risen in recent years.

The annual number of confirmed cases of chlamydia seen at these clinics nationally, steadily increased each year over the five years from 1995 to 2000.^{xi} In 1995 approximately 1500 cases were seen nationally. By the year 2000 over 2500 cases were seen.

It is interesting to note, in a recently published paper discussing the composition of New Zealand STI diagnoses, lament is expressed that chlamydia, a treatable bacterial

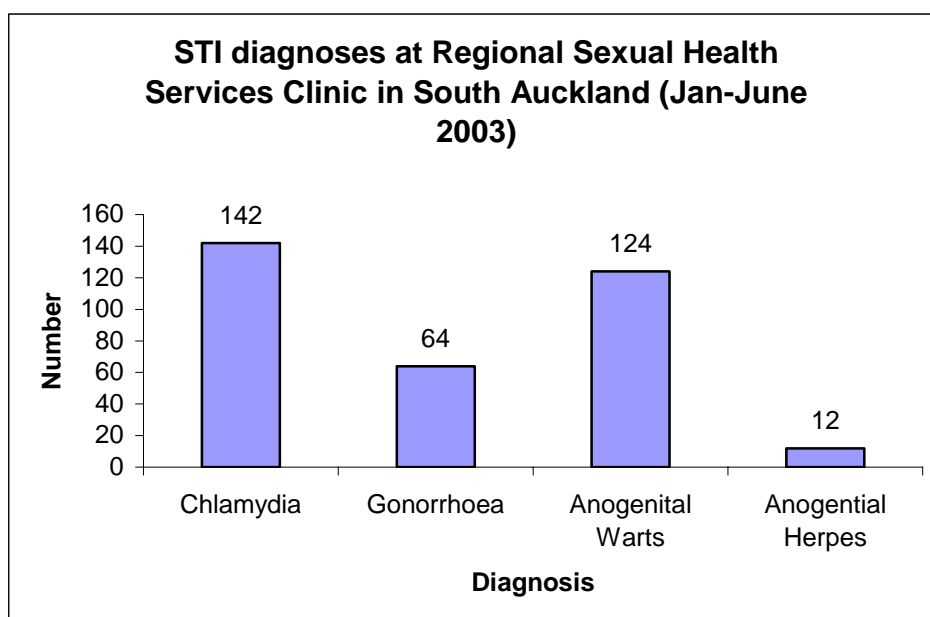
STI, has overtaken genital warts to form a greater proportion of national STI diagnoses over the last decade.^{xii} This paper reports that this scenario would have seemed ‘unbelievable’ ten years ago.

On a national basis there was also a slight increase in the numbers of Gonorrhoea cases seen. Gonorrhoea is more of an issue in the South Auckland area, however, than it is for New Zealand as a whole, as will be described in this chapter. Numbers of cases of the viral STIs, genital warts and herpes, seen in sexual health clinics nationally decreased annually over this period.

New Zealand is classified by the World Health Organisation as a “low prevalence” country for HIV/AIDs. Gradual changes in the demographic composition of those being diagnosed with HIV in New Zealand have been occurring over recent years however, with increasing diagnosis of this condition in previously relatively uninvolved groups such as women.^{xiii} This may herald greater spread into the general population and highlights the importance of sexual health promotion and disease prevention measures.

3.3.4 A profile of sexually transmitted infections (STIs) seen by the Regional Sexual Health Services Clinic in South Auckland and relevant comparisons

Despite the caveats discussed above, data on diagnosed STIs seen at the Regional Sexual Health Services clinic in South Auckland is presented below. The most commonly diagnosed STI during this period was Chlamydia (42% of diagnoses), followed by Anogenital Warts (36% of diagnoses). Substantial numbers of Gonorrhoea cases were also diagnosed (19% of diagnoses) at the South Auckland clinic over this period.



In comparison, diagnosis rates for the whole Northern region of New Zealand for the quarter April to June 2003, were comprised of 40% chlamydia, a lesser 13% gonorrhoea, 39% warts and 8% herpes.

It can be seen from these figures that whilst the proportions of STI diagnoses that were chlamydia or anogenital warts, were similar for the South Auckland clinic compared with the whole Northern region, gonorrhoea diagnoses form a more prominent component of those made at the South Auckland clinic (19% versus 13%).

As opposed to just laboratory diagnoses, STI-related hospitalisation rates in Counties Manukau have been shown to be higher than they are for the country as a whole. Age-standardised discharge rates for people hospitalised for an STI-related reason or with an ectopic pregnancy were found to be 86 per 100,000 (95% CI 82-90) for the Counties Manukau region, whilst they were 77 per 100,000 (95% CI 76-79) for New Zealand as a whole^{xiv}. (Sexually transmitted infections have been previously shown to be a major cause of ectopic pregnancies^{xv}, therefore ectopic pregnancy rates have been used as a marker of STI prevalence in communities^{xvi}).

3.3.4.1 Gender profile

The gender breakdown of those in which positive STI diagnoses were made at the South Auckland Sexual Health Clinic finds a slight preponderance of males. This is largely inconsistent with the national sexual health clinic diagnoses picture, with more females visiting these clinics nationally and not surprisingly a greater percentage of diagnoses therefore generally occurring in females.

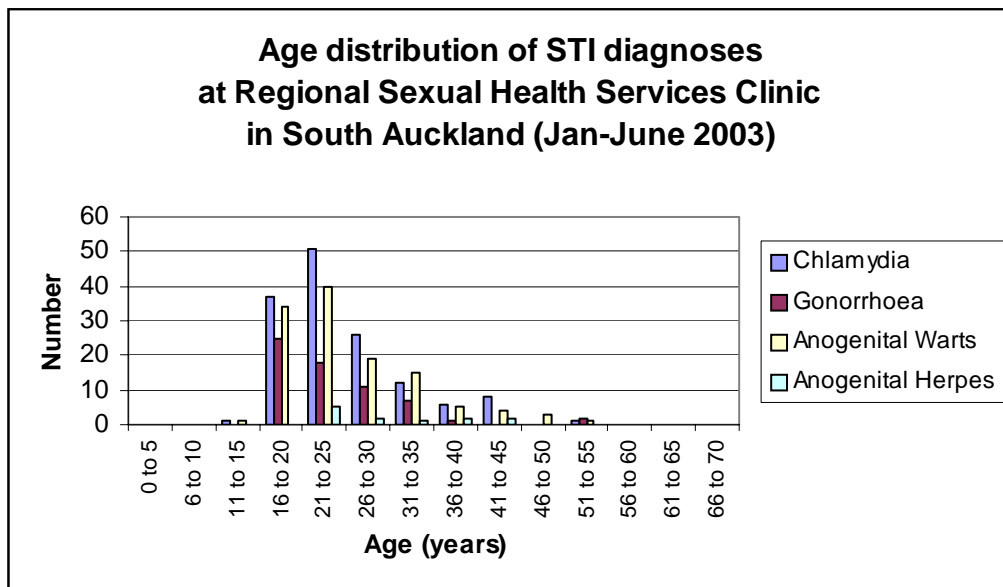
	Gender Breakdown of Positive Diagnoses			
	Male		Female	
	South Auckland Clinic (Jan-June 2003)	STI Clinics Nationally (April-June 2003)	South Auckland Clinic (Jan-June 2003)	STI Clinics Nationally (April-June 2003)
Chlamydia	56%	45%	44%	55%
Gonorrhoea	59%	62%	41%	38%
Anogenital Warts	55%	48%	45%	52%
Anogenital Herpes	67%	47%	33%	54%

The reasons why the South Auckland clinic appears to see a greater proportion of male rather than female clients, than is typical nationally, needs to be considered in relation to service provision understanding and planning for the region. Possible hypotheses that may explain this scenario could include that a greater proportion of women in the South Auckland region either choose, or for some reason other than conscious choice, attend a GP or Family Planning Association clinic for their sexual health needs. Other reasons could include geographic access (only one RSHS clinic in South Auckland based in Mangere) or awareness (possibly not aware of this clinic/service), for example. Inversely, a greater number of males may be actively seeking appointments at the South Auckland RSHS clinic, than males generally in the country. This may reflect a greater STI burden in the South Auckland community than exists nationally on average and/or a greater preference to use this service as opposed to a family doctor or FPA clinic and/or a greater need to use this service due to the fact it is free and/or a lack of awareness of the free appointments for under 22 year olds at FPA and some PHOs.

As the above proportions are obviously dependant on each other, the true reasons behind these differences are difficult to firmly identify. However, given that young males are generally recognised to attend health care services only reluctantly, the hypothesis that there is substantial need for STI treatment amongst the local young male community must carry some weight and the fact that substantial numbers are utilising the specialist clinic setting to do so, needs to be recognised. This may indicate the need for increased free, specialist sexual health clinic service provision in the South Auckland area.

3.3.4.2 Age profile

Most of the RSHS South Auckland clinic clients with positive STI diagnoses fell between the ages of 16 and 30 years, and more specifically between the ages of 21-25 years. Gonorrhoea, however, was most commonly diagnosed in the younger years of this age range (16-20 years), followed by a decreasing number of diagnoses in the age groups 21-25 years, 26-30 years and 31-35 years.



The predominance of young people in the STI diagnosis figures above, concurs in general with the patterns of STI prevalence reported in the literature. STI rates are typically known to be higher amongst young people than the rest of the age spectrum^{xvii}. Furthermore, the Counties Manukau region is notably home to a large number of young people.

The relatively young age profile of those being diagnosed with STIs indicates the importance of effective sexual and reproductive health promotion and education for this

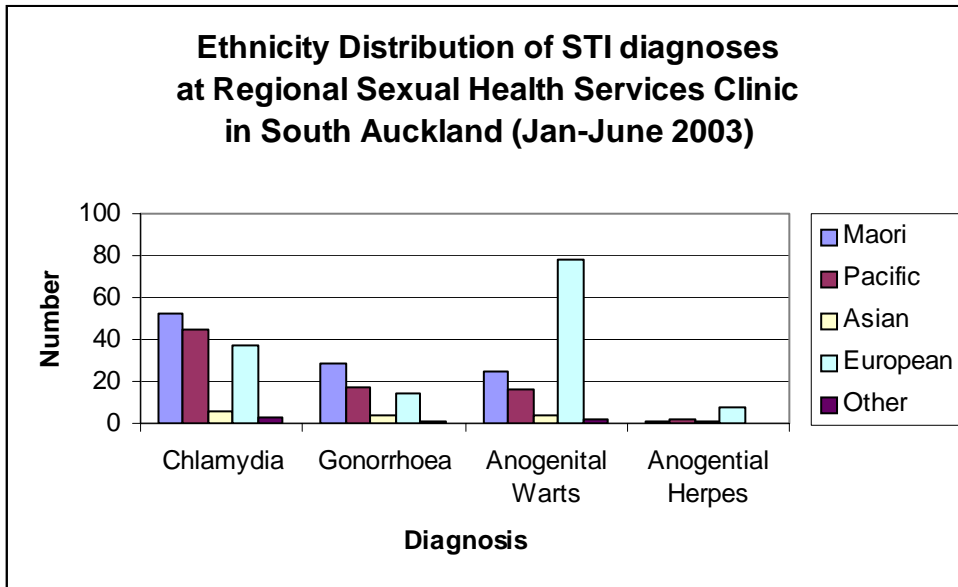
age group and those in preceding years. It appears that further work is needed in this area to effectively influence attitudes and practices around 'safer' sex and possibly enable better access to contraceptives.

Furthermore, the fact that young people, particularly those who are not in an earning situation, may have limited access to money or transport and may prefer not to visit their family doctor for sexual health care should be recognised.

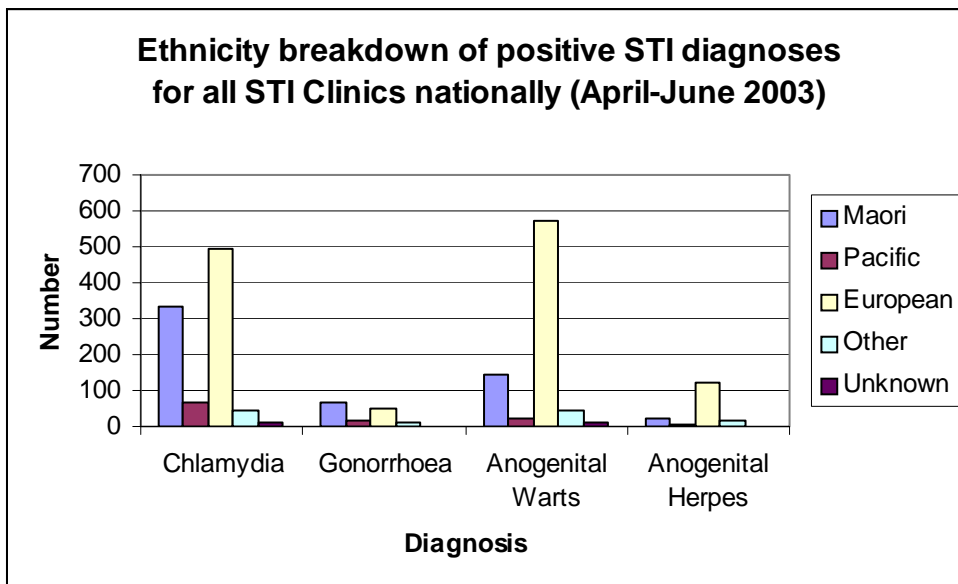
For this reason, in addition to preventative strategies, consideration should also be given to enabling individuals to seek free, accessible sexual health care, possibly outside the setting of their usual family doctor. The higher rates of STI-related hospitalisations for CM, compared with nationally, indicate there is potential room for improvement in STI treatment in this area. A perceived lack of anonymity may particularly put young people, who suspect they have STI, off seeking treatment. Strategies and services should therefore be in place so that individuals can confidentially seek treatment at a GP or PHO other than their usual one or access services from a 'specialist' clinic setting. (It should be noted that substantial use of nurse-led consultations is made in 'specialist' clinics. Not all patients need to be seen by a specialist doctor).

3.3.4.3 Ethnicity profile

A breakdown of STI diagnoses made at the South Auckland clinic of the Regional Sexual Health Service demonstrates that bacterial STI diagnoses were more commonly made in Maori and Pacific clients, whilst viral STIs (genital warts and herpes) were more commonly diagnosed in European clients, as is shown in the following graph. This reflects previously documented national findings^{xviii}.



The above graph depicting the situation for the South Auckland STI clinic can be compared with the one below, depicting the situation for all STI clinics nationally.



It can be seen that bacterial STI diagnoses are made in substantial numbers of Maori and Pacific people, as well as NZ Europeans, in the South Auckland region. This is not surprising given South Auckland's demographic composition and the findings of previous research. It is also of some service provision importance because bacterial

STIs are easily treatable with antibiotics, thus avoiding potential complications such as pelvic inflammatory disease (PID) and future ectopic pregnancies. In contrast, viral STIs are essentially incurable and despite treatments may recur. For these reasons it is of particular importance that those with a bacterial STI are seen and treated, whilst those with genital warts or herpes may be somewhat more able to manage the condition on their own (if they recognise the importance of continued barrier contraception use).

Previously published rates of Maori and Pacific peoples STI and ectopic pregnancy discharges for the Counties Manukau region have found these were disproportionately high, both in comparison with other Counties Manukau residents and in comparison with Maori and Pacific peoples elsewhere.^{xix} Local rates of 146 per 100,000 (95% CI 129,163) amongst Maori compare with national rates of 113 per 100,000 (95% CI 108,117). Local rates of 122 per 100,000 (95% CI 110,135) amongst Pacific peoples compare with national rates of 107 per 100,000 (95% CI 100,104). The rate amongst non-Maori non-Pacific Counties Manukau residents was found to be 62 per 100,000 (95% CI 58,66).

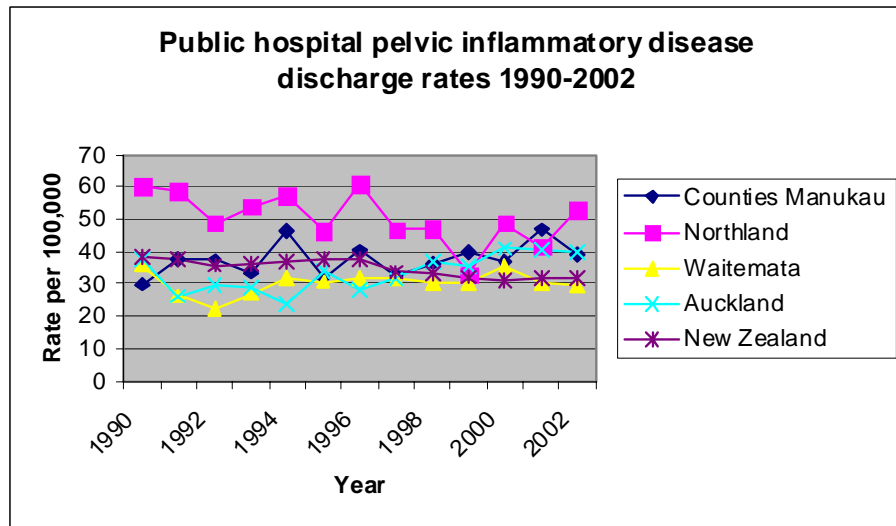
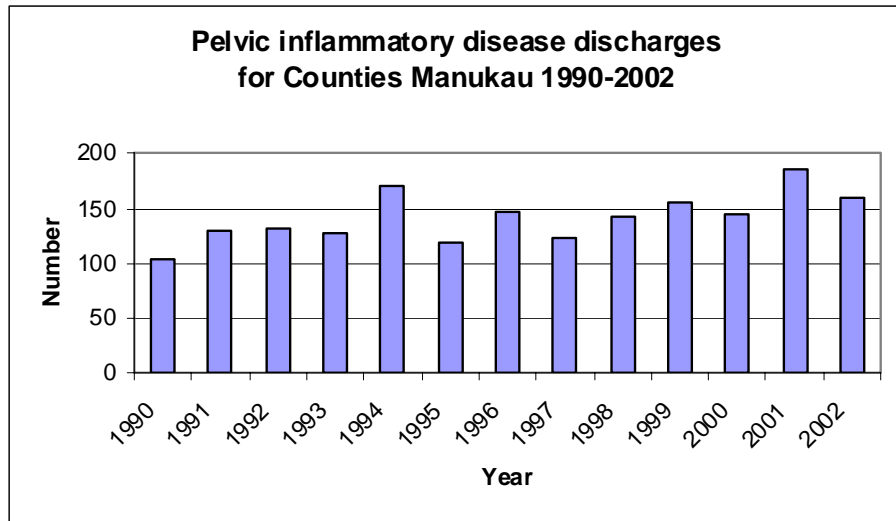
An increased prevalence of STIs amongst ethnic minority groups has also been found in overseas studies, with deprivation thought to be an important factor in this association^{xx}. Lower socio-economic status has also been independently associated with STI risk in overseas studies^{xxi}. The Counties Manukau district contains a higher proportion of people who fall into the highest NZDep96 deprivation decile (21%) than almost all other districts in New Zealand. Relatively high proportions of Maori and Pacific peoples also live in the Counties Manukau District.

These factors highlight the importance of ensuring sexual health services are accessible and acceptable to those of Maori and Pacific ethnicities, as well as to those of a NZ European background. The importance of ensuring sexual health services are accessible to those of limited economic means is also highlighted.

3.3.5 Pelvic inflammatory disease and ectopic pregnancy hospital-based statistics for the Counties Manukau area

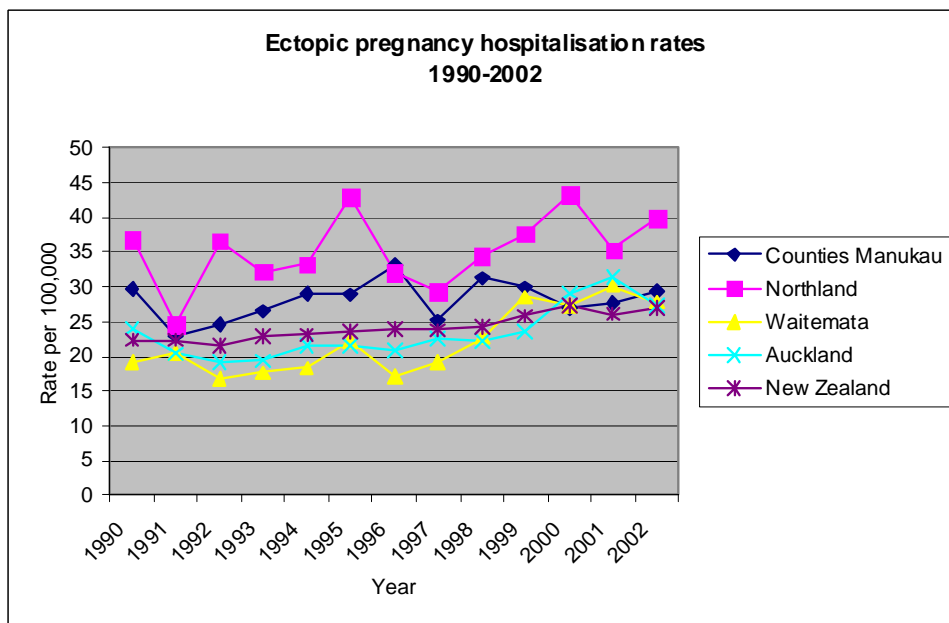
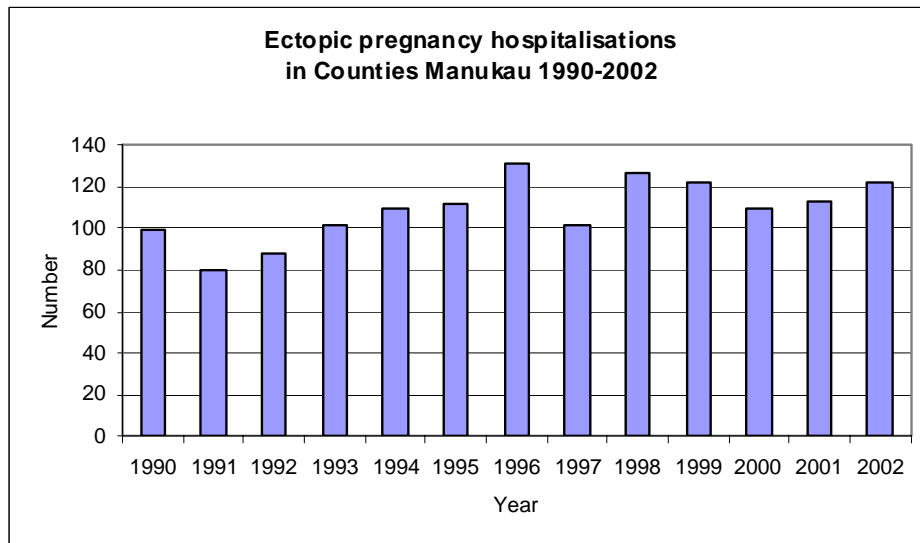
Pelvic inflammatory disease can develop as the consequence of a bacterial STI, such as chlamydia and gonorrhoea, being left untreated. The term pelvic inflammatory disease (PID) is used medically to describe an often purulent infection within the pelvis. This typically requires admission to hospital and treatment with intravenous antibiotics.

The numbers of patients discharged from hospital following an admission with pelvic inflammatory disease are shown below. It appears that there has been a slight increase in these numbers annually over the last decade.



The annual rate of PID hospital inpatient episodes in Counties Manukau has exceeded the national rate on many occasions over the last decade. The rate of inpatient episodes for Counties Manukau also appears to be slightly increasing.

Ectopic pregnancies in many cases occur due to a woman's fallopian tubes being scarred by a previous episode of an STI/PID. Similar to the numbers of annual PID hospital inpatient episodes over the last decade, the numbers of ectopic pregnancy inpatient episodes also appear to be slightly increasing.



The rates of ectopic pregnancy inpatient episodes also appear to have been increasing slightly over the last decade.

3.3.1.1 *In summary*

- The numbers of bacterial STIs diagnosed at sexual health clinics nationally have been rising over recent years
- Chlamydia is the most common STI nationally and in South Auckland
- Gonorrhoea forms a greater proportion of STI diagnoses in South Auckland than it does nationally
- Males are slightly over represented in local sexual health clinic STI diagnosis statistics
- Young people under the age of 30 years are the most common group in which STIs are diagnosed
- Gonorrhoea is particularly diagnosed in the young
- High numbers of Maori and Pacific patients have had bacterial STIs diagnosed at the South Auckland sexual health clinic
- Hospital admissions for PID and ectopic pregnancies appear to have been increasing over recent years

3.4 Teenage Pregnancies

3.4.1 Introduction

Teenage pregnancies, as a general grouping, are of potential concern because of their capacity for adverse consequences for the young woman and her child.^{xxii} Young mothers may miss out on educational and training opportunities due to their motherhood at a relatively early age, potentially limiting their own prospects for the future and ability to provide for their child.

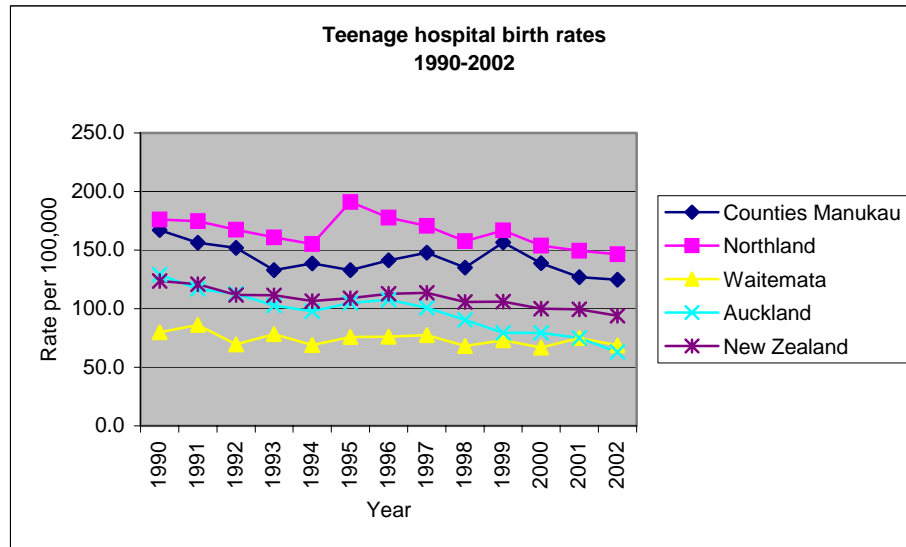
There is also a relatively high rate of unexpected/unwanted pregnancies amongst this group. It was found in the Dunedin Multidisciplinary Health and Development Study that 60% of pregnancies that occurred before the age of 25 years were unintended.^{xxiii} About one third of pregnancies among participants of the Christchurch Health and Development Study (aged up to 21 years) ended in abortion.^{xxiv} It should be remembered, however, that some young women choose motherhood at a relatively early age and many, many young women, whether or not their pregnancy was a deliberate choice, are delighted to become mothers.

New Zealand has a comparatively high rate of teenage births (27.3 per 100,000), in comparison with other developed nations.^{xxv} Our teenage birth rate was found to be the third highest of 28 nations in a UNICEF study, behind only the United States (at 52.1 per 100,000) and United Kingdom (at 30.8 per 100,000). The rate of teenage births among Maori young women in this country is particularly high (74 per 100,000).

Addressing teenage pregnancy as an issue for the CMDHB population is likely to require not only ensuring young people's opportunity for 'choice' in the matter is maximised through measures including effective health promotion, contraceptive and TOP awareness and service provision, but also that teenage mothers are supported through the pregnancy and motherhood process with appropriate educational, medical and social resources.

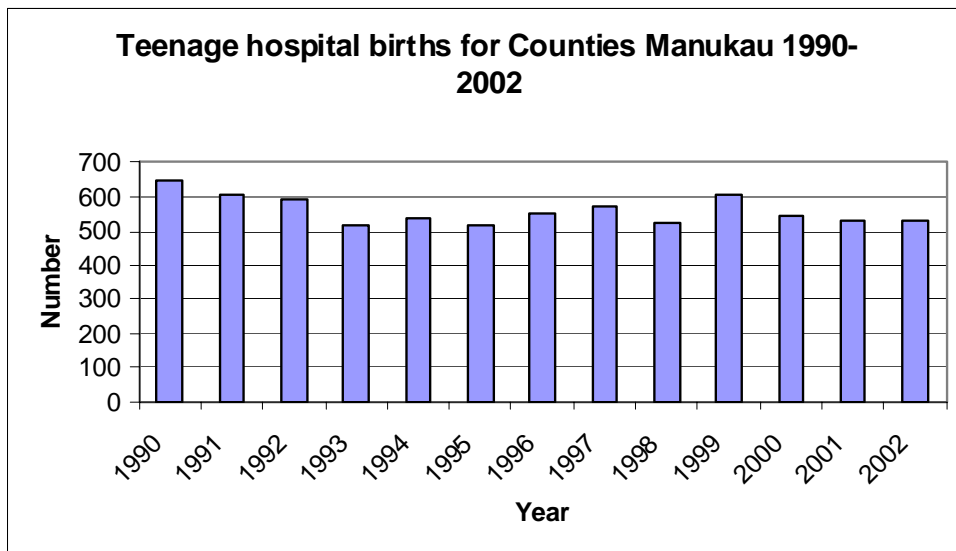
3.4.2 Teenage deliveries for the Counties Manukau population

The incidence of teenage births is particularly high in Counties Manukau. Figures from the last ten years show the rate of teenage births in the Counties Manukau district substantially exceeded the national rate each year, as well as the rates of several other neighbouring districts.



Furthermore, a recent health profile of South Auckland young people found teenage mothers accounted for nearly 1 in 10 births at the CM Obstetrics Department^{xxvi}. Within this group there was an excess of low birth weight babies (<2000g) and pre-term deliveries.

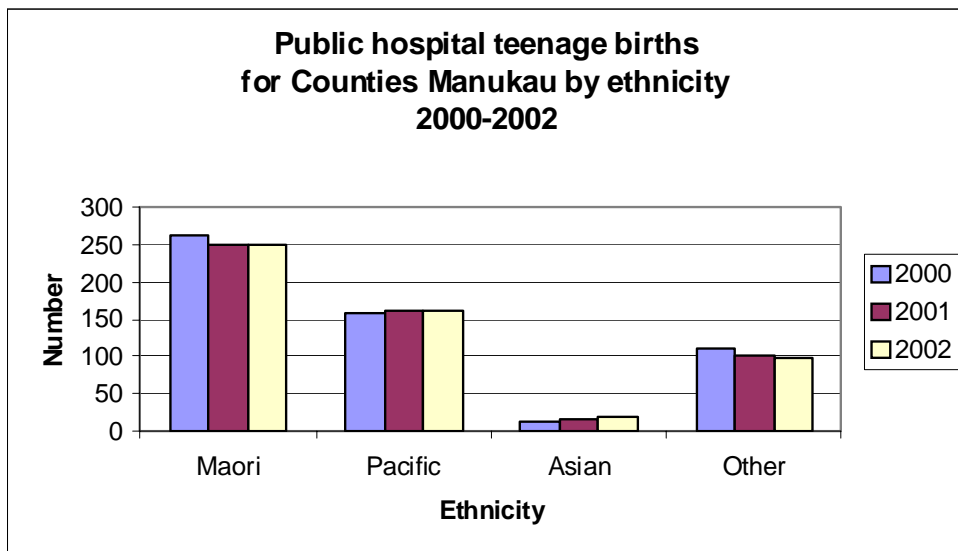
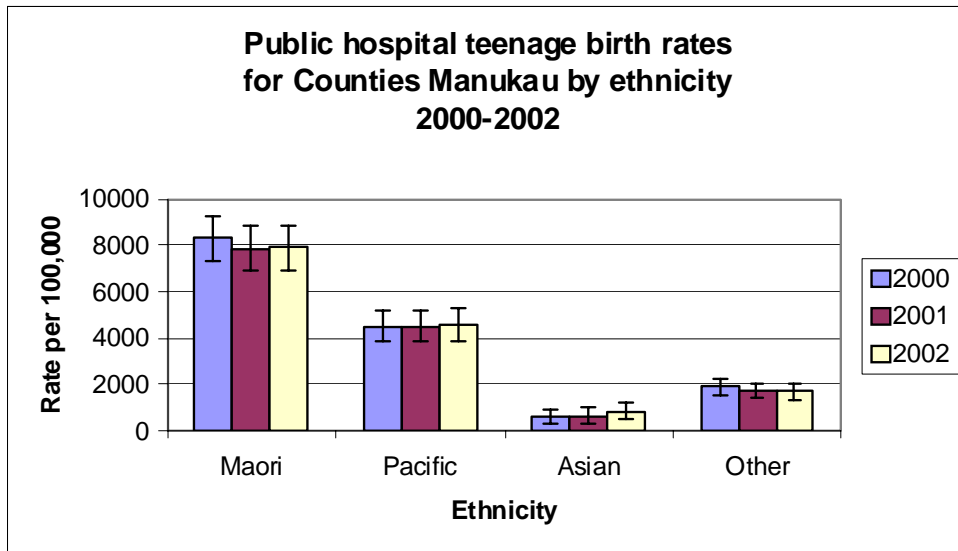
Absolute numbers of hospital deliveries to teenage mothers are illustrated in the following graph. This shows no particular trend in the numbers of these births in the district over the last decade.



3.4.3 Teenage births amongst Maori and Pacific young women in Counties Manukau

Rates of teenage deliveries amongst Maori and Pacific young women of the Counties Manukau area are higher than those amongst local women of other ethnic groups. The absolute numbers of teenage deliveries involving Maori and Pacific women of the area are also higher. This is further illustrated in the following graphs.

These differences may well reflect different cultural attitudes to teenage motherhood, as much as any differences in access to health promotion programmes and services. ‘By Maori for Maori’ initiatives clearly have a role to play however, as do similar Pacific initiatives, given the demographic differences that are evident in relation to this issue.



3.4.4 Teenage births and socio-economic status (SES) correlations in the Counties Manukau area

The rate of teenage births across the Counties Manukau district varies considerably across locales of differing socio-economic status. A higher rate of teenage births occurs amongst young women of the more deprived NZDep96 quintiles, compared with the less deprived ones.^{xxvii} This pattern was found to be consistent across the five years for which it was examined (1995-1999) in the Counties Manukau Health Profile. Areas of greater SES deprivation in the Counties Manukau region, using the NZ Dep96 decile classification system, include Otahuhu, Favona, Mangere, Otara, Flat Bush, Wiri,

Clendon and Takanini. The north-eastern parts of the DHB's area, around the greater parts of the Buckland's Beach peninsula, are notably amongst the least deprived parts of the district.

For these reasons, programmes that work to support young mothers in preparing for pregnancy and motherhood, whilst building/maintaining their links with friends, whanau, education and training are of importance. These need to be alert to the needs of Maori, Pacific and lower income young mothers, by being culturally appropriate, financially affordable and appropriately accessible, either by means of vehicular transport and/or appropriate location.

In summary

- Teenage births can be of concern as early parenthood can limit some opportunities for the mother and child, and due to the higher proportions of unintended and/or unwanted pregnancies that have been found amongst young peoples' pregnancies
- Low birth weight and preterm deliveries are also over-represented in teenage births
- Annual numbers of teenage births in Counties Manukau have remained relatively static over the last decade
- Greater numbers of Maori and Pacific young women have a child during their teenage years than Pakeha young women
- A greater rate of teenage births is found in the more socio-economically deprived areas of the Counties Manukau region

3.5 Terminations of Pregnancies

3.5.1 Introduction

Pregnancy terminations are legally regulated in New Zealand under the Contraception, Sterilisation and Abortion Act 1977.^{xxviii} This requires that patients meet specific health and duration of pregnancy requirements in order to obtain an abortion. Such patients are required to be assessed by two consultant doctors who confirm that they meet the necessary criteria. These ‘certifying’ and termination-performing consultants also need to meet specific requirements under the Act. Abortion premises need to be licensed as such under the Act. Abortion provision in New Zealand is overseen by a national supervisory committee who report to parliament regularly.

3.5.2 NZ Termination of pregnancy (TOP) statistics

National abortion figures reveal the number of abortions being performed annually in New Zealand has been steadily rising over recent years.^{xxix} National abortion rates have also been steadily increasing annually.

New Zealand as a country has higher abortion rates than a variety of other countries, such as the Netherlands, Germany and Finland, however our rates are lower than Australia and comparable with Sweden.^{xxx} The ratio of abortions to known pregnancies is also felt to be relatively high in this country, at 23% of known pregnancies.^{xxxi}

Nationally, the five-year age band of women for whom the greatest number of abortions are performed is the 20-24 year old age band. This is also the age band in which the greatest rate of increase appears to be occurring in this country.^{xxxii}

In the year 2002, 49.4% of women having an abortion reported being solely of a European ethnic background, 16.2% reported solely being Maori, 10.0% reported solely being of a Pacific ethnic group, 15.7% reported solely being of an Asian ethnic group and 7.3% identified with more than one ethnic group.^{xxxiii} In comparison, the 2001 New Zealand Census found 80.0% of the total population to be European, 14.7% to be Maori and Pacific and Asian ethnic groups each to constitute 6.5%. This suggests nationally that there is an over-representation of Asian, Pacific and Maori women in abortion statistics. Analyses of the ratios of abortions to known pregnancies have found that Asian women nationally have the highest rate (364/1000), followed by Maori women (280/1000) and Pacific women (255/1000).^{xxxiv}

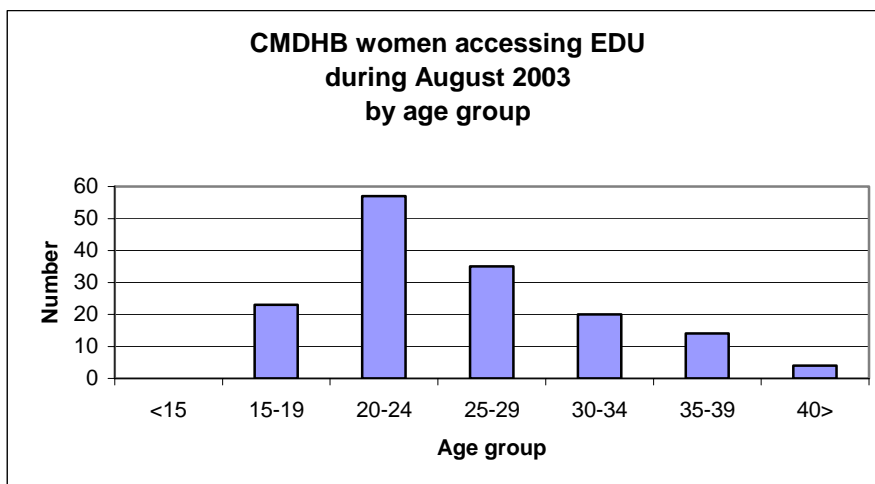
Around half of the women who had an abortion in 2001 had previously had one or more children. For around 2/3s it was the first time they had had an abortion, while a third had previously had an abortion.

3.5.3 Statistics for the Counties Manukau population

Limited statistics are available from the Epsom Day Unit (EDU); for just the month of August in fact, as prior to this data was not classified according to the residency of attendees.

3.5.3.1 Age profile

The age of EDU attendees from the Counties Manukau region is illustrated below and as can be seen, the greatest number of these patients were in their early twenties, followed by those in their late teens or late twenties. Overall, however, the age of patients seeking abortions ranged between 15 and more than 40 years.



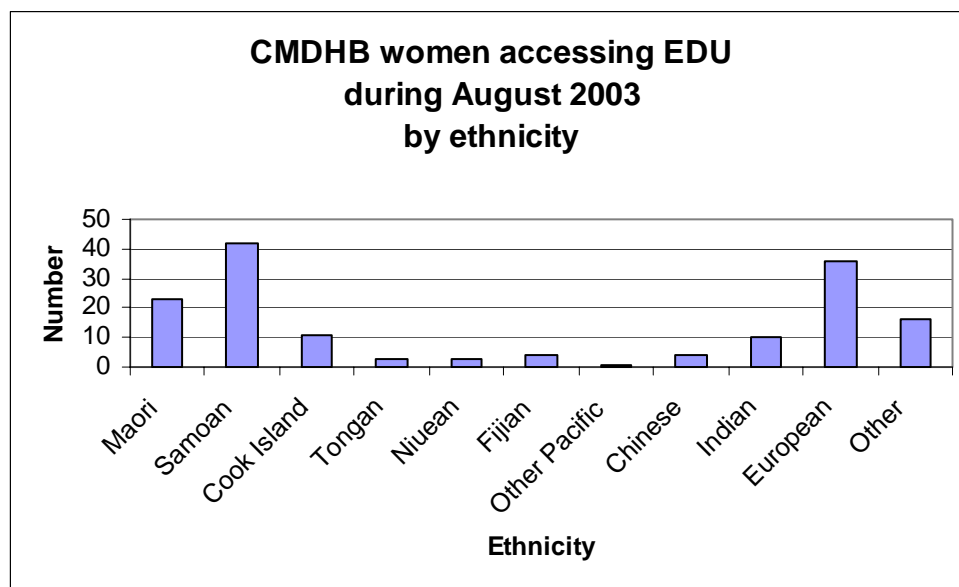
The age profile of CMDHB women accessing this service over this period generally reflects the national age distribution of women seeking abortions.

The above age distribution suggests that women in their twenties particularly, as well as secondary school-aged young women, may need to be assisted to access and effectively use contraception, as well as to be aware of how to access and use the Emergency Contraceptive Pill. Termination of pregnancy figures suggest these things are not happening as effectively as they could be.

Young people in their twenties are a less 'captive market' to reach than teenagers, because whilst the majority of teenagers can be reached through the secondary school system, young women in their twenties may be doing a variety of different things with

their lives (for example working, studying, caring for children at home or looking for work). Whilst relatively greater efforts appear to be being put into secondary school students' sexual and reproductive health education and in some cases service provision, more consideration of how to reach those who no longer attending school may be needed. These women are likely to have received some sexual and reproductive health education in the past, however, further public health work may be needed to again reach these young women in their twenties. Methods such as radio or television advertising could be used to inform them about initiatives such as availability of the ECP over the counter in chemists and the use of this product. For a more rounded preventative approach this could also be coupled with information on how to also access standard contraception cheaply; for example where free condoms are available and that FPA clinic and some PHO appointments are free for under 22 year olds. Consideration may also need to be given to the 22 year old age 'cut-off' and the rationale behind this.

2.5.3.2 Ethnicity profile

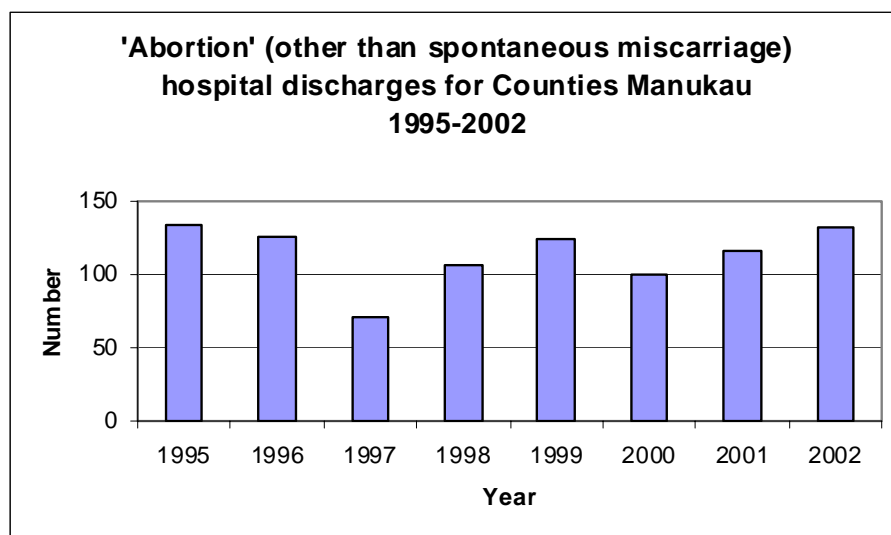


Presently available ethnicity data on CM women accessing EDU is limited due to the fact it represents only one month's 'worth' of attendees and therefore may well not be particularly representative.

The national statistics suggest TOPs should be a health issue that is considered in the CM area, particularly due to the high numbers of Asian, Maori and Pacific women in our catchment area, as well as the high numbers of young people.

Given the not insubstantial numbers of CM women having TOPs, efforts should be made to ensure as many of these women as possible are knowledgeable about and can access earlier management options, such as the Emergency Contraceptive Pill (which is now available from many pharmacists). Contraceptive education and availability is also obviously an important preventative priority.

A brief snapshot of Counties Manukau inpatient hospital ‘termination of pregnancy’ episodes is also shown below for comparison with the EDU figures. The majority of these terminations are likely to have been conducted as inpatient hospital procedures due to the mother being in her second trimester of pregnancy. As the graph below illustrates, the numbers of inpatient TOPs performed is substantially fewer than the numbers of first trimester, outpatient TOPs that are performed through the EDU.



Clearly, for the health of the mother involved, first trimester TOPs are preferable to second trimester TOPs, which carry a much higher medical risk. Strategies should therefore seek to minimise the numbers of ‘late’ TOPs being performed, as much as possible, by enabling those who wish to have a TOP to access this service early on in their pregnancy.

3.5.3.3 *In summary*

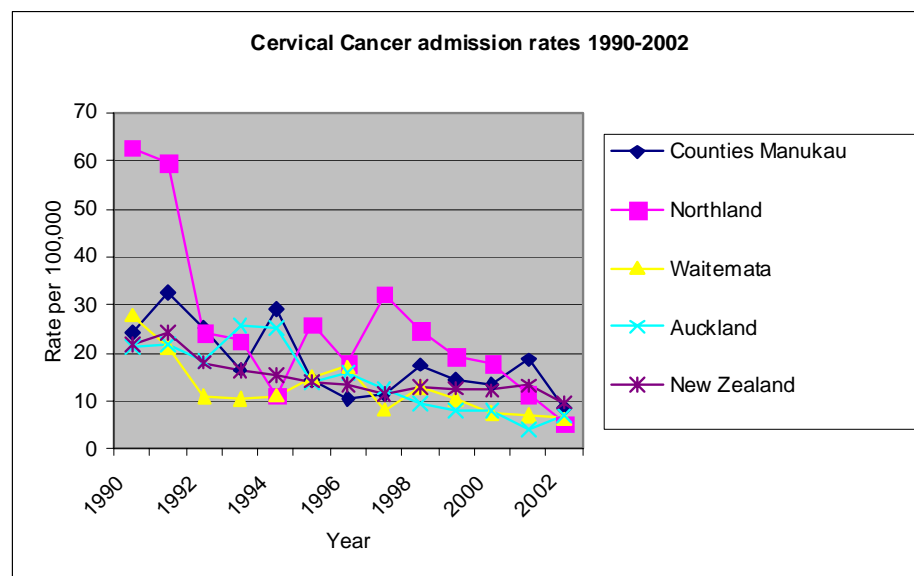
- The number of abortions performed annually in New Zealand has risen steadily over recent years
- The most common age of women having abortions is 20-24 years
- Asian, Pacific and Maori women are over represented in abortion statistics nationally

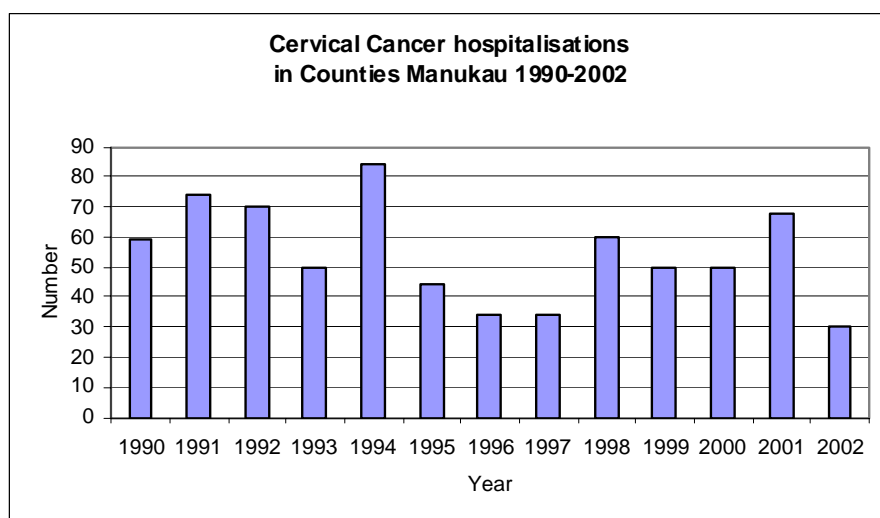
3.6 Cervical cancer

Cancer of the cervix is one of the most preventable forms of cancer. It is a disease that can be readily treated if detected at an early stage and for this reason the National Cervical Screening Programme is run in this country. Priority target groups identified by the screening programme, presumably due in part to relatively low screening coverage rates, are elderly women, Maori women and Pacific women.^{xxxv} Cancer of the cervix has also been found in previous research to be the leading site of cancer amongst Maori and Pacific women in New Zealand.^{xxxvi} Given the high proportion of the South Auckland population who are of Maori or Pacific ethnicities, local general practitioners may need to be alert to the need to promote cervical screening amongst their patients. Hospital practitioners may also need to be alert to this as a potential diagnosis.

Relatively recent research has linked the carriage of human papilloma virus (HPV), the virus that causes genital warts, with the subsequent development of cervical cancer.^{xxxvii} This means that using barrier contraception to prevent HPV transmission is also a preventative measure against cervical cancer.

Positively, annual hospital admissions for cervical cancer in Counties Manukau appear to have declined slightly over recent years. This is illustrated in the following graphs. This may reflect beneficial effects of the National Cervical Screening Programme.

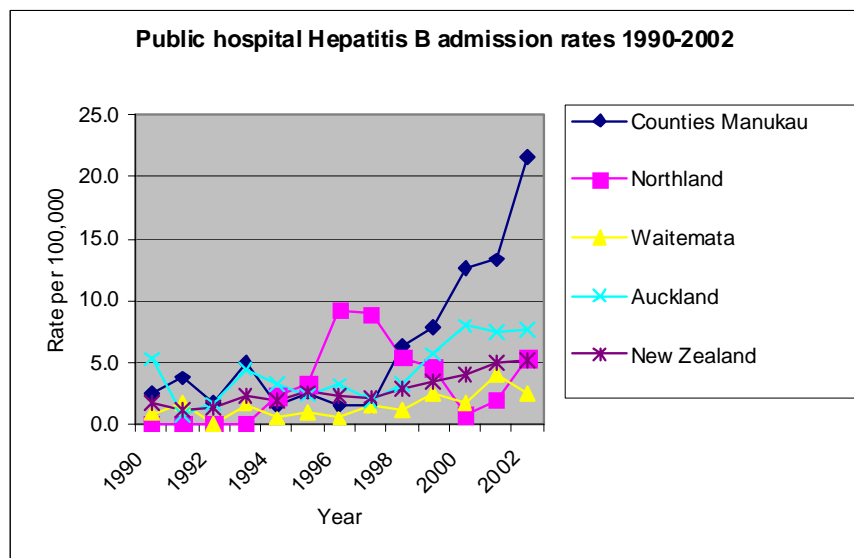
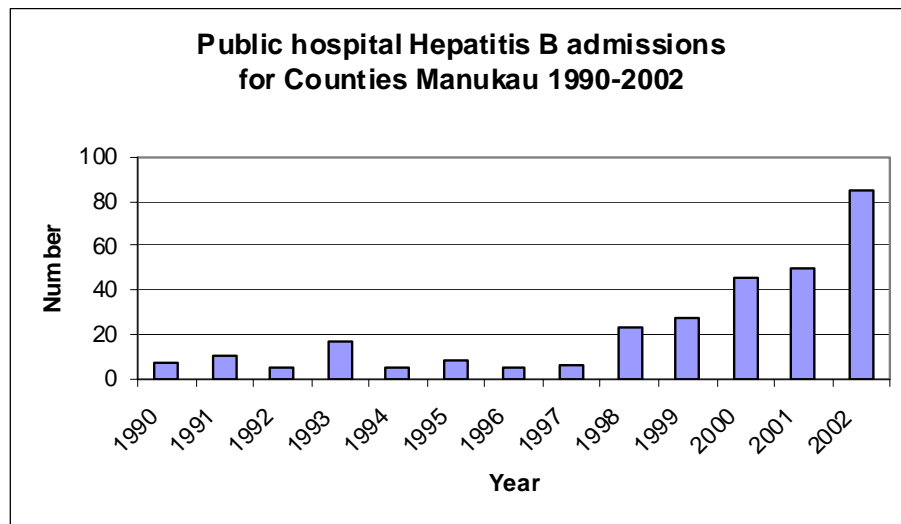




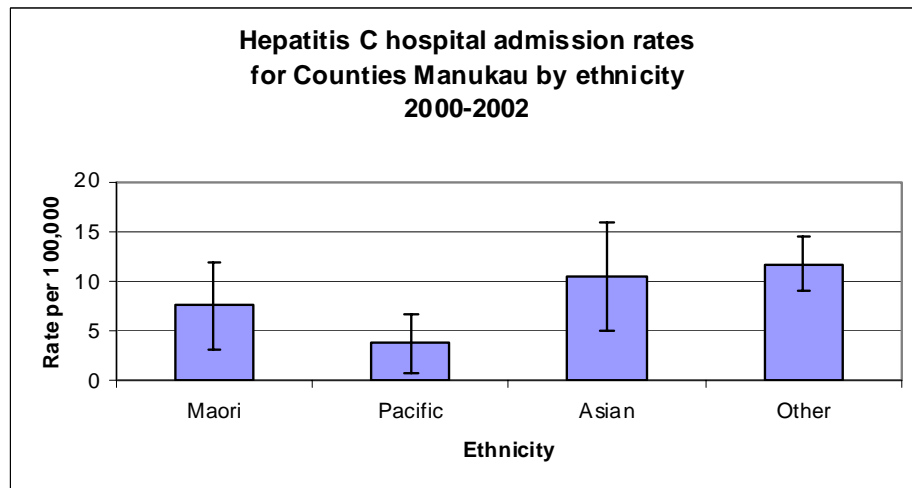
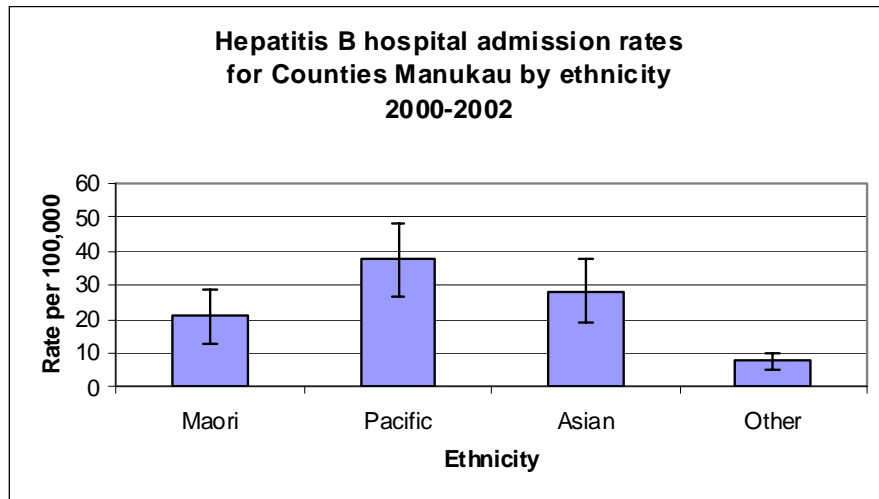
3.7 Hepatitis B & C

Hepatitis B and C are viral diseases that can be spread through sexual contact, in addition to other potential forms of transmission, such as through blood contact. Hepatitis B and C cause inflammation of the liver. Immunisation to prevent the acquisition of Hepatitis B infection is available, however there is no vaccine for Hepatitis C. Both diseases can develop into a chronic form that is associated with a risk of hepatocellular carcinoma, a form of liver cancer. New Zealand research has shown that hepatitis B carriage is more common amongst Maori and Pacific adults than it is amongst NZ European/Pakeha adults.^{xxxviii} The prevalence of hepatitis C antibodies has been found to be higher in homosexuals and sexual health clinic attendees, than amongst the general population of blood donors.^{xxxix}

Counties Manukau hospital inpatient episodes coded with the diagnosis of Hepatitis B or C appear to have risen over the last five years. This may reflect increased awareness of testing facilities for these conditions, with these being provided by the Middlemore Hospital laboratory in recent years, as well as the effects of the Hepatitis B screening programme.



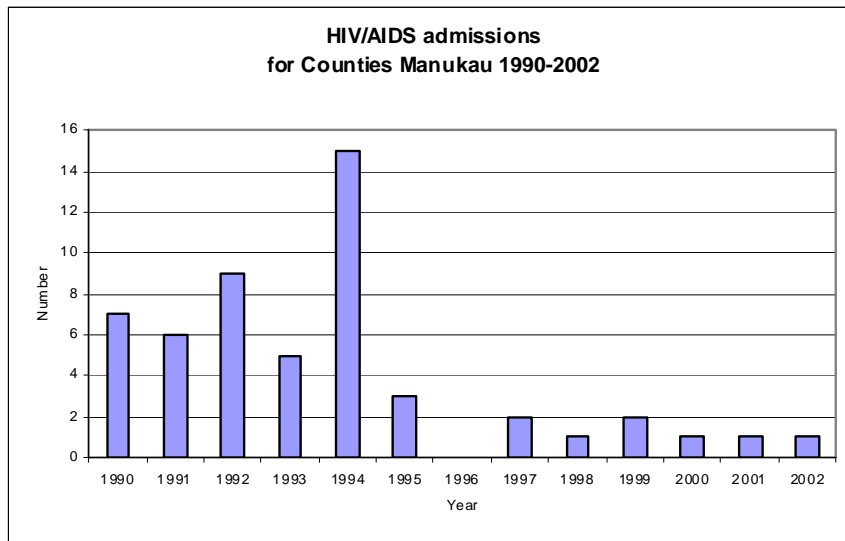
Greater numbers of males compared with females have been admitted with Hepatitis B or C over the last few years. Rates of admissions for Hepatitis B in Counties Manukau have been higher amongst people of Pacific or Asian backgrounds, than those of NZ European backgrounds, although absolute numbers of NZ Europeans admitted annually remain greater. Rates of Hepatitis C admissions have not been high amongst the Maori or Pacific ethnic groups, with the majority of these patients being of non-Maori, non-Pacific ethnic backgrounds.



3.8 HIV/AIDSs

Only small numbers of HIV/AIDSs patients are seen at Middlemore Hospital because a specialised HIV/AIDSs service is offered by the Infectious Diseases Department at Auckland Hospital. This is likely to be a well-placed, central geographic location for such services to be provided from within the Auckland region.

Middlemore Hospital, due to its proximity to the international airport may, however, encounter a greater number of patients presenting with HIV/AIDSs than many other hospitals in New Zealand. In practice numbers of HIV/AIDSs admissions for Counties Manukau have not been particularly large over recent years, though, as is illustrated in the following graph.



From a public health point of view, however, cognisance and vigilance around preventing HIV transmission is paramount, if the Counties Manukau population is to avoid the brunt of this disease in the future. Evidence of limited contraceptive use amongst young people in South Auckland, coupled with evidence of high rates of STI-related conditions in this area, mean that HIV/AIDS may well become much more prevalent in the future, if action to improve barrier contraception use is not taken.

3.9 Prostitution

There are several established massage parlours in the South Auckland area and it is likely that these establishments will be re-identified as brothels in the near future, given the recent prostitution law reforms that have occurred. It is unclear at this stage how the law reforms will impact upon DHBs in terms of any requirements to provide health services to workers in licensed brothels. The Occupational Health and Safety (OSH) service are currently developing guidelines for prostitutes' health and safety provisions in relation to their work. The Auckland Regional Public Health Service, in a recent submission to the Auckland City Council, note that a number of providers already cater to this clientele; themselves, the Auckland Sexual Health Service, the NZ Prostitutes Collective, FPA and the NZ AIDs Foundation.^{x1}

Anecdotally key informants suggest that there is also an opportunistic prostitution scene in South Auckland that occurs outside the bounds of traditional brothels, in settings such as bus stations and often involves relatively young individuals. Accessing these

young people to cater to any specific healthcare needs they may have, could be practically difficult as this prostitution scene appears to be geographically transient. The Prostitutes Collective do provide an outreach service, however, that can refer individuals to health care providers. The Manukau City Council, in conjunction with Family Planning, have also developed an outreach proposal to address this issue, although it is uncertain if necessary funding will be available. Facilities such as youth centres could also potentially engage with such young people (if they attended the centre) and be able to offer them sexual and reproductive health promotion, education and service-linkages.

4 Programme and service provision in Counties Manukau

4.1 Introduction

A variety of different groups provide sexual and reproductive health programmes and services for the Counties Manukau population. These will now be profiled using the categories of:

- sex and sexuality education
- training programmes for healthcare professionals
- primary healthcare service provision
- contraceptive service providers
- STI treatment service providers
- termination of pregnancy services

4.2 Sex and Sexuality Education

4.2.1 Introduction

The New Zealand Health and Physical Education Curriculum identifies sexuality education as a curriculum area to be addressed by School Boards of Trustees. These Boards are legally required to consult with their communities and then to direct or refrain from directing the school regarding the elements of sex education to be taught.^{xli} Given this process, there is significant room for variability in whether or what schools provide in terms of sex and sexuality education.

4.2.2 Review of Sexuality Education in Schools

A review of the sexual and reproductive health education provision, in a sample of 100 schools from around New Zealand, was conducted by the Education Review Office in 1995.^{xlii} This found some problems with the content of schools' programmes with

regard to relatively limited information provision to form 1 and 2 students and a piecemeal approach being used by many schools at the secondary school level, with the omission of some core subject areas in many cases. Few schools in this review were found to provide as much as 14 hours per year of sexual and reproductive health education, as is suggested by research to be necessary for effective education in this area.^{xliii} There appeared to be little assurance that many schools had chosen the teaching resources they use as the best ones available, rather than the ones most easily obtained. While many schools surveyed their students to determine their sexual and reproductive health education needs and/or evaluated programmes after they had been delivered, few reviewed the programmes delivered to increase their effectiveness. Programme delivery was usually by school staff in conjunction with outside ‘experts’, rather than just by one or the other. Only a minority of schools provided clinical support services, such as a school nurse, health clinic or visiting health professionals, to back up their education programmes. These have been previously thought to be important to the effectiveness of sexual and reproductive health education programmes in schools.^{xliiv}

The ERO’s selected review of 100 schools nationally in 1995 appears to be the most recent time this curriculum area has been reviewed by the office. Current online Education Review Office (ERO) reviews of schools in the South Auckland area, contain little if any information on their sex and sexuality education programmes and the office reports that this is not routinely included in the material they review.^{xlv}

4.2.3 Programmes available in the Counties Manukau area

A variety of different organisations in the Auckland area appear to be involved in the delivery of sexual and reproductive health education (and/or support) programmes in schools within the Counties Manukau district.

The Auckland Regional Sexual Health Service runs a Peer Sexuality Support Programme (PSSP). This trains selected students to work in a support role with other young people on sexuality issues. They also offer more traditional sex and sexuality education sessions to schools that request this.

A process evaluation of this programme was conducted by a Sexual Health Medicine Registrar, Dr Susan Ritchie, in 1999.^{xlvi} This compared achievements of the programme in the areas of access, effectiveness, efficiency, acceptability and safety, against contract obligations determined by the then Regional Health Authority. Findings of this review were that ‘access’ objectives to train 100 students from 20 schools were not quite achieved. This was thought to be due to the influences of some churches and the Christian Heritage Party on schools during the implementation period, as well as reluctance by some schools themselves to be involved with the programme. Effectiveness in terms of the educators developing skills in how to deliver sexual health support were achieved, however effectiveness in terms of these young people being able to implement their ideas in their schools were more limited in some cases, due to particular school environments. Measures of effectiveness in terms of achieving

behavioural change in the school student populations were not attempted. Issues around the efficiency of PSS students being able to achieve their aims within schools were similar to those indicated above. Acceptability, particularly in terms of cultural acceptability, the author found to be good. Safety, in terms of appropriately trained people delivering the programme to the PSS students, was achieved. Ongoing monitoring of the PSS students performance in schools does not appear to have been investigated.

A recent issue of the World Health Organisation's European sexual and reproductive health magazine *Entre Nous* has focused on the role of peer education in sexual and reproductive health.^{xlvii} This feature profiles the valuable role of peer education, whilst also indicating the need for appropriately qualified health professionals to back this up. It also highlights a potential role of medical students, who may not yet be seen as intimidating authority figures, in 'peer' education.

The Family Planning Association in New Zealand offers sex and sexuality education programmes to schools (amongst other groups) through their education unit. In addition, this unit produces a variety of educational resources and informative pamphlets outlining both medical information and practical options on topics ranging from unplanned pregnancy choices to sterilization options. The resources are available to be ordered from their education unit in Wellington.

Other providers of sexuality-related education in the CM area include Family Life Education Pasefika (FLEP), who provide innovative, drama and music based sessions for young people in settings such as schools and churches.

Awhitia, a Maori health provider, also provide innovative health promotion/education sessions to young people. These seek to enable attitudinal change and utilise drama and performing arts mediums.

Also the Manukau Youth Centre provides some sex and sexuality education sessions to a variety of young people, including those in its alternative education programme, in conjunction with staff from the Centre for Youth Health.

To gather further information on sexual and reproductive health education programmes and services in schools in the Counties Manukau area, local secondary schools have been contacted in the process of doing this work, requesting further information on what they provide in this regard. Some of this information is still being returned by the schools contacted. Given the concerning contraception usage, STI, PID, ectopic pregnancy, TOP and teenage birth statistics outlined already in this document, further development in this area may be beneficial.

In addition to sexuality education programmes, as can be seen above, some schools also provide on-site sexual and reproductive health services. This can take the form of a Family Planning Association nurse regularly visiting the school and providing contraception and STI testing, for example.

At the tertiary education level, the Manukau Institute of Technology has a health clinic with a GP on-site for 8 hours per week. This clinic is usually staffed by nurses, who can perform pregnancy tests and dispense condoms and the ECP. No STI checks or standard oral contraceptive pill provision, however, is available from the nursing staff. The clinic reports they are not running any particular health promotion or disease prevention programmes at present.

From the information that has been gleaned from schools thus far and from the above example of a tertiary institution, it seems that sexual and reproductive health service provision is variably available, but likely to be beneficial in the supporting of young peoples' sexual and reproductive health. Further scope for improvement in the level of service that is available to young people in these settings, appears to be evident in many instances. It also appears that considerable scope for health promotion/disease prevention initiatives may exist and could potentially be progressed by outside providers such as the Sexual Health Service, Family Planning or PHOs working with these institutions.

4.3 Training for Primary Healthcare Professionals in Sexual and Reproductive Health

The Family Planning Association provides a variety of courses for health professionals on topics such as prescribing contraception and taking cervical smears. These are generally free to community-based health professionals, such as PHO staff, and are a resource that should be fully utilised to maximise the delivery of optimal community-based services.

Also, the Regional Sexual Health Service report there has been some discussion with CMDHB regarding using a room in the health centre adjacent to the Mangere Sexual Health Clinic for primary healthcare professional training sessions.

Good provision and uptake of courses, such as those mentioned above, is likely to be necessary to support the provision of optimal sexual and reproductive health care provision via primary care. Courses such as these may also allow practice nurses to take a more active role in sexual and reproductive health care provision, potentially improving access to these services at a minimal cost.

4.4 Primary healthcare service provision

General practitioners and primary health care organisations provide a large number of sexual and reproductive health related appointments. However, comprehensive data on this is unfortunately not available.

The recent NatMedCa national general practice study did not include enough general practitioners' appointments to be able to provide relevant regional and consult-type specific information, such as information on sexual and reproductive health GP appointments for Counties Manukau.¹

Some relevant information on this subject was provided by Procure, however, in their U22 programme funding proposal dated October 2002. Procure is the largest PHO in the Auckland region with a total catchment population of almost half the Auckland population.^{xlviii} They reported at this time that they had around 50,000 14-22 year olds enrolled. Over a 2 ¼ year period they reported around 14,000 consultations for under 22 year olds were conducted for sexual and reproductive health purposes. The proportion of clients who specifically sought out this service, aware that it was free, is unclear however.

90% of ProCare U22 consultations described in this document were for female clients and just over half were for contraceptive purposes. About a third of consultations were for STI purposes, with 17% involving the taking of STI screening tests and 12% relating to STI follow-up or treatment. 57% of consultations were for Pakeha/NZ Europeans, 20% were for Maori (which is above the proportion of the Auckland population that is Maori), 9% were for Pacific peoples and 8% were for Asian peoples.

Additional benefits of the programme were that refresher training was provided to a large number of ProCare general practitioners, by sexual health specialists such as Dr Janet Say. Contact tracing procedures were also set in place in conjunction with this programme. These procedures involve 'contacts' being referred to the Regional Sexual Health Service if the index case reports they will not pursue treatment or if the index case does not return for follow-up.

Other PHOs such as the Middlemore PHO have also developed free sexual and reproductive health consultation programmes. The level of public awareness of this free service is also unclear, however, as this PHO has reported their quota for these consultations has not been filled to capacity. The ethnic composition of patients utilising Middlemore PHO's U22 service illustrates, however, that good proportions of Maori (35%) and Pacific (41%) patients are using this service. It is therefore reaching

¹ Personal communication. NatMedCa study group.

some target populations, however young patients are using this service less than older ones, with 53% of patients being 25 years of age or older. As with ProCare's U22 service the majority of patients are female (95%) and attend for contraceptive purposes (81%).

Additional benefits of the Middlemore PHO's programme have been that the issues of GP credentialing for IUCD insertions and vasectomies have been addressed. Two vasectomy declarations (to enable GPs within the PHO to perform these procedures) and six IUCD declarations had been received by the PHO to date by 3/9/03.

Skilled, accessible primary care provision of sexual and reproductive health services is obviously desirable. Whether a wider pool of general practitioners would benefit from a course updating their sexual and reproductive health care skills may warrant consideration.

Raising community awareness of the fact that free appointments for these purposes are available and where they can be accessed is likely to be vital to the success of initiatives to improve sexual and reproductive health care access for those who previously may not have sought attention due to cost barriers.

4.5 Contraceptive Services

4.5.1 Providers of temporary contraception

Temporary contraceptives are available from a variety of providers in the Counties Manukau DHB region. These include the Family Planning Association clinics at Manukau, Papakura and their drop-in centre at Highland Park, as well as their clinics run in conjunction with other services. General practitioners also provide these services and individuals can buy condoms directly from venues such as supermarkets, chemists and service stations.

Providers:

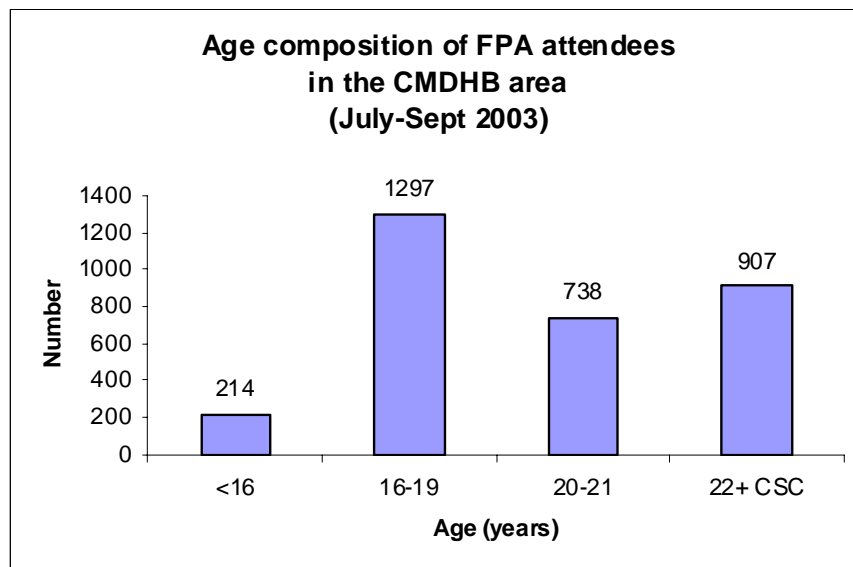
- Family Planning Association Clinics –Manukau, Papakura, Highland Park
- General Practitioners and PHOs
- Other unique clinics - such as FPA's clinic at Awhitia & school-link clinics
- Regional Sexual Health Services clinic –although this is more a by-product of their main intended service provision

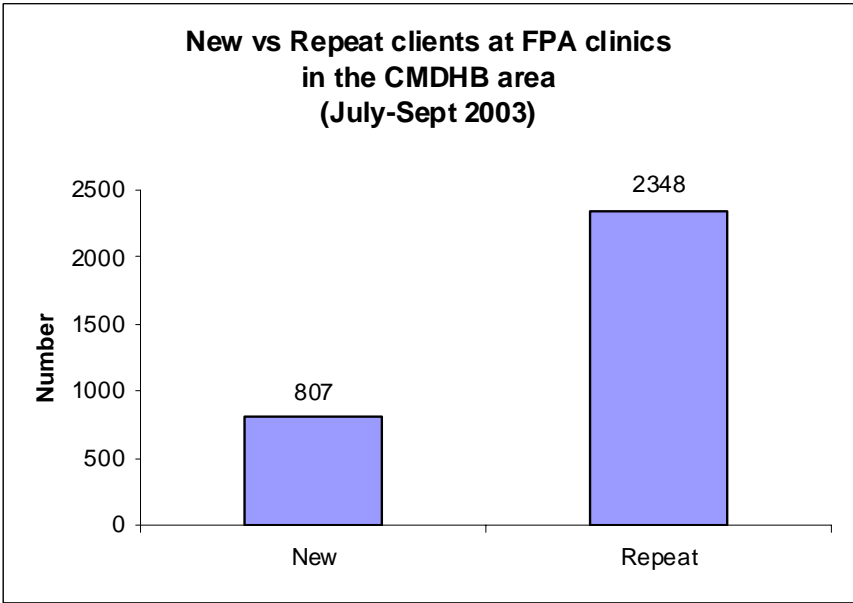
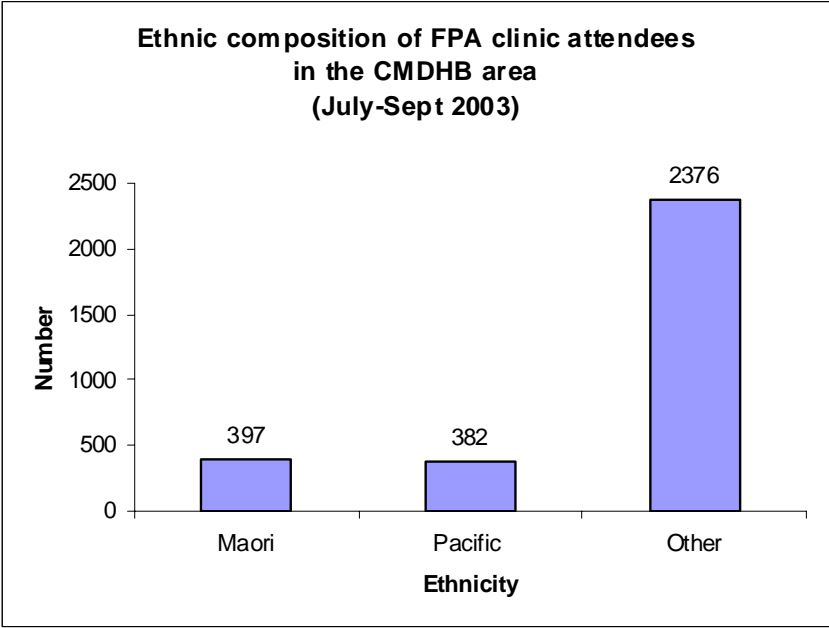
4.5.1.1 Family Planning Association (FPA) Clinics

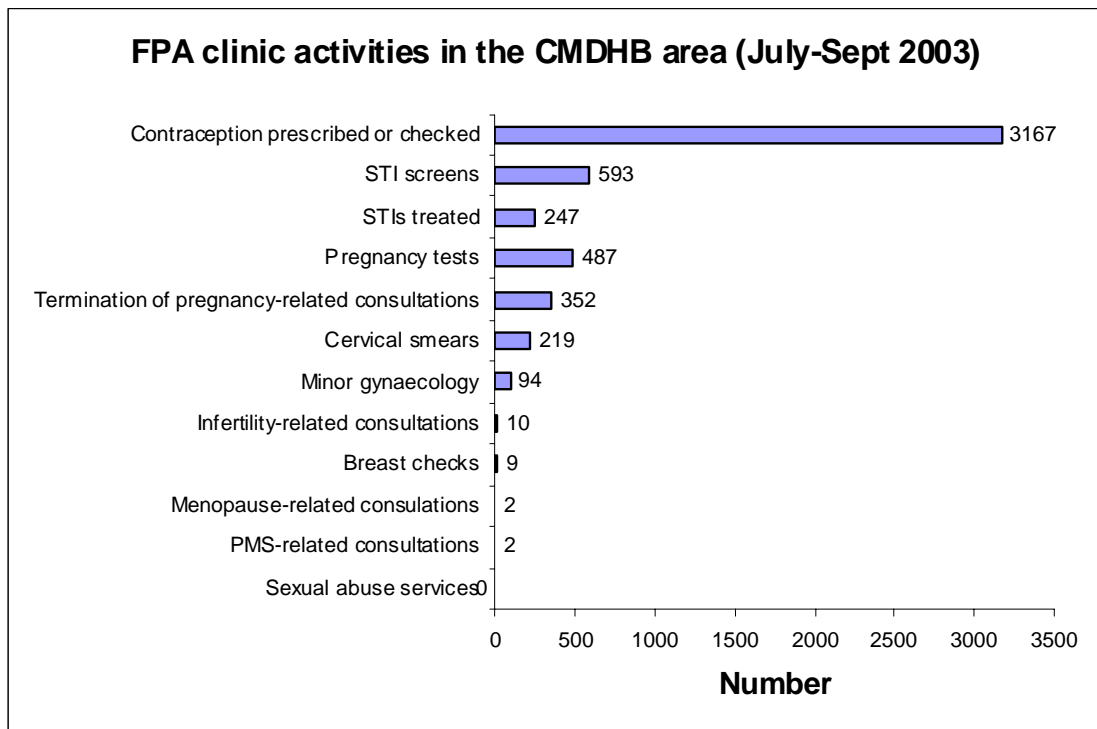
The Family Planning Association runs 'full service' clinics in Manukau, within the Manukau City shopping mall and in Papakura, that are open most days of the week. These are staffed by both doctors and nurses. IUCD insertions are available and vasectomies are likely to be available in the near future.

The association also has a doctor-run clinic one day per week at the Maori sexual and reproductive health service provider Awhitia and a nurse-run 'drop-in' clinic in Highland Park. Some periodic clinics are also run in conjunction with schools.

Data on the attendees of Family Planning Association clinics in the Counties Manukau region over the 3 months July-September 2003 is only available for those aged under 22 years or who had a Community Services Card. This shows that the majority of clients accounted for in this data were female (98%), attended for contraceptive purposes, about 2/3s were repeat clients and the majority were not of Maori or Pacific ethnic backgrounds. These features are illustrated in the following graphs.







3.5.1.2 *General issues to consider*

Issues that may need to be addressed with regards to the provision of temporary forms of contraception include those of awareness, access, cost and acceptability.

Whilst providers such as Family Planning and some PHOs provide free appointments to all under 22 year olds, the Regional Sexual Health clinic provides free appointments to all, and in some cases the contraceptives themselves are provided free, the proportion of the community who are aware of these services and deliberately access them is unclear.

The role that 'specialist' services have to play in this field is clear however, as individuals may wish to access a different provider than their usual GP for the provision of sexual and reproductive-related services. This may be due to confidentiality issues, or to the relative ease of raising sexual and reproductive health topics in these settings. Furthermore, Family Planning provide a comprehensive service and have considerable knowledge in the field, thereby making them a provider of choice for many women. Awhitia is a Maori provider of sexual and reproductive health care in the CM region. This service incorporates a weekly Family Planning Association clinic which deals with contraceptive issues amongst others.

Having discussed the important role of ‘specialist’ and ‘specific’ services, issues of transport and accessibility are, however, of substantial importance in the relatively vast geographical areas of southern and eastern Auckland. Particularly in the socio-economically deprived parts of southern Auckland, individuals may not have easy access to transport to attend specialist services that may be some distance away. For this reason, raising awareness of and increasing provision of inexpensive contraceptives at the grassroots community level may be of substantial importance if a difference in STI and teenage pregnancy rates are to be made. This would obviously need to be coupled with work promoting healthy attitudes to sexual health including the importance of using contraception to avoid unintended pregnancies/STIs. (It should be noted however, that Awhitia do provide a ‘pick up’ and ‘drop off’ service for their clients.)

Strategies to raise awareness of services already provided could include advertising campaigns around schools, day-care centres and kindergartens (to capture young parents), backs of toilet-doors in bars and nightclubs etc. Greater ‘visiting professional’ services in schools could also increase access. As could the provision of a reasonable number of free or very inexpensive condoms to those requesting them, through pharmacies for example, to encourage individuals to access these and keep them at hand in case of the need to use them.

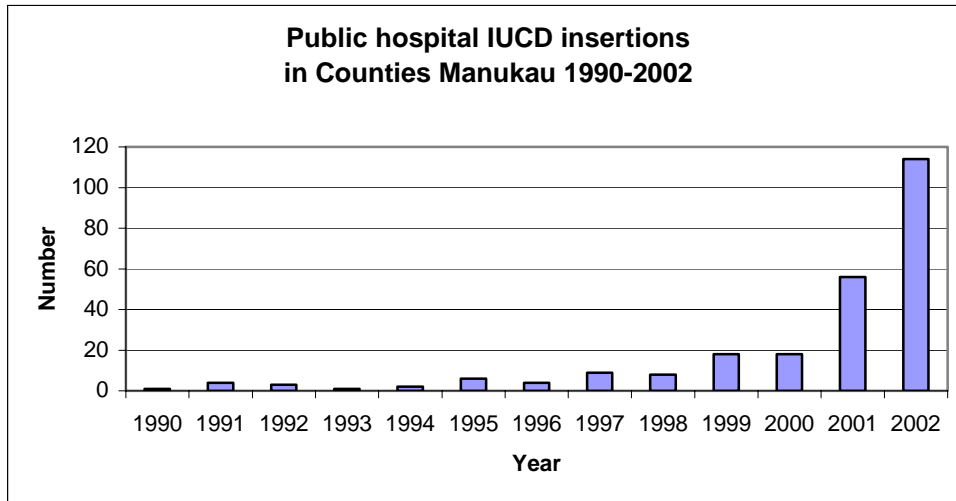
Further ethnic-specific services may also have a part to play and if this is the case need to be embraced by members of the relevant communities, so they are truly relevant and well-utilised.

4.5.1.3 *Intra-uterine Contraceptive Devices (IUCDs)*

Intra-uterine contraceptive devices (IUCDs), as a more long-term although still temporary contraceptive option, warrant special discussion. In the community IUCDs are inserted at the Family Planning Association clinics in Manukau and Papakura and by some GPs in the South Auckland region. Copper IUCDs are the standard type used in the community setting for women with a history of normal menstrual flow rates, as these are substantially cheaper than Mirena IUCDs. Under Pharmac special authority guidelines Mirena IUCDs are only available free-of-charge for insertion in the community for women who haven’t responded to/can’t tolerate other pharmacological treatments for menorrhagia and have a low haemoglobin or serum ferritin.^{xlix}

In addition to the community, IUCDs are also inserted in the hospital setting. The numbers of IUCDs inserted within the public hospital system in the Counties Manukau region has increased substantially over recent years. This may perhaps be due to increased use and popularity of the Mirena-type IUCD, or due to increased attempts to

provide alternative long-term contraception to women of the region who may potentially be facing a waiting time for a public hospital tubal ligation.



At present work is being done within the DHB (by the Sterilisation and Long-term Contraception Steering Group) to assess the relative merits and appropriate funding and service provision levels for the various forms of longer term contraception; IUCDs, tubal ligations and vasectomies. Efforts are also being made to streamline GP referrals onto the tubal ligation waiting list (by the Elective Services Project) and to increase the numbers of IUCDs inserted by GPs.

4.5.2 Permanent contraceptive methods

4.5.2.1 Tubal ligation services

Tubal ligations are a publicly provided procedure. There has been a long waiting list for this service in recent times, however, and for this reason additional funding has recently been allocated to the provision of this service, to reduce waiting times. An additional 250 tubal ligations were funded for the 2003/04 year, on top of the 250 pa usually funded.

Greater need for the public hospital system to be utilised to provide these services is likely in the South Auckland region, due to the relative expense of this service when performed privately. For this reason greater public expenditure on this service in the CM area may be necessary, compared with that of other DHBs of a similar population size.

4.5.2.2 Vasectomy services

Vasectomies are not generally offered as a public hospital service in South Auckland and only a few are performed each year by visiting urologists.

Vasectomies are provided by a handful of private practitioners, however, who have clinics in the Counties Manukau region and surrounding areas. These include Dr Sydney Choy who is based in Papakura and Dr Robin Smart who has clinic rooms in Botany Downs and Papakura, but performs the actual procedures at his Remuera rooms.

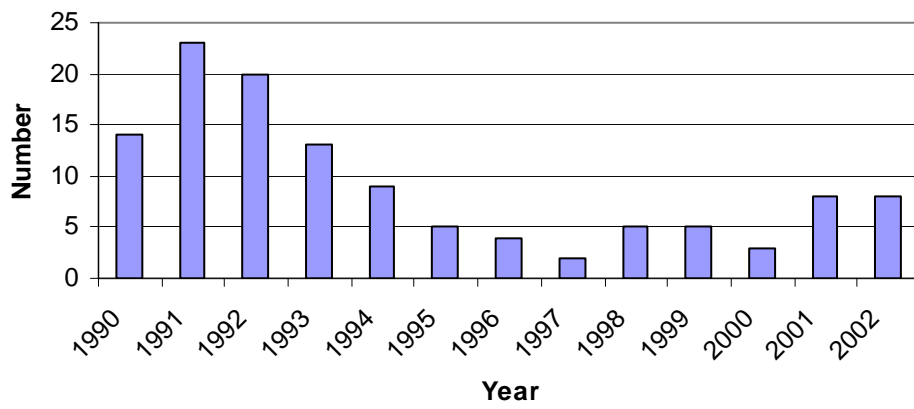
Further private practitioners offering vasectomies are situated in the suburbs of Mt Wellington and Onehunga, which neighbour the Counties Manukau region.

The Family Planning Association, who have clinics in Manukau, Papakura and a drop-in clinic in Highland Park, also offer vasectomies. These are performed only at their Newmarket or Takapuna clinics at present, however, although they hope to reinstate the provision of this service at their Manukau clinic in the near future.

The cost of a vasectomy performed in private practice appears to range from about \$300 to about \$470.

Cost and accessibility may therefore be barriers to this form of contraception in South Auckland and the public provision of a number of vasectomies in South Auckland is recommended.

Public vasectomy hospitalisations for Counties Manukau 1990-2002



4.6 Sexually Transmitted Infection (STI) treatment services

Sexually transmitted infection treatment is provided by the specific Regional Sexual Health Services clinic in Mangere, as well as by general practices and Family Planning Association Clinics, in the Counties Manukau area.

Providers:

- Regional Sexual Health Services clinic - Mangere
- General Practitioners and PHOs
- Family Planning Association clinics – Manukau, Papakura
- Other unique clinics – such as FPA's clinic at Awhitia

4.6.1 Regional Sexual Health Services Clinic

The Regional Sexual Health Services clinic was located in Manukau until earlier this year, at which time the lease on its premises expired and it was relocated to Mangere, a location chosen in part due to its lower decile nature.

Regionally the Sexual Health Services are contracted to provide 23,500 visits annually, spread over the three DHB areas.

Services provided at the Regional Sexual Health Service's Clinic in Mangere as well as the assessment of patients, screening and advice on contact tracing, include onsite preliminary microscopic analysis of patient specimens and the dispensing of pharmaceutical treatments (and some contraceptives) directly to the patient. This has the benefit of maximising the rapidity and accuracy of diagnoses, the best selection of antibiotic treatment and optimising treatment compliance.

As well as attending to self-referred patients with potentially primary care level sexual health care needs, the Regional Sexual Health Services also receive referrals from other providers in the field, such as GPs, Family Planning and midwives, for the provision of secondary level care. The Australasian College of Sexual Health Physicians five year specialist training programme, which is about to be amalgamated under the Royal

Australasian College of Physicians, means that fellows and even trainees under these programmes have considerable specialist experience in the assessment, diagnosis and treatment of sexually transmitted diseases. As well as providing secondary level care themselves, these practitioners also provide telephone advice to other doctors who request it, and as such are a source of expertise in the community.

Waiting times for an appointment at the Mangere clinic are generally nil to one day, however waiting times for the evening sessions on Thursdays are up to a week. Clinic staff report anecdotally that callers from Pukekohe/Waiuku often opt not to come when made aware of the clinic's location, due to the travelling distance; some women also opt not to do so, which clinic staff feel may be due to security concerns.

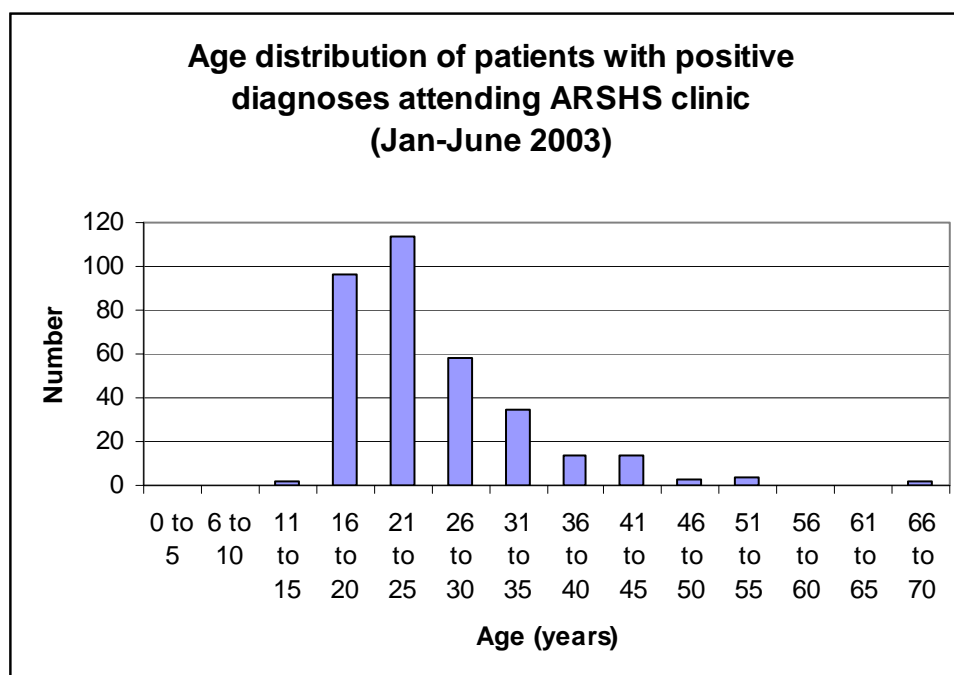
The gender distribution of attendees at the South Auckland Regional Sexual Health Services Clinic is shown in the following table. This shows a slight preponderance of male first-time clientele. This has been further discussed in the earlier section on STIs. It is notable however, that follow-up clients are less likely to be male.

Period Jan-June 2003	Gender	
	Male	Female
First Visit	604 (53.3 %)	530 (46.7 %)
Follow-up Visits	546 (48.7 %)	576 (51.3 %)

An ethnicity breakdown is shown in the next table. This shows relatively high rates of Maori and Pacific clients attending the service, as would be hoped, given the South Auckland population composition.

Period Jan-June 2003	Ethnicity		
	Maori	Pacific	All other
First Visit	260 (22.9 %)	185 (16.3 %)	689 (60.8%)
Follow-up Visits	207 (18.4%)	164 (14.6%)	751 (66.9%)

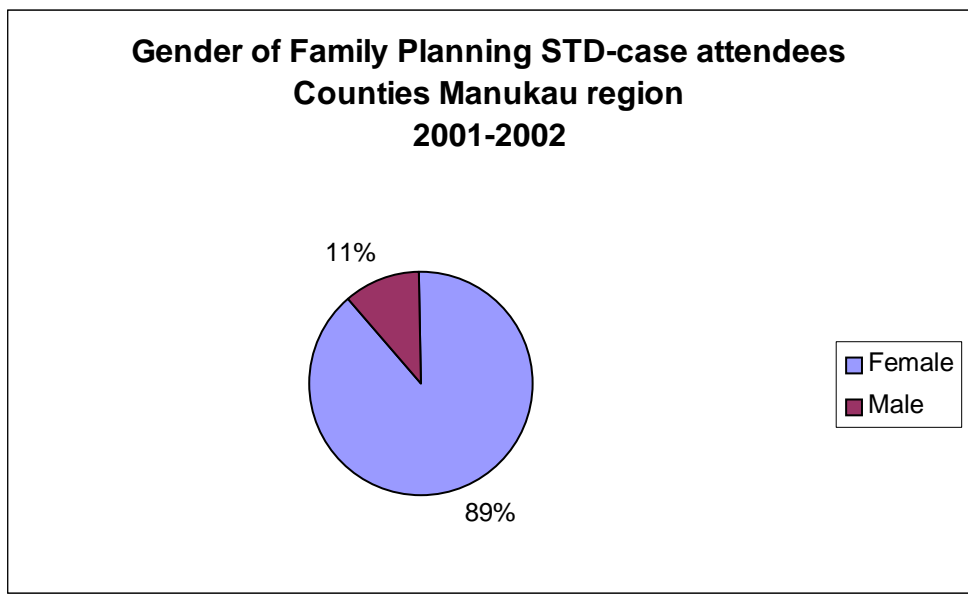
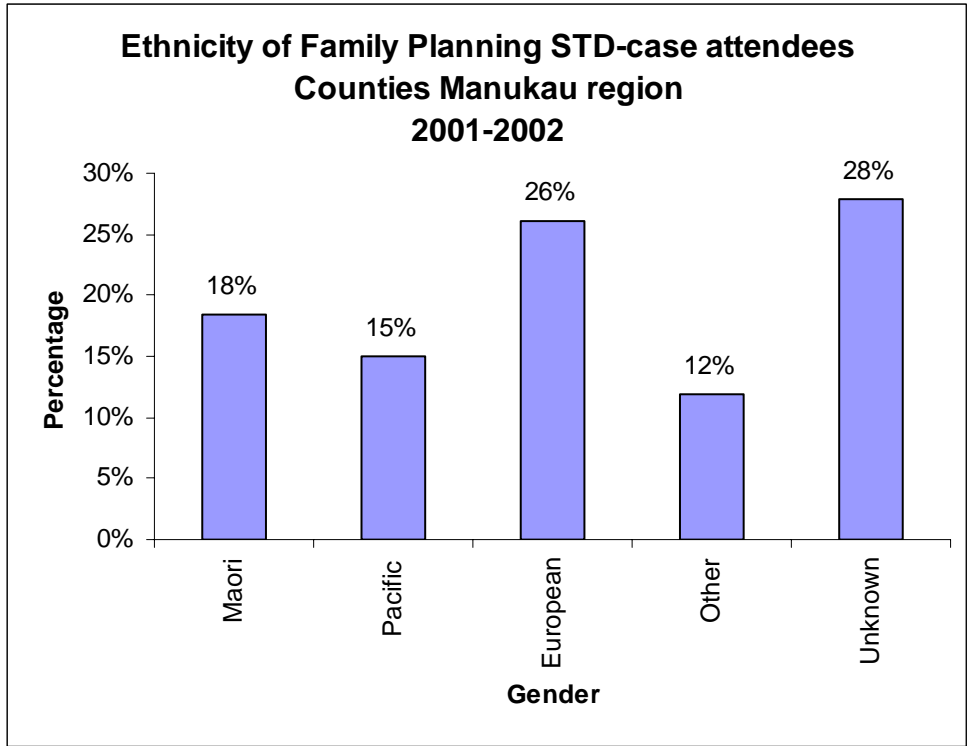
The age distribution of those diagnosed with an STI is shown in the following graph, rather than that of all attendees, as this is the data available. This indicates that the majority of clientele attending the clinic are aged between 16 and 30 years, and especially between 16 and 25 years of age.

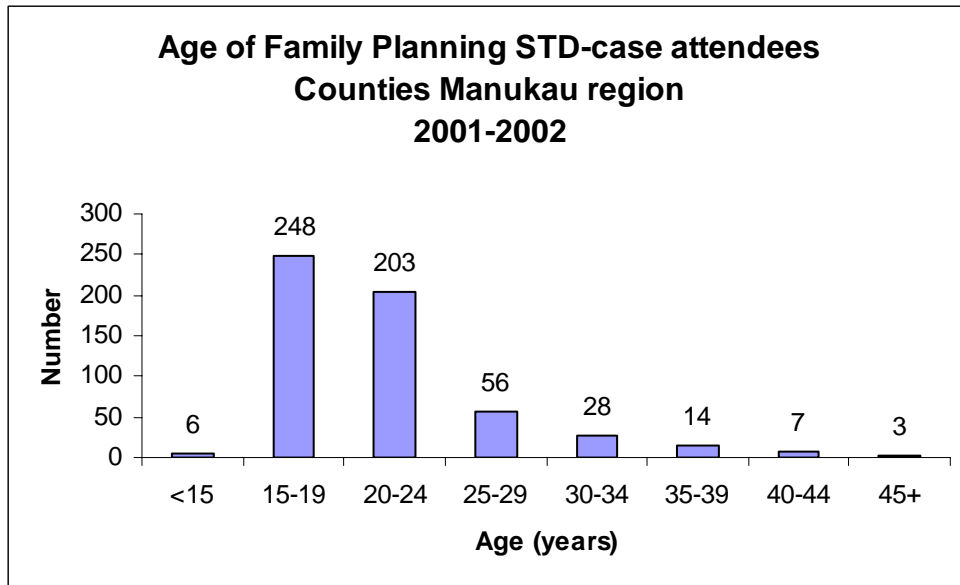


4.6.2 Family Planning Association clinics: STI cases

Information on STI-case attendees of the Family Planning Association clinics is provided below.¹ Whilst these are perhaps not the ‘core business’ of the Family Planning Association clinics in general, a reasonable number of such cases are seen and treated in this setting. (Refer to the previous section for further details on the composition of FPA clinic visit purposes).

As can be seen, the large majority of these cases, as for most of Family Planning's clients, are female. Data on the ethnicity of this clientele is limited because for 28% no ethnicity is recorded.





Information on STI-case FPA clinic attendances in the Counties Manukau region finds these were mainly aged between 15 and 24 years.

The clinic doctor at the FPA clinic at Awhitia reports a relatively large proportion of the consultations she sees are STI-related.

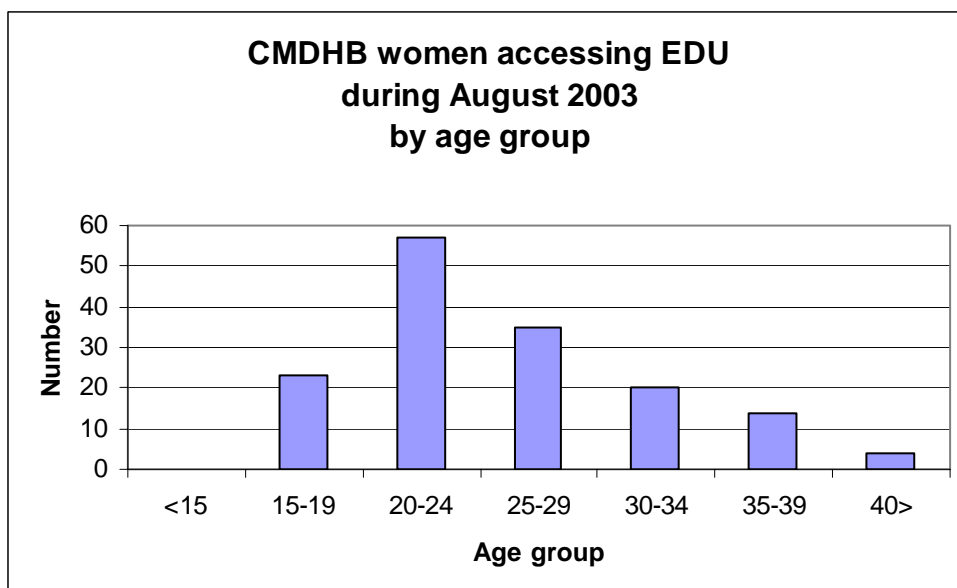
4.7 Termination of pregnancy services

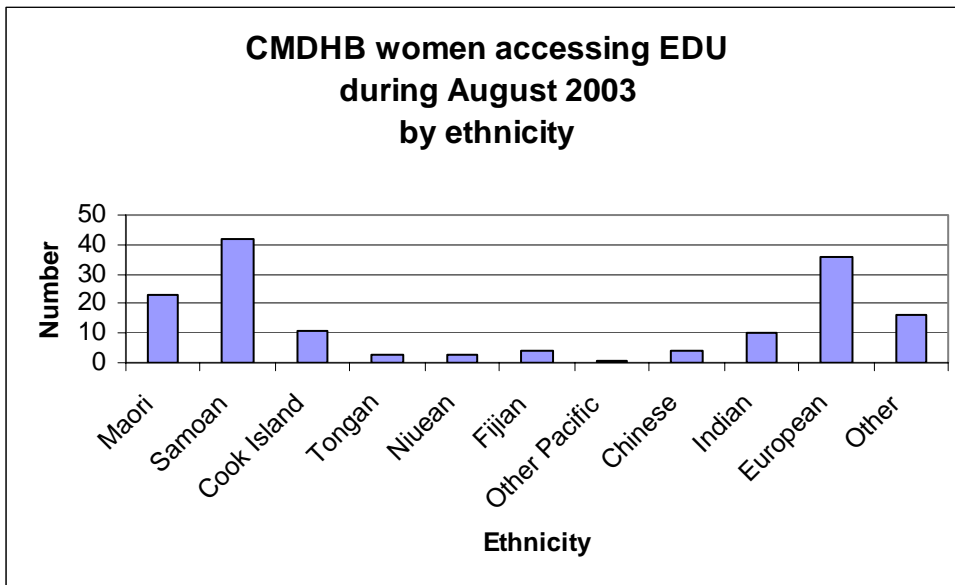
Termination of pregnancy services for the Auckland region are primarily provided at the Epsom Day Unit at National Women's Hospital. This is a free, public hospital service that performs about 5,500 terminations per year.ⁱⁱ About one third of these are for women from the Counties Manukau area.

Regionally about 1,000 terminations annually are also performed privately at the Auckland Medical Aid Trust. A termination at this service costs the consumer about \$750. This service offers women who are <7 weeks pregnant the option of a 'medical' first trimester termination of pregnancy using RU486, rather than just the standard suction termination procedure.

A smaller number of second trimester terminations for Counties Manukau women are carried out as inpatient hospital procedures. Some of these are performed within CMDHB, however a number are also referred on to National Womens Hospital.

The age and ethnic breakdown of Counties Manukau women accessing the Epsom Day Unit during the month of August can be seen in the following graphs. As is illustrated, the most common age group of women accessing this service were in their 20s, although women across the reproductive age range do access this service.





The ethnicity breakdown above may be misleading, as it represents one month's data only and should be interpreted with caution.

Advice on termination of pregnancy options is offered by several places in South Auckland including the Family Planning Association and general practitioners.

Issues of importance regarding the provision of TOPs to CM women include the relatively long distance they need to travel to the EDU and the generally increasing demand for this service annually from women of all 3 of its 'feeder' DHBs – perhaps indicating the need to address a South Auckland-based service at some point in the future.

5 National Sexual and Reproductive Health policy in New Zealand

5.1 Introduction

Three national sexual and reproductive health policy documents have been published by the Ministry of the Health in recent years. These are the *Sexual and Reproductive Health Strategy* (1996), the *Sexual and Reproductive Health Strategy – Phase One* (2001) and *Sexual and Reproductive Health: A resource book for New Zealand health care organisations* (2003). These documents outline key priorities as identified by the Ministry, the direction they see sexual and reproductive health programme and service provision taking in this country and in the final document, suggested approaches that DHBs and local providers can use in this regard.

5.2 National strategies

Two national sexual and reproductive health strategy documents have been released by the Ministry of Health in recent years, in 1996 and 2001 respectively. These strategies will now be outlined so that their relationship with this plan can be identified.

5.2.1 *Sexual and Reproductive Health Strategy (1996)*

Several national priorities for sexual and reproductive health were identified firstly in 1996. These were to:

- Reduce abortion rates
- Reduce rates of unwanted pregnancies
- Reduce the spread of and prevent STIs including HIV/AIDs
- Improve access to contraceptive information and products
- Develop evidence-based policy for the delivery of sexual and reproductive health services to Rangatahi
- Improve delivery of sexual and reproductive health services to Pacific people

- Gather improved information about the delivery of sexual and reproductive health education in schools
- Gather information about the interrelationships between reproductive and sexual health, education, employment and family life – for ongoing policy development

These priorities concur in many regards with key sexual and reproductive health issues for the Counties Manukau area that have already been identified in this document.

Several key strategies put forward nationally in 1996 to address these issues were to:

- Reduce cost barriers to contraception
- Evaluate how the sexual and reproductive health curriculum has been implemented in intermediate and secondary schools
- Consider any changes in the prescribing of contraceptives that would improve access
- Aim to prevent STIs

Building on these more general strategies, a series of more specific national initiatives were developed in 1996. These were to:

- Provide (the then) RHAs with additional funding to reduce the cost of consultations sought for the purpose of obtaining contraception (especially for women experiencing high rates of abortion, “in particular women under 25 years, Maori and Pacific women”) and to increase the subsidy level for oral contraceptives, so that at least one within each prescriptive category would be available fully subsidised.
- Commission the Education Review Office (ERO) to evaluate the current provision of the school sexual and reproductive health curriculum for forms 1-7 and for this to inform the development of a new draft curriculum.
- Commission the Ministry of Health to produce a discussion paper on Rangatahi sexual wellbeing and reproductive health to facilitate discussion on the subject and policy development.
- Given awareness of the high abortion rate amongst Pacific women at this time, address developing programmes for Pacific people.
- Consider a MOH discussion paper on STI prevention, looking at issues such as surveillance, education and health promotion, treatment and other service standards and contact tracing.
- Consider direct sale of the emergency contraceptive pill (ECP) to women by pharmacists.
- Consider lengthening the prescription period for oral contraceptives and nurse prescribing of these.
- Establish a ministerial advisory group on ways to reduce abortion rates.

- Obtain additional data related to this area through the “NZ Women: Family, Education and Employment” national survey
- Continue school-based programmes such as PSST.

As a result of these initiatives several advancements were achieved. (1) Fully subsidised contraceptives within each category are available. (2) The ERO produced a review of sexual health education in a national sample of schools, which raised several issues that have been discussed earlier in this report. (3) Maori sexual health policy development is reflected in subsequent Ministry documents and at least within the Auckland area, both Maori and Pacific-specific programmes are running. (4) STI surveillance is coordinated nationally by the ESR, however there are still some problems with the completeness and coordination of this data. ESR data is drawn from a variety of sources including sexual health clinics, family planning clinics and some laboratories, but not the general practice setting, and it may not accurately represent the disease burdens in communities given that it represents only test-diagnosed STIs. (5) The ECP is now available over the counter at pharmacies and nurse prescribing initiatives in general have been advanced in this country. (6) Progress on reducing abortions has not been good however, with the numbers of these increasing over recent years. (7) Periodic data supplementations have been achieved through initiatives such as the NZ WFEE survey, however more regular data supplementation is now planned by including a sexual and reproductive health component in the Ministry of Health’s National Population Health Survey. (8) A variety of school sexuality education programmes are now provided, with different schools appearing to use different programmes. How well schools are informed about the available options and actively select the programme(s) they feel are best for their school is unclear. This was also raised as an issue in the ERO review of schools’ sexual health education.

5.2.2 Sexual and Reproductive Health Strategy – Phase One (2001)

Building on the progress made in 1996 the Ministry released their *Sexual and Reproductive Health Strategy- Phase One* in 2001. This again highlighted the issues of reducing STIs and unwanted/unintended pregnancies, as well as maximising the health of ‘at risk’ groups such as youth, Maori and Pacific peoples.

This document discussed the broad range of social and behavioural factors that influence sexual and reproductive health. Identified factors were **predisposing factors** (such as education, knowledge, attitudes, beliefs, socio-economic status, background of abuse, violence, mental health and disability, alcohol and drug use etc), **reinforcing factors** (such as feed-back received in response to behaviour, which may encourage or discourage such behaviour, eg responses from partners, family, peers, community etc) and **enabling factors** (environmental factors that facilitate healthy behaviour and the skills and resources to realise that behaviour).

A potentially broader set of strategic directions were identified in this document, as influences on sexual and reproductive health that need to be addressed. These include:

- Societal attitudes, values and behaviour
- Personal knowledge, skills and behaviour
- Services (and ensure these are accessible, appropriate, sustainable and address workforce development, are able to supply necessary related products, meet established standards etc)
- The limited evidence base available

The next step identified in this strategy was the development of action plans. That is the goal towards which this document has been developed. Concurrently with the development of this document the Ministry has produced a guiding document on how health care organisations could approach these issues. This is entitled *Sexual and Reproductive Health: A resource book for health care organisations* (2003). Some ways in which this document can help guide progress for the Counties Manukau region will now be discussed.

5.2.3 Sexual and Reproductive Health: A resource book for New Zealand health care organisations (2003)

This resource book discusses approaches that ‘work’ in designing effective services and highlights particular points to consider in service planning. The Ministry’s work has identified that a **multi-pronged approach** is most likely to be effective. The evidence reviewed in the creation of this document also suggests that short term programmes are less likely to be effective than **longer term initiatives**.

For young people necessary prongs identified were:

- **comprehensive sexuality education**
- **youth-focused primary health care**
- **ready access to condoms and contraceptives**

5.2.3.1 Comprehensive Sexuality Education

As previously discussed in this document a number of different providers work with schools, and to a lesser extent with other organisations such as churches and alternative education programmes, providing sexuality education. As raised in the ERO report on the subject, it is somewhat unclear to what extent schools are aware of all the options and actively select the provider(s) with whom they most prefer to work. It is also unclear how effective these programmes are in influencing young peoples’ attitudes and behaviours around contraception use, especially barrier contraception use, given the issues already discussed in this document.

The scope for development of sexuality programmes in institutions other than schools, such as those listed above and others such as tertiary institutions, is also rather unclear;

however it could be seen to be quite considerable if appropriate goodwill and funding were available. A general appraisal of the likely benefits per resources used in targeting groups other than secondary school students may need further assessment. Some settings may require specific adaptations of the techniques used and methods delivered. For example a more 'life course' perspective may be necessary for engaging in Pacific church-related settings, if this were thought to be a good approach.

The work of Kirby, a key theorist on teenage pregnancy who is quoted in the Ministry's work, identifies some specific characteristics of effective sex education programmes.^{liii} Some of the key features he identifies are to:

- Deliver and consistently reinforce a clear message about either not having sex or using contraception
- Provide basic information about the risks and methods of protection
- Address social pressures
- Provide examples of and practice with communication, negotiation and refusal skills
- Involve participants in teaching, to help personalise the information
- Make programmes appropriate in terms of students' ages, experiences and cultural backgrounds.
- Allow enough time and use enthusiastic, trained leaders.

Despite the efforts of enthusiastic sexuality educators providing programmes that are likely to address the above elements, the contraception use, STI, teenage pregnancy and TOP statistics already discussed indicate that from a health outcomes perspective there is still room for progress. Statistics obtained from abortion clinic attendees suggest that whilst most were aware of possible methods of contraception and how to use them, they did not do so consistently. This indicates that attitudinal change at a population level is necessary, with resulting behavioural change. One method to achieve this could be the use of a 'hard hitting' approach to bullet point one above. This could emphasise the potential harm that catching HIV/AIDs or an incurable STI would cause, along with the potential impact of early parenthood on one's life choices and opportunities.

The aforementioned abortion clinic attendee research did also find however, that some Pacific women felt they lacked sufficient contraceptive knowledge. More recent abortion clinic research has also identified a potential lack of knowledge amongst Asian attendees, in particular relatively new immigrants from China. These findings may indicate the need for the provision of specific practical information within these communities.

Two key determinants of teenage birth rates that have been identified by UNICEF are those of '**motive**' and '**means**'. Motive is described in this context as a sense of self-esteem and that one has options for the future that are more desirable than early parenthood. Means is described as being well prepared and equipped to cope in a highly sexualised society. Sexuality education and health services are most likely to be appropriately placed to address the 'means' element of this equation. Some education

programmes may also address elements of ‘motive’, such as the FLEP programme I believe. Further work in this area may fall into the realm of youth development programmes and governmental initiatives to reduce inequalities in society.

5.2.3.2 Youth-focused Primary Health Care

School-based health centres have been specifically identified as initiatives that improve young people’s access to health care, particularly for young people from disadvantaged backgrounds.^{liii} It is noted whilst research on whether these alter health outcomes is lacking, anecdotal benefits of these clinics include improved access to health care, especially for boys, a reduction in unwanted pregnancies and an improvement in students practising safer sex.

In the South Auckland area it appears that schools have taken different approaches to health service provision with some relying on a school nurse to respond to students needs that arise (and arrange transport and appointments as necessary), while others have arranged for regular (for example weekly) clinics by providers such as Family Planning or possibly general practitioners.

Another key facet of designing services that work was identified to be the involvement of **young people in programme design**. It doesn’t appear that young people have generally been particularly involved in service design in the South Auckland area. Some ideas from young people (collated in the Ministry’s document) include: improving advertising about where young people can go for help; having youth-friendly, accessible services; having young, non-judgemental staff, providing confidential advice; making trained peer supporters available; providing information to young people about their options including via innovative mediums such as columns in magazines, leaflets in toilets, posters in places that young people go, as well as on the internet. To advance this aspect in South Auckland young people could be consulted about how sexual and reproductive health services and programmes could be improved. Service providers may also seek to offer young people a better service by explicitly considering and revising how they deal with young people. For example, general practitioners may improve their practice by actively discussing preventative health measures with young people when they seek a consultation for another purpose. More specifically general practitioners could discuss with young people whether they would like any contraceptives.

From the Ministry’s review of **primary care features** that have been shown to be associated with increases in condom and contraceptive use, the following features were identified: *one-on-one discussions* with clients about their needs, *readily available information about options*, *clear messages about the risks* and *direct provision of condoms or contraceptives*.

These aspects of health care provision are accessed by some of South Auckland’s population, however many individuals may never seek a one-on one consultation about

their sexual and reproductive health needs. This may be due to the cost of an appointment, lack of knowledge about where to go for this, or most probably the absence of ‘getting around to this’ or feeling a need to do so. For this reason emphasis on the availability and benefits of doing so should be included in school-based sexuality education, as well as these services being advertised more generally. Providers of free consultations could perhaps also increase awareness of their services by advertising in schools, other community settings and possibly on the radio, on stations such as Mai FM.

5.2.3.3 *Ready access to condoms and contraceptives*

Condoms and contraceptives are provided on site by some health care services, such as sexual health and FPA clinics, however this should become the norm in other primary care settings as well. This may be particularly useful in the case of the oral contraceptive pill, where it is important that the patient clearly understands how they should use the pill packet.

Condoms are also available on a practitioner’s supply order and could easily be provided to young people, in particular, within the practice setting. Having contraceptives available on-site in the doctor’s practice and readily discussing them with patients may raise the profile of contraception and the use of it.

It is also questionable why consumers should pay relatively high prices for small packets of condoms when purchasing these directly from a store. It would seem a sensible public health measure to allow the purchase of government-subsidised condoms without a prescription, as there is no real reason why a doctor needs to be consulted about condom use, and this may improve people pre-emptively ‘arming themselves’ with condoms.

Support for making inexpensive condoms obtainable from store settings, rather than just through healthcare practices can be found from the fact that most adolescents reported obtaining or planning to obtain condoms from stores rather than healthcare settings in a US study.^{liv} Furthermore, research in the US has found that cost is a real barrier to condom use^{lv}. Also, in an investigation into the fate of condoms distributed in a free initiative in the Republic of South Africa it was reassuringly found that less than 10% wastage had occurred by the 5 week follow-up mark.^{lvi}

6 Sexual and Reproductive Health

Strategies outside New Zealand

In the Ministry's *Sexual and Reproductive Health: A resource book for New Zealand health care organisations* some common features of societies with relatively good sexual and reproductive health outcomes are highlighted.^{lvii} These include:

- An 'inclusive society'
- Relative income equality
- Good retention of young people in the education system
- Honesty and openness about sexuality at all levels of society
- Ongoing public education campaigns through the media about safety and pleasure
- Young people are valued in society rather than being seen as problems
- Policy and programmes are research-based
- Free or low cost contraception is accessible
- Issues arising from cultural diversity/differing values are carefully worked through

Some of these issues relate to the way society is structured in these countries and are unlikely to be easily altered at the DHB level. Others offer opportunities for effective advocacy or action at the DHB level. DHB generated programmes could seek to explore sexuality amongst specific groups (such as ethnic groups), provide public education and provide low cost or free contraception (perhaps to target groups).

Further useful information can be gained by looking at specific examples of how other countries manage sexual and reproductive health.

The Netherlands is often identified in international comparisons as a front-runner in the area of sexual and reproductive health because they have the lowest teenage pregnancy and abortion rates in the developed world. A Dutch Senator, Ans Zwerver, recently visited New Zealand, speaking about how the Netherlands has achieved these rates.^{lviii} She indicated that "so-called freedom in the Netherlands" is strongly linked with a sense of responsibility. She highlighted the importance of sexuality education from a young age and open discussion in families. "Young people will make their own decisions about when to have sex and we had better take care to ensure that they are protected" stated Ans Zwerver. She discussed that Dutch children are urged to use two forms of contraception, such as the oral contraceptive pill and a condom to protect against STIs and said that "most Dutch people would not consider having sex without

two forms of contraception”. She also raised that whilst some might believe that overt discussion about sex may encourage young people to have sex earlier, the average age of first sexual intercourse in the Netherlands was older than in most other developed countries. Finally Ans Zwerver highlighted the importance of realistic investment in sexual and reproductive health programmes, so that good outcomes can be achieved.

New Zealand may be able to learn from the Netherlands open attitude to sexuality, by developing health promotion programmes that encourage open discussion within families and society on sex-related topics, coupled with instruction on how to manage sex safely, possibly using two form of contraception (barrier and other).

Great Britain is another developed country that has recently made substantial investment in the area of sexual and reproductive health. Great Britain’s Department of Health released their *National strategy for sexual health and HIV* in 2001, a strategy that they themselves described as “ambitious and comprehensive”, requiring “a ten-year commitment to deliver what it proposes”.^{lix} “As a start” the strategy details that an extra 47.5 million pounds will be invested over the initial two years to support a range of initiatives outlined in the strategy. The impetus for this strategy was drawn from rising infection rates, the arrival of the HIV epidemic, evidence of increased risk taking and a doubling of attendance numbers at the UK’s genito-urinary medicine clinics over the preceding decade.

Specific strategies identified in Britain include:

Better prevention, through:

- National information campaigns, supported by local initiatives
- Guidance on evidence-based prevention
- Setting national targets re HIV prevention (reducing the numbers of new cases, the levels of unsafe sex and raising awareness of services) and reporting

Better services, through:

- Strengthening the role of primary care
- Setting national standards for sexual health services
- Managing sexual health service networks
- Making services more accessible
- Piloting one-stop-shops in sexual health
- Screening target groups for chlamydia
- Setting targets to reduce the number of undiagnosed HIV infections
- Setting targets for hepatitis B vaccination

Better local commissioning of services, through:

- Local multi-agency commissioning panels with identified lead commissioners
- Local targets, linked to national priorities and based on local needs assessment and partnership with professionals
- User and community involvement in service planning and commissioning

Supporting change, through:

- Reviewing current information and data collation
- Improving the evidence base
- Developing professional education and training

The strategies identified in Britain can also inform planning here, although considerable national investment would be necessary to replicate their programme here. Specific initiatives in their strategy could well be effective here. These strategies could include a public information campaign, strengthening the role of primary care, setting standards within the field, screening targeted groups (such as those presenting post unprotected sex) for chlamydia and setting Hepatitis B targets.

7 Literature evidence for selected specific Sexual and Reproductive Health initiatives

7.1 Partner notification

A review of the evidence on partner notification performed for the *British Medical Journal* found no good evidence that this resulted in an increased rate of relationship violence, abuse or abandonment, something that had previously been raised as an issue of concern.^{lx}

Several different forms of partner notification are used in different healthcare settings internationally.

These include **patient referral**, **provider referral** and **contract referral**. **Patient referral** involves health service personnel encouraging index patients to directly inform partners of their possible exposure to STIs. **Provider referral** involves thirds parties (usually health service personnel) notifying partners identified by index patients, without disclosing the name of the patient to the partners. **Contract referral** (also known as conditional referral) involves index patients being encouraged to inform their partners, with the understanding that if they do not visit the health service within a set period of time, that health service personnel will independently notify them.

Several studies have shown that employing greater measures than simply leaving the index case to notify their previous partners on their own, result in more potentially infected individuals being assessed by healthcare services.^{lxi} One systematic review comparing notification strategies in people with HIV found that offering a choice between **provider** and patient referral was more effective than offering patient referral alone. Similarly in cases of gonorrhoea infection **contract referral** significantly increased the percentage of patients presenting for treatment in comparison with patient referral alone. Furthermore in chlamydial infections **provider referral** was found to significantly increase the proportion of partners assessed per patient.

The above evidence supports offering CM patients with an STI, at least the option of some form of **provider referral**. This could potentially take the form of a letter or telephone call rather than necessarily requiring the engagement of additional staff and

resources to visit people in their homes, however this could be a very valuable use of resources, enabling saving on downstream costs and adverse health outcomes.

Contract referral could also be an option of use.

Initially cases of specific STIs, where the tracing and treatment of contacts is of particular importance, could be focused upon. These conditions could include gonorrhoea (a condition which South Auckland appears to be experiencing somewhat of an epidemic in recent times). HIV/AIDS is also obviously another condition in which contact tracing is necessary, however this is a notifiable disease, for which local Medical Officers of Health (and the Regional Public Health Service) therefore have a particular responsibility.

Further consideration should be given to ensuring provider referral procedures and resources are developed and adequate.

7.2 Single dose, observed treatment for STIs

Several providers to Counties Manukau patients are presently using azithromycin as a single-dose antibiotic treatment for STIs, especially *Chlamydia trachomatis*, and for prophylaxis against the development of significant post-TOP infections. Azithromycin is preferred over other potential treatments such as doxycycline by many providers, because it requires the patient to take only a single dose, which can be taken in the consultation room, avoiding the risk of uncompleted treatment courses. This treatment regime for *Chlamydia* has been shown to be clinically effective^{lxii}. Pharmacoeconomic data from the US also supports the use of azithromycin in women with confirmed *C. trachomatis*, if the evaluation perspective taken is that of the whole health care system or a third party payer. However, from the perspective of individual clinics doxycycline is the less costly option.^{lxiii} The Ministry's *Resource Book* document indicates that adding azithromycin to the practitioner's supply order schedule is presently being considered. This may improve the capacity of primary care to effectively achieve STI cures.

7.3 Screening for Chlamydia

Chlamydia is often carried by infected individuals who are unaware that they have the disease. This means they may not act to prevent its transmission to others, through the use of condoms. They may also experience long-term adverse effects such as pelvic inflammatory disease in women, a potentially serious infection often requiring hospitalisation, and/or damage to the fallopian tubes that can result in infertility or an ectopic pregnancy.

Screening initiatives amongst asymptomatic young people attending a contraceptive service in Britain found about 10% were infected with chlamydia.^{lxiv} Selective

screening of women with a combination of the risk factors of being under 25 years, reporting a change of sexual partner, non-condom use, unintended pregnancy or an inflammatory cervical smear result has been promoted by some.^{lxv} This can easily be achieved in the primary care or sexual or reproductive clinic setting, and has become more acceptable to patients with the advent of urine testing for chlamydia, rather than a need to take a cervical swab.

Laboratory data in New Zealand finds that the majority of chlamydia tests are performed in women, suggesting opportunistic screening is being pursued by some practitioners when women present for related gynaecological reasons, in addition to those women who present with a suspected STI.

Given the overseas evidence of high rates of chlamydia detection in asymptomatic individuals, the value of opportunistic screening is clear and should be encouraged. As noted in a recent Australian paper this should be considered in men also, because whilst they don't suffer the same effects of undiagnosed infections as women do, they may be a "forgotten reservoir" for the disease.^{lxvi} Population-based screening studies have identified that chlamydia is just as prevalent in heterosexual males in the population, as it is in females.^{lxvii lxxviii lxxix}

The available evidence on the value of chlamydia screening highlights that this is a valuable strategy, that should be considered in the Counties Manukau region. A sensible place to start would be to ensure screening is being done, when appropriate, on an opportunistic basis. There appears to be no reason why this should be limited to just female patients. Screening male patients with a history of unprotected sex would seem to be just as likely to be fruitful, if these patients can be identified.

8 Opportunities for progress

The statistics discussed in this document regarding low rates of consistent contraceptive use and relatively high or rising sexually transmitted infection (STI), pelvic inflammatory disease (PID), ectopic pregnancy, teenage birth and termination of pregnancy (TOP) case numbers suggest that further work on sexual and reproductive health promotion, disease prevention and access to acceptable, quality services is needed. Workforce development and increased training opportunities may also be necessary to achieve these objectives.

8.1 Disease prevention, health promotion and health education

Research involving abortion clinic attendees has indicated that while most are aware of what contraceptives are and their general use, many do not use them consistently.^{lxx} Catalysts to change attitudes around consistent contraception use and resulting behavioural action are needed and health promotion and disease prevention programmes may be able to achieve this.

There appears to be a place for the general public dissemination of sexual and reproductive health messages. Initiatives directed at the general population could help improve the discussion of these issues in families, improving openness in society, a feature that is associated with relatively good sexual and reproductive health outcomes. This may fall more into the realm of 'public' rather than 'personal' health, however, and for this reason may be most suitable for Ministry/Public Health Service funding rather than DHB funding. The DHB may be able to encourage such initiatives, however, within these other spheres.

Reducing barriers to the acquisition of effective means of contraception and sexual and reproductive health services is another determinant of good health outcomes that does, however, fall within the DHB sphere. Large proportions of the population may be unaware that free sexual and reproductive health appointments are available from Family Planning, certain PHOs and the Sexual Health Service. This therefore undermines the value of these initiatives in improving access and enabling people to maintain/better their own health. Furthermore, large proportions of the population may be unaware that they can obtain the emergency contraceptive pill from pharmacies, and the time frame within which they need to do this. This also undermines the value of this initiative. Mediums such as the posters on the back of toilet doors, radio and/or television advertisements and other forms of advertising could be used to reach the general population. Slightly different demographic groups could obviously be best reached through slightly different mediums, for example Mai FM is likely to reach a

younger radio-listening demographic and different toilets are likely to be frequented by different members of the population. These factors would need to be considered in designing a savvy awareness raising campaign.

Strategies to improve access to barrier contraception, as a preventative initiative, could involve removing restrictions to the provision of this at the government-subsidised price, but without prescription, through pharmacies. A reduction in the cost of obtaining the emergency contraceptive pill from a pharmacist (around \$30) could also be pursued. For young people and those on a limited income \$30 may be a discouragingly large expense. Reducing this cost could allow unwanted pregnancies to be prevented and future abortions avoided.

Further to initiatives targeted at the general population, programmes targeted at young people, particularly the relatively 'captive' audience of secondary school students, have an important role to play. These can provide young people with the 'motive' and the 'means' to achieve sexual and reproductive health. An emphasis on the potential risks of unprotected sex, including life-long untreatable STIs such as genital herpes or warts, the acquisition of eventually fatal HIV/AIDs, or potential life-course disruption due to relatively early parenthood, may be necessary for young people to 'take on board' the benefits of consistent barrier contraception use in non-permanent relationships. Young people also need the knowledge of how to access relevant products and services. It could be hoped that if these attitudes are established during the secondary school years, their application would carry on after leaving school.

Optimal coordination and delivery of school based sexuality education may require further work. This could be tackled by providers in this area and the education sector. More intensive reviewing of schools' sexuality and sex education programmes by the Education Review Office may also assist this process and ensure schools are meeting the goals set by their communities via the Boards of Trustees. Further provision of practical educational material to schools to accompany the Ministry of Education's *Sexuality Education* guide may also be of help. It should be noted that opportunities for progress in this area may be explored in more detail in youth health and education sector strategic planning. Further health promotion and disease prevention work could also involve secondary schools being more proactive in their provision of healthcare services, such as contraception and pregnancy tests, to 'back-up' their sex education sessions. This may require increasing engagement with sexual and reproductive healthcare providers such as Family Planning, PHOs and potentially the upskilling of existing school nurses.

General practices and PHOs also have an opportunity to enhance the use of youth health screening and health promotion practices within their organisations. For example the practice of deliberately raising issues such as contraception use during consultations sought for other purposes, and screening those who have had unprotected sexual intercourse for chlamydia, should be promoted. The ready use of strategies such as these in general practice may require training and awareness-raising initiatives, however, by secondary care providers and places such as the Centre for Youth Health.

Given that the greatest number of abortions are performed for women in their 20s, health promotion initiatives that raise consciousness and advertise how to access contraceptives and the emergency contraceptive pill could be used within settings such

as tertiary education institutions, sports clubs and bars. Mediums for doing this could include posters on the backs of toilet doors and above urinals. There may also be scope for PHO health promoters to work on tackling initiatives in such settings, perhaps aided by the DHB funded provision of free/low cost condoms for distribution to target groups. The provision of condom machines in toilets could also be encouraged, as a longer term strategy.

Some consideration in the longer term should also be given to health promotion and disease prevention initiatives for the more mature population. Programmes for this population could tackle issues such as longer-term contraception options (vasectomies, intrauterine contraceptive devices (IUCDs) and tubal ligations) and how to access these. The benefits of cervical cancer screening and how to access this could also be broached, as could issues such as how to talk about sex-related issues with your children.

Ethnic-specific health promotion and disease prevention initiatives are also likely to be potentially fruitful. In particular, programmes addressing awareness and discussion around topics related to reproduction and sexuality in Maori and Pacific ethnic groupings could enable health gains. Also, abortion clinic research indicates the potential for work within the Asian and more specifically the Chinese immigrant community. This is of relevance for Counties Manukau given the substantial Asian population within the eastern parts of our district. This may need to involve language-appropriate resources and information on topics such as contraceptive options and access.

8.2 Access to services

The upward trend in numbers of women admitted to hospital each year in Counties Manukau with PID or ectopic pregnancies suggest that some people are not accessing optimal (or any) treatment for their STIs. This may in part be due to individuals not being aware of the need to do so. However, part of the answer is likely to lie in the provision of STI testing and treatment services that people know about, want to use, can get to and can afford.

The Regional Sexual Health Service, which is provided by Auckland Healthcare, has one clinic in the Counties Manukau area. This is in Mangere. The core business of this clinic is the diagnosis and treatment of STIs. This service is free, well utilised and accessed by substantial numbers of men as well as women, and Maori and Pacific clients as well as those of a NZ European/Pakeha background. The level of public awareness of this service is, however, unknown. The Sexual Health Service regionally has only a very modest budget at present to raise public awareness of the services they provide. These clinics are clearly listed, however, in the telephone book. There are almost no waiting times for appointments at the Mangere clinic during office hours, however waiting times for the clinic's evening session are up to a week. Given this clinic's free appointment structure, considerable expertise in the field of sexual health, potential for facilitating contract tracing and direct provision of pharmaceuticals to clients, it is foreseeable that a second clinic in the more southern parts of the CMDHB area could potentially be well attended, particularly if its existence were publicised.

The potential for better provision of Sexual Health Clinic services to southern South Auckland was discussed in the planning workshop. Whilst the Waitemata DHB area contains 3 public Regional Sexual Health Service Clinics (at Glenfield, Henderson and Wellsford), there is only one in Counties Manukau at present. The possibility of the Regional Sexual Health Service potentially providing further services to Counties Manukau was raised, through either a further primary and secondary care level clinic service in the southern parts of the district, such as at Papakura, or by having a secondary care level (referral only) clinic service at the Manukau Superclinic. (It is notable that there is already a Family Planning clinic at Papakura, however mainly women access this service at present. The potential for site sharing between the Sexual Health Service and another provider such as Family Planning or an 'afterhours clinic', for example, could be explored in southern South Auckland.)

With optimal healthcare professional training, by staff from services such as the Regional Sexual Health Service and the Family Planning Association, it is foreseeable that a substantial amount of sexual and reproductive healthcare provision could also be achieved within primary practice. This service provision is likely to require secondary level 'back up', however, to be truly comprehensive. Some PHOs have already focused upon providing good quality, accessible sexual and reproductive health services, however this is not necessarily consistent across the sector. Further training for primary care professionals may well be necessary for this to be achieved across the board. Provision for telephone advice, possibly treatment guidelines and the option of referring to the secondary services when needed, are all likely to be key components of increased primary care provision of sexual and reproductive healthcare services. Some secondary care providers such as the Family Planning Association already provide a range of courses for primary care professionals, such being able to train 3 general practitioners per year in IUCD insertion. Allowing primary care professionals to increase their service provision capacity is likely to require investigation into whether adequate training opportunities such as these exist, whether primary care professionals are adequately aware of these and whether there are sufficient incentives to encourage these individuals to undertake training.

The success of free primary care provision of sexual and reproductive health appointments, in terms of achieving the desired goal of improving access, is only likely if these are well publicised. For example, the Family Planning Association have a relatively strong market brand. The public may therefore be able to identify the Association if someone mentions to them that they have free appointments for under 22 year olds, whilst many members of the public have no idea what a PHO is. The Sexual Health Service, whilst probably not as clearly branded as Family Planning, is also likely to be a reasonably clearly identifiable entity to the public. Advertising is likely to be necessary if progress is to be made in attempting to control rates of the identified sexual and reproductive health problems in South Auckland via primary health care provision of free appointments.

A savvy local media campaign could improve public awareness of the existence, locations and scope of the free sexual and reproductive health services that already exist in the community (the public Sexual Health Service, free Family Planning under 22 appointments and free appointments with some PHOs), as these services are probably not being accessed as much as they could be by those least able to pay. Avenues such as advertising in toilets, advertising on local radio (such as Mai FM) and/or on access TV

or advertising around venues where teenagers are present, for example in conjunction with administration of the upcoming meningitis vaccinations to teenagers, are all possible strategies. Increasing awareness that the emergency contraceptive pill can be obtained over the counter in chemists and the time frame this can be done within (not just the morning after) could also be very useful and could be coupled with the provision of local service awareness raising (if this is not to be tackled in a national campaign in the near future).

The Family Planning Association clinics within the Counties Manukau region are located in Manukau, Papakura, Highland Park, at Awhitia and periodically in certain schools. Family Planning is contracted directly by the Ministry of Health, so is essentially outside the influence of the DHBs. Consideration of the services that Family Planning provide locally is, however, important if comprehensive delivery of services to the Counties Manukau population is to be achieved. As previously mentioned, the vast majority of Family Planning clients are female, and overall, large numbers of Maori and Pacific peoples don't appear to utilise this service. Therefore whilst Family Planning Association clinics appear to provide services to a good number of NZ European female clients, particularly those seeking contraception, a more limited number of male clients and Maori or Pacific clients appear to access this service at present. It is foreseeable that an advertising campaign, raising awareness that FPA is not just for women, has free appointments and offers services such as contraception and STI checks, could facilitate more diverse uptake of this service. This is something, however, that Family Planning would have to consider. It is of importance to note that the Family Planning Association are funded for a certain number of visits and as they are already over their 'cap' in this region they have been reluctant to spend money on further advertising. For this reason 'harder to reach' groups and individuals may be missing out on this service. There appears to be scope for the investigation of whether a deprivation-weighted funding formula could be used for Family Planning services, so that greater service provision in Counties Manukau would be possible, along with attempts to increase the proportion of 'harder to reach' populations using this service.

The provision of a *contact tracing* service of personnel who can reach into the community to deliver antibiotics directly to sexual contacts of those who have been diagnosed with an STI, who are unlikely to seek treatment for themselves, is common internationally. This is not provided locally, however, despite awareness in the profession of some hard-to-reach individuals within the community who may be spreading STIs and the high rate of gonorrhoea in South Auckland. As a result, potentially infected contacts may be being left untreated, as casual or ill-reconciled partners do not wish to or may not be able to contact their previous partners. The Regional Sexual Health Service is probably the best organisation to drive the development of a contact tracing service for Counties Manukau, given their expertise in this area, however this would optimally also involve Sexual Health Service staff engaging with PHOs and building the capacity of their community health workers to deliver this service into the future.

Sexual and reproductive healthcare provision within schools appears to be an area with scope for further development. Whilst some schools offer services such as Family Planning Association clinics to their students on-site, others do not appear to provide this level of service. Such clinics, or the services of a visiting GP, or the up-skilling of

school nurses to enable them to provide a greater range of services to students could all be options to improve on-site healthcare provision to students in schools where this isn't currently available. Initiatives such as these may require PHOs and sexual and reproductive health care providers to take the lead in approaching schools regarding collaborating over such services.

The potential role of nurses has increased in scope over recent years, with nurses in some settings now able to prescribe, after completing the appropriate training course. This potential expansion of role could be very beneficial in either the school or PHO setting. However this may take some time to be achieved. The Family Planning Association also provide a range of sexual and reproductive health training courses for professionals such as nurses. Good uptake of these courses could enable primary care to offer a greater range of services to their populations at minimal cost.

One of the main secondary care issues that needs addressing in Counties Manukau, is the essential local lack of publicly-funded vasectomy provision. This is a routine, minimally-invasive procedure that is provided by some hospitals. Given the lower socio-economic status of many parts of the Counties Manukau region, vasectomies should be publicly provided in this area, as cost may be a barrier to some men seeking a vasectomy. Support for the public provision of some vasectomies in Counties Manukau was expressed in the workshop. It is foreseeable that there is likely to be demand for a number of publicly funded vasectomies in Counties Manukau. These could potentially be contracted out to an existing private provider, however referral processes should ideally remain central and a needs-based criteria for publicly-funded provision should apply, to ensure these are available to those of more limited economic means.

The distance women have to travel to the Epsom Day Unit for first trimester, publicly-funded abortions was also highlighted at the workshop, as well as the annually increasing demand for this service regionally. For these reasons the potential future need for Counties Manukau to provide this as a service was recognised, however this is unlikely to occur in the foreseeable future as most of the presently employed staff within the Counties Manukau Women's Health Service do not wish to perform terminations. This is an issue that will require monitoring to ensure adequate service planning into the future and consideration in Obstetrician/Gynaecologist contract negotiations, so that future employees may be more prepared to provide this service, if this becomes necessary in the future.

Ethnic-specific services, such as Awhitia and the in-development Pacific Teen Parent Unit, also have an important role in the delivery of services appropriate to their target populations. Awhitia already has innovative initiatives in place to improve service access, such as a pick-up and drop-off service for clients. The Pacific Teen Parent Unit is still undergoing development.

8.3 Workforce development and training

Workforce development and training appears to be a key way in which greater services could be offered via primary care and community clinics, such as school-based clinics. Community-based health care professionals should be informed about, and encouraged to participate in, practical training courses for ‘up-skilling’ in the sexual and reproductive health area, such as those provided by the Family Planning Association. These are often free.

The Regional Sexual Health Service and Family Planning representatives present at the workshop recognised the potential role they have to play in primary care workforce development. This could enable PHOs and primary care providers to be appropriately aware of and responsive to the sexual and reproductive health needs of the communities that they serve. Appropriate training could increase awareness and skills amongst primary care practitioners around screening young people for typical ‘youth health’ issues, such as contraception needs, when they attend the practice for another purpose. Urine screening of asymptomatic teens, who have previously had unprotected sexual intercourse, for chlamydia, could also be pursued. Further skills such as IUCD insertion could also be passed on to primary care practitioners, with appropriate training by providers such as Family Planning. (At present Family Planning are able to train 3 doctors per year in this technique). Concern was raised at the workshop, however, that funding contracts for services such as the Regional Sexual Health Service may need to change to allow a greater training and primary care development role to be taken on by this service, rather than the largely service-provision role it is funded to provide at present. Issues around ensuring that IUCD inserters perform adequate volumes of these procedures to maintain their competency were also discussed.

Workforce development so there are adequate numbers of nurses, doctors and health promoters/educators to provide specialist services in sexual and reproductive health into the future should also be ensured. In particular the training of Maori, Pacific and Asian people for these roles is likely to be particularly important. This could be encouraged by the use of relevant training scholarships.

8.4 Service quality improvement

There appears to be scope for increasing the level of service acceptability, across all service providers, with regards to the youth, Maori, Pacific and Asian populations. Practical ways to achieve this could include services organising focus groups of young people/Maori/Pacific peoples/Asian peoples, who are shown through service facilities and processes, and then discussing how these could be improved so that they are appropriate and welcoming.

Service quality improvement could also be facilitated by the development and distribution of 'best practice' guidelines by leaders in the various areas of sexual and reproductive health. These may help other providers ensure they are providing what is considered best practice in the field, as well as enabling primary care to do so. The Sexual Health Service have indicated they have developed such guidelines, which they are consulting with primary care on at present, and the Family Planning Association are also in the process of updating their information manual.

The Ministry of Health's *Sexual and Reproductive Health: A resource book for New Zealand health care organisations* document suggests that making azithromycin available on a Practitioner's Supply Order is possible in the near future. This would enable greater use of this medication in the primary care practice setting, allowing a potential improvement in the quality of such services. This innovation would mean that patients could receive a one dose treatment for chlamydia in many cases, avoiding the risk of prescriptions not being collected or patients not completing their treatment courses. Liaison with Pharmac by interested parties may help facilitate this process.

Increasing the availability of interpretation services within community sexual and reproductive health services could also potentially improve their service provision quality and capacity.

8.5 Sector communication, coordination and representative governance

Given the number of players in the sexual and reproductive health field locally, many of whom have specialist expertise in particular aspects, maximising communication and liaison appears to be vital. Several providers offer clients a range of services other than their core services. Service co-operation is therefore likely to be important to ensure clients receive the highest standard of care (or referral) from all providers.

Collaborative discussion could also assist cohesive programme and service planning for the people of southern and eastern Auckland. For this reason a workshop to

discuss these issues was held as part of this piece of work. Further meetings could also potentially be arranged in the future.

A specific communication issue that was highlighted during key informant interviews, was the need for hospital discharge summaries be sent to the referring doctor (such as a Family Planning Association (FPA) clinic doctor) as well as the usual GP. This is important so that the referring party does not have to 'chase' this information.

The DHB is at present working upon measures to streamline GP referral processes into the public system, for services such as tubal ligations and gynaecological ultrasound scans. This initiative will improve referral processes between primary and secondary care.

Opportunities for expanding Sexual Health Clinic services in southern South Auckland could involve exploration of whether these could be potentially sited with an existing Family Planning, 'afterhours' clinic or the Superclinic premises. This could be fruitful in terms of collaboration, as well as expense-minimisation.

A steering group for the Regional Sexual Health service, which is provided by Auckland Healthcare but funded by the three DHBs in the Auckland region, could be established. This may enable regionally representative governance, that can optimally consider and provide for the needs of the whole region. Representatives from women's health, infectious diseases and primary care could, for example, be included in this group.

8.6 Potential collaboration around proposed Pacific Teen Parent Unit

Potential future involvement of the providers present at the workshop with the Pacific Teen Parent Unit that is presently being scoped. This unit is envisioned for Tangaroa College and the development project is being managed by Jude Woolston of CMDHB. Scoping of the funding of this initiative by the Ministry of Education is presently underway.

9 Proposed Action Plan

	Proposal
1	Access to services
1.1	Local campaign to raise public awareness of the often free but somewhat fragmented sexual and reproductive health services already provided
1.2	Development of a contact tracing service for STIs and/or training capacity to enable primary care workers to fulfil this role in Counties Manukau, in particular for gonorrhoea in the first instance
1.3	Trial provision of further Sexual Health Clinic services to southern South Auckland
1.4	Publicly funded provision of a number of vasectomies annually in Counties Manukau
1.5	Seek a 'deprivation-weighted' funding formula with a higher level of capped numbers that FPA can see locally, so that this (often free) service can reach greater numbers of CM individuals and that they are able to promote themselves to more 'hard to reach' groups without fear of exceeding budgetary limits.

1.6	Review termination of pregnancy service capacity for Counties Manukau women into the future and future funding/workforce planning if indicated by this review
2	Workforce development and training
2.1	Primary care workforce development and training, in particular in the areas of screening young people for ‘youth health issues’ during routine consultations, such as undeclared contraceptive needs or asymptomatic chlamydia, possibly IUCD insertion skills for GPs, ECP prescription capacity development etc for nurses and contact tracing skills for practice nurses/community health workers.
2.2	Work with primary care regarding the distribution of workable best practice guidelines for the management of STIs (+/- contraceptive prescription) in the community
2.3	Explore creation of scholarships to allow Maori and Pacific members of the health workforce to upskill in community sexual and reproductive health provision. (This could potentially be incorporated within existing health scholarship initiatives).
3	Service quality improvement
3.1	Advocate for the availability of azithromycin on a practitioner’s supply order
3.2	Ensure the acceptability of general services is maximised for young people, Maori, Pacific and Asian peoples.

4	Prevention
4.1	Enable increased use of opportunistic screening, including screening for ‘youth health’ issues, such as contraceptive needs, in routine consultations and screening for chlamydia in asymptomatic individuals who have had unprotected sexual intercourse. Also opportunities for the promotion of cervical screening within primary healthcare.
4.2	Reduce cost barriers to condoms and the emergency contraceptive pill obtained without prescription
4.3	Explore further development of sexual and reproductive health promotion and education in schools and other community settings
4.4	Explore further development of sexual and reproductive health service provision in schools
5	Teen Parent Units
5.1	Propose health promotion/prevention/service collaboration around the proposed Pacific Teen Parent Unit in South Auckland
6	Governance
6.1	Explore improved Counties Manukau representation in the governance of Regional Sexual Health Services through the establishment of a steering group

10 Appendices

10.1 Glossary

Access PHOs	PHOs in identified areas of high need who receive additional funding to reduce cost barriers to access
Azithromycin	An antibiotic that can be used in a single dose to treat chlamydia
Chlamydia	In relation to sexual and reproductive health, a bacterial STI
CMDHB	Counties Manukau District Health Board
CSC	Community Services Card
ECP	Emergency contraceptive pill
EDU	Epsom Day Unit: the publicly funded regional termination of pregnancy service at Greenlane
FLEP	Family Life Education Pasefika: a Pacific sexual and reproductive health promotion/service provider
FPA	Family Planning Association
Genital warts	A viral STI
Genital herpes	A viral STI
Gonorrhoea	In relation to sexual and reproductive health, a bacterial STI
IUCD	Intrauterine contraceptive device
Mirena	A brand of IUCD which has the added function of releasing small doses of the hormone levonorgestrel with the uterus
MOH	Ministry of Health
PHO	Primary Health Organisation
RSHS	Regional Sexual Health Service: a service funded by the 3 DHBs of the Auckland Region but provided by Auckland Healthcare
STI	Sexually transmitted infection
TOP	Termination of pregnancy
U22	Free appointments for sexual or reproductive health purposes at selected practices within the Procure PHO

10.2 Key informants interviewed and/or at planning workshop

- Allan Moffitt, Clinical Advisor Primary Care, CMDHB
- Bernard Te Paa, GM Maori Health, CMDHB
- Christine Roke, National Medical Advisor/Medical Services Manager, Family Planning Association
- Danah Cadman, Manager Epsom Day Unit, Auckland Healthcare
- Gary Jackson, Manager Public Health/Public Health Physician, CMDHB
- Gilli Sinclair, Project Manager, CMDHB
- Jude Woolston, Project Manager, CMDHB
- Ian Brown, Chief Medical Officer, CMDHB
- Keith Allenby, Clinical Director for Women's Health, CMDHB
- Manukau Youth Centre staff
- Margie Fepulea'i, GM Pacific Health, CMDHB
- Miria Andrews, Manager, Awhitia
- Murray Reid, Clinical Director, Regional Sexual Health Service, Auckland Healthcare
- Nettie Knetsch, GM Children's and Women's Health, CMDHB
- Pauline Hanna, Programme Manager, Hospital and Specialist Services, CMDHB
- Peter Watson, Youth Health Physician, Centre for Youth Health, CMDHB
- Rick Franklin, Specialist Sexual Health Physician/Manager Community and Ambulatory Services, Auckland Healthcare
- Selwyn Lang, Clinical Head Infectious Diseases, CMDHB
- William Pua, Manager, Family Life Pasefika

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