NZ Parliamentarians' Group on Population and Development

The New Zealand All-Party Parliamentary Group

Youth Sexual Health: "Our Health, Our Issue"

The Report of the New Zealand Parliamentarians' Group on Population and Development ***'Open Hearing on Youth Sexual and Reproductive Health'***

(4 December 2006)

April 2007

KEY FACTS

Young people are becoming sexually active at an earlier age. At age 17, nearly half of young men and women have had sexual intercourse.

Of those having sex, more than half (63.3% males and 59.7% females) report always using contraception to prevent pregnancy. In other words, up to two in five young people are not always using contraception.

Teenage pregnancy

- New Zealand has the second highest rate of teenage pregnancy in the OECD.
- In 2006 the fertility rate for teenagers was 28.4 per 1,000 women aged 15-19, compared to 27.4 per 1,000 in 2005, and 25.6 per 1,000 in 2002.
- Maori young women have the highest teenage fertility rates, followed by Pacific women and then European women.
- Between 2000-2002 the fertility rate for Maori teenagers was 70 per 1,000.
- Pacific teenagers' fertility rate (48 per 1,000) was 50% above the national level, and more than twice the European rate in 2000-2002 (22 per 1,000).

Sexually transmitted infections

- Young people are at high risk of STIs, with those aged under 25 having the highest rates of chlamydia, gonorrhoea, genital herpes and genital warts.
- Figures for 2005 show that, in sexual health clinics, the highest rate of diagnosed genital warts were in the 15-19 years age group. More than 70% of those attending sexual health clinics in 2005 with concurrent infections were aged under 25.
- Laboratory data from Auckland, the Bay of Plenty and Waikato in the second quarter of 2006 show that between 64 and 77% of positive chlamydia tests were in under 25 year olds.
- Young Maori have higher rates of STIs than those of European ethnicity, especially for chlamydia and gonorrhoea. The 2005 annual surveillance report from Environmental Science & Research showed that Maori are twice as likely to have concurrent infections.
- STI surveillance figures for 2005 show Pacific peoples had higher rates of chlamydia and gonorrhoea than those of European ethnicity. Pacific peoples were three times more likely than Europeans to be diagnosed with concurrent infections.

Abortion

- In 2005 teenagers had an abortion rate of 25 per 1,000 women aged 15-19 compared to 26 per 1,000 in 2004.
- Maori women are more likely to have abortions than European women. From 2000 to 2002, the abortion rate for European teenagers was 21 per 1,000. The Maori teenage abortion rate was 30.

Access to sexual health services

- The Youth2000 survey found that about half of all students (males 45.9% and females 50.3%) identified barriers to obtaining health care.

Young people with diverse sexualities and genders

- In the Youth2000 survey, 7.8% of respondents identified that they were attracted to the same sex, both sexes, neither sex, or were unsure. Only 30% of those who said they were attracted to the same sex or both sexes had "come out".
- A 2003 University of Otago study reported that only 5% of more than 800 students and 7% of more than 400 staff believed gay/lesbian/bisexual students would feel safe at their school.

Sexual assault

- Youth2000 found that 11.3% of males and 22.2% of females under 18 reported being touched in a sexual way or forced to do sexual things they didn't want to do.

Acknowledgements

The New Zealand Parliamentarians' Group on Population and Development (NZPPD) would like to thank the United Nations Population Fund (UNFPA) for providing funding for the *Open Hearing on Youth Sexual and Reproductive Health*. UNFPA places a high priority on safeguarding young people's rights, promoting gender equality and supporting their successful transition to adulthood. It recognises that opportunities for learning and for protecting the health of young people (including sexual and reproductive health) are crucial if they are to reach their full potential.

The NZPPD extends its gratitude and thanks to all the individuals and organisations who made written and oral submissions, and attended the Hearing. The Group appreciates the time and effort that was spent preparing for this Hearing. We are particularly grateful to Evolve, the Family Planning Association of New Zealand and the Family Education Network for providing photographs.

We also thank Anne Weyman, Chief Executive of the UK Family Planning Association, for her presentation on England's Teenage Pregnancy Strategy, and for acting as an expert advisor to the NZPPD at the Hearing.

Steve Chadwick MP
NZPPD Chair

Submitting organisations/agencies/individuals[1]

Activate Youth Advisory Group for the Ministry of Youth Development
Abortion Law Reform Association of New Zealand
Auckland Regional Sexual Health Service, Auckland District Health Board
Bay of Plenty District Health Board
Catherine Gillies, Crises pregnancy and post-abortion counsellor
Counties Manukau District Health Board
Dr Sue Bagshaw, 198 Youth Health
Family Education Network Inc
Family Planning Association of New Zealand
Ministry of Education
Ministry of Health
Ministry of Women's Affairs
New Zealand AIDS Foundation
New Zealand Association of Adolescent Health and Development (NZAAHD)
New Zealand College of Midwives
New Zealand Medical Association
New Zealand Nurses Organisation
New Zealand Sexual Health Society
Office of the Children's Commissioner
OUT THERE!
Public Health Centre, Wanganui
Rape Prevention Education
Regional Public Health, Hutt Valley District Health Board
Southland District Health Board
Te Puawai Tapu Trust
Tertiary Women's Focus Group, New Zealand Union of Student's Associations
YWCA of Aotearoa New Zealand

1 Organisations who made oral submissions are highlighted in bold.

Contents

Executive summary and recommendations

The NZPPD *Open Hearing on Youth Sexual and Reproductive Health* was held in the context that New Zealand has one of the highest rates of unplanned teenage pregnancy in the OECD, and high rates of sexually transmitted infections (STIs) among youth.

Youth sexual and reproductive health is a crucial issue for New Zealand, and one that must be addressed by government. A recent UNICEF report, *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*, showed that the United States is the only OECD country with a worse teenage pregnancy rate than New Zealand. In 2006 the New Zealand fertility rate for teenagers was 28.4 per 1,000 women aged 15-19, compared to 27.4 per 1,000 in 2005, and 25.6 per 1,000 in 2002.[2]

Furthermore young people are at high risk of STIs, with those aged under 25 having the highest rates of chlamydia, gonorrhoea, genital herpes and genital warts. In 2005 more than 70% of those attending sexual health clinics with concurrent infections were aged under 25.[3]

The Hearing provided an opportunity for key government agencies, non-governmental organisations and other individual experts to present submissions to parliamentarians around youth sexual and reproductive health issues.

Submissions identified a complex picture of the current state of youth sexual health in New Zealand. Young people are having sex earlier, with environmental factors such as the media, peer pressure and alcohol being key factors in their decision-making. New Zealand has large disparities in sexual health, with Maori and Pacific youth being over-represented in both teenage pregnancy and STI rates. Despite the government's Sexual and Reproductive Health Strategy and Health and Physical Education Curriculum, the NZPPD heard that sexuality education is inconsistent and young people are facing barriers in accessing sexual health services.

The NZPPD strongly supports the establishment of a Ministerial Taskforce, including the ministers of Health, Education, Youth Affairs, Women's Affairs and Social Development, to address the issues around youth sexual and reproductive health. This report brings together the key messages and recommendations from the Hearing and submissions, and provides government with a baseline and framework for future monitoring and evaluation of youth sexual and reproductive health policies and services.

To fully address the issues of youth sexual and reproductive health in New Zealand, sexual health must be prioritised and a multidisciplinary and cross-government approach is vital. Furthermore, young people must be part of the solutions and consulted on future policy considerations.

Summary of recommendations

Recommendation 1:	The Ministry of Health must prioritise sexual and reproductive health, and it is essential that it becomes one of the key population health objectives of the New Zealand Health Strategy.
Recommendation 2:	The Sexual and Reproductive Health Strategy and HIV/AIDS Action Plan must be fully implemented and resourced.
Recommendation 3:	Develop a cross-agency teenage pregnancy strategy.
Recommendation 4:	Establish a sexual and reproductive health advisory group.
Recommendation 5:	Develop a comprehensive database of STI surveillance through Environmental Science and Research (ESR).
Recommendation 6:	Evaluate all current youth sexual and reproductive health and education initiatives to develop a consistent nationwide programme.

2 UNICEF, 2007. Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries

3 Population and Environmental Health Group, Institute of Environmental Science and Research Ltd (ESR), 2005. Sexually Transmitted Infections in New Zealand Annual Surveillance Report 2005

Recommendation 7:	Young people need consistent and comprehensive sexuality and relationships education in both schools and non-educational settings, delivered by trained specialist teachers or facilitators. Government must prioritise sexuality and relationships education, and ensure that all schools deliver comprehensive programmes.
Recommendation 8:	Consider a similar approach as the UK Speakeasy programme, for parent groups in the Strategies with Kids, Information for Parents (SKIP) programme and other parent education/support programmes.
Recommendation 9:	Develop effective and positive education awareness strategies for all young people, accounting for ethnic and sexual diversity. Campaigns must be consistent, ongoing and developed with young people.
Recommendation 10:	Develop and fund an Integrated Youth Health Service Model to include school-based services, community services and mobile services. Every school should have a paid nurse able to offer sexual and reproductive health services.
Recommendation 11:	As a minimum, condoms and emergency contraception should be free, and accessible services for dispensing need to be developed, particularly in rural locations.
Recommendation 12:	Sexual assault care must be adequately funded and resourced. A database of counsellors and related services for young people should be developed.
Recommendation 13:	Introduce a target to reduce the number of abortions being carried out in the second trimester, and make safe medical methods of abortion available as an option for women. Review the current legal framework (Contraception, Sterilisation, and Abortion Act 1977), particularly around clinical guidelines and licensed institutions, as there have been advances in abortion procedures since legislation was introduced.
Recommendation 14:	Develop a workforce plan to deliver sexual and reproductive health services.
Recommendation 15:	Implement training in sexual and reproductive health for primary care practitioners.
Recommendation 16:	Adequately invest in youth development programmes to fully implement the Youth Development Strategy and introduce youth development training for teachers and other professionals.
Recommendation 17:	Multiple strategies are needed to improve the sexual and reproductive health of young Maori, including a government-wide approach, increased 'by Maori, for Maori' clinical services, and better access to kaupapa Maori sexual and reproductive health training and information.
Recommendation 18:	Pacific views on sexual health issues, and fa'a Samoa and other Pacific-specific ways of working, need to be incorporated into policy development on sexual and reproductive health services. Young Pacific people need access to culturally appropriate sexuality and relationships education and information, and sexual and reproductive health services.
Recommendation 19:	A range of support for young parents is needed, including teen parent units, financial assistance and incentives to continue their education, and increased benefit levels and extended assistance at a younger age.
Recommendation 20:	Ensure that young people with diverse sexualities and genders have safe and supportive school and youth service settings. Both the Health and Physical Education Curriculum and sexual health services must fully address the needs of young people with diverse sexualities and genders.

Introduction

On 4 December 2006, the New Zealand Parliamentarians' Group on Population and Development (NZPPD) held an *Open Hearing on Youth Sexual and Reproductive Health in New Zealand*. The aim of the Hearing was to raise awareness among parliamentarians of the current issues around young people and sexual and reproductive health in the context that New Zealand has one of the highest rates of unplanned teenage pregnancy in the OECD, and high rates of sexually transmitted infections (STIs) among youth.

Both written and oral submissions to the Hearing were received from a range of government agencies, non-governmental organisations (NGOs) and other professionals working in youth, health and education services. In total, 27 submissions were made.

The Hearing followed the format of a Select Committee meeting, with government agencies, NGOs and other professionals presenting evidence to a cross-party group of MPs. Anne Weyman OBE, Chief Executive of the UK Family Planning Association, also presented information on England's Teenage Pregnancy Strategy.

The purpose of the Hearing was to take evidence from government agencies, NGOs and other professionals about their work in order to:

- summarise the current situation and issues
- identify what is currently working well for young people in New Zealand
- make clear recommendations for future policy considerations in this area.

The submissions provided a wide range of information and recommendations, and the content and structure for this report are largely based on the submissions.

Section one provides an overview of the key sexual and reproductive issues facing young people in New Zealand. Section two summarises what is currently working well for young people in New Zealand, and provides information on several local projects. Section three makes a number of recommendations to government for future policy considerations to improve the sexual and reproductive health of young New Zealanders.

Appendix one details current legislative and policy frameworks in New Zealand. Appendix two provides an international background and examines England's Teenage Pregnancy Strategy.

A list of further reading is also included at the end of this report.

Youth Sexual Health: "Our Health, Our Issue"[4] will be used to inform and influence government, parliamentarians, public servants and other interested parties. It will provide government with a framework for future monitoring and evaluation of youth sexual and reproductive health policies and services.

It will also be a key resource for sharing information and useful approaches with the Pacific Parliamentary Assembly on Population and Development (PPAPD) and within the Asian Forum of Parliamentarians on Population and Development (AFPPD) network.

The current situation in Aotearoa New Zealand

Young people and sex is a subject which regularly attracts the attention of politicians, the media and society. The Hearing was held in the context that New Zealand has one of the highest rates of unplanned teenage pregnancy in the OECD, and high rates of STIs among youth.

While the focus tends to be on the negative aspects of youth sexual and reproductive health, it is important to recognise that sexual and reproductive health goes beyond this. The World Health Organisation's suggested definition of sexual health makes this point:

> *Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality*

4 Quote from a member of the Activate Youth Advisory Group for the Ministry of Youth Development

and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Young people are becoming sexually active at an earlier age. Findings from the Youth2000 survey[5] show that across the 12-18 age range 32.4% of males and 30.4% of females have had sexual intercourse. At age 17, nearly half have had sexual intercourse (49% of males and 49.5% of females).

Of those students having sex, more than half (63.3% males and 59.7% females) report always using contraception to prevent pregnancy. In addition, most sexually active students (males 76.5%, females 68.8%) report having used a condom as protection against an STI the last time they had sex. These figures show that up to two in five young people are not always using contraception.

The submissions highlighted a wide range of issues facing young people today around their sexual and reproductive health.

Teenage pregnancy

- New Zealand has the second highest rate of teenage pregnancy in the OECD.
- In 2006 the fertility rate for teenagers was 28.4 per 1,000 women aged 15-19, compared to 27.4 per 1,000 in 2005, and 25.6 per 1,000 in 2002.[6]
- Maori young women have the highest teenage fertility rates, followed by Pacific women and then European women.

While there has been a general downward trend in teenage pregnancy since 1995, rates remain high and have been increasing again since 2002.

Fertility rates for teenagers (1995-2006)[7]

December year	*Under 15 years*	*15-19 years*
1995	0.3	33.4
1996	0.2	33.0
1997	0.4	32.8
1998	0.2	29.2
1999	0.2	28.9
2000	0.2	28.2
2001	0.2	27.5
2002	0.2	25.6
2003	0.2	26.1
2004	0.2	27.3
2005	0.2	27.4
2006	0.2	28.4

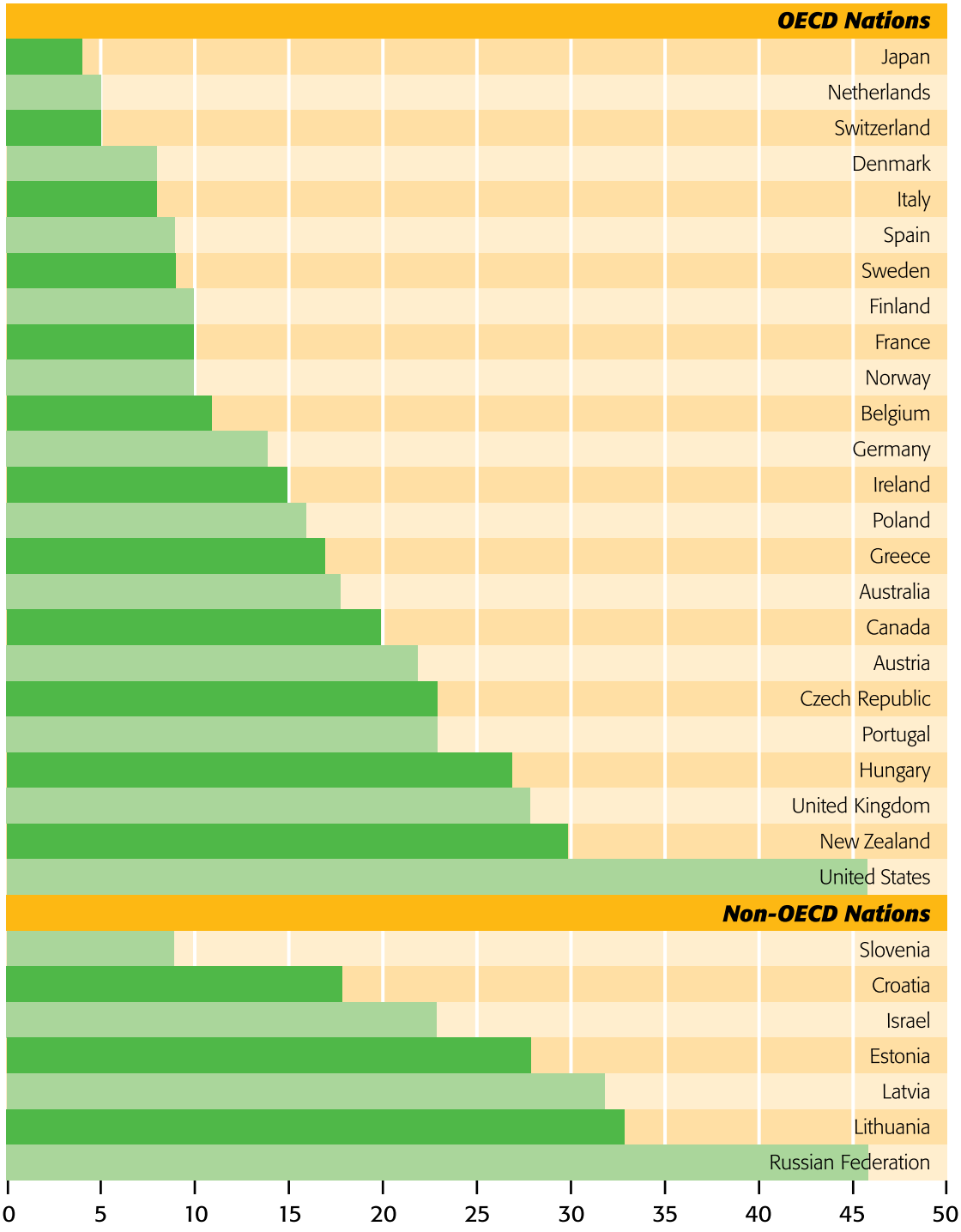
5 The University of Auckland, 2003. New Zealand Youth - a profile of their health and wellbeing, A National Secondary School Youth Health Survey. The largest health and well-being survey to date with 12-18 year olds in school across New Zealand. The survey took place in 2001, and is commonly referred to Youth2000.

6 Statistics New Zealand, 2007. Births and Deaths, December 2006 quarter

7 Ibid

New Zealand has higher rates of teenage pregnancy than most other OECD countries. The recent UNICEF report, *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*, indicates that New Zealand's teenage pregnancy rate is 30 births per 1000 teenage girls aged 15 to 19. The United States, with a teenage pregnancy rate of just over 45 births per 1000 teenage girls aged 15 to 19, is the only OECD country that fares worse than New Zealand.[8]

Teenage fertility rate: births per 1,000 women age 15-19, 2003



8 UNICEF, 2007. Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries

In 2003 a report to the New Zealand government by the United Nations Committee on the Rights of the Child noted, among other things, concern that New Zealand has high rates of teenage pregnancy.[9] The Committee recommended that New Zealand:

> *Undertake effective measures to reduce the rate of teenage pregnancies through, inter alia, making health education, including sex education, part of the school curriculum, and strengthening the campaign of information on the use of contraceptives.*

The Family Planning Association's submission identified that a key contributing factor to New Zealand's high rate of unplanned teenage pregnancy is the low use of oral contraception in this country compared with other countries. Contraceptive use is a complex behaviour requiring considerable skill in negotiation and repeated motivation to use a method of contraception, so information alone is not sufficient.

While there is concern focused on unplanned teenage pregnancy, it is important to note that there are cases where teenage pregnancies are planned and culturally acceptable.

Sexually transmitted infections (STIs)

- Young people are at high risk of STIs, with those aged under 25 having the highest rates of chlamydia, gonorrhoea, genital herpes and genital warts.
- Figures for 2005 show that, in sexual health clinics, the highest rate of diagnosed genital warts were in the 15-19 years age group.
- More than 70% of those attending sexual health clinics in 2005 with concurrent infections were aged under 25.[10]
- Laboratory data from Auckland, the Bay of Plenty and Waikato in the second quarter of 2006 show that between 64 and 77% of positive chlamydia tests were in under 25 year olds.[11]
- Untreated STIs can lead to long-term health problems such as pelvic inflammatory disease, subfertility, ectopic pregnancy and chronic diseases.

Submissions from the New Zealand Sexual Health Society, Auckland District Health Board (DHB) and others highlighted current limitations in the reporting and monitoring of STIs. With the exception of AIDS, STIs are non-notifiable diseases. Surveillance is based on voluntary data from sexual health clinics, family planning clinics, and a few youth clinics as well as most laboratories. Not all STIs can be diagnosed by laboratory tests; therefore only chlamydia and gonorrhoea results are used for laboratory surveillance. It is thought that the number of STI cases reported through these systems underestimates the true burden of disease.

The figures are also underestimated because some STIs are diagnosed by other health care providers, particularly primary health care practitioners. Furthermore, STIs are commonly asymptomatic, and many people do not present for care so remain undiagnosed.

There are currently no national screening programmes in New Zealand for STIs. A number of submissions recommended national targeted screening for chlamydia. Chlamydia is currently the most commonly diagnosed bacterial STI in New Zealand and is mostly asymptomatic, so would be a suitable candidate for a screening programme. The FPA chlamydia testing pilot in Wellington, 2005, proved the acceptability of routine testing for young women and men.

9 UN Committee on the Rights of the Child, Thirty-fourth session 2003. Consideration of reports submitted by Sates parties under Article 44 of the Convention, concluding observations: New Zealand

10 Population and Environmental Health Group, Institute of Environmental Science and Research Ltd (ESR), 2005. Sexually Transmitted Infections in New Zealand Annual Surveillance Report 2005

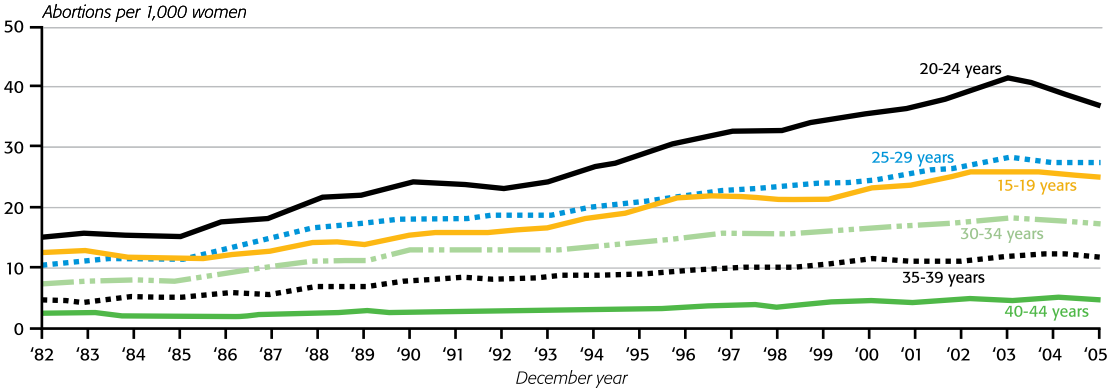
11 STI Surveillance Team, Population and Environmental Health Group, Institute of Environmental Science & Research Ltd, 2006. Laboratory Surveillance of Chlamydia and Gonorrhoea in New Zealand, April to June 2006

Abortion

- In 2005 teenagers had an abortion rate of 25 per 1,000 women aged15-19 compared to 26 per 1,000 in 2004.

In 2005, women aged 20-24 had more abortions (37 per 1,000 women aged 20-24 years) than other age groups, accounting for approximately three out of 10 abortions in any year. Women aged 25-29 had an abortion rate of 27 per 1,000 in 2005. In both 2004 and 2005, abortion rates decreased for all women aged 15 years and over, showing the first sustained reduction for many years.[12]

Age-specific Abortion Rates *1982 - 2005*



Several submissions noted that some young women face barriers in accessing abortions, such as doctors refusing to refer them and some District Health Boards not providing abortions. For example, Invercargill women must travel to Christchurch. The Tertiary Women's Focus Group highlighted that free and unbiased counseling before *and* after abortion should be available.

Submissions also stated that there are lengthy delays between referral and termination. Medical abortion is available in only two publicly funded locations. As a result, large numbers of abortions are being carried out after eight weeks gestation; 7% of New Zealand terminations are in the first eight weeks compared with 77% in the Netherlands.[13] The Abortion Law Reform Association of New Zealand submission argued that early medical abortions should be more widely available in New Zealand.

Sexuality education

12 Office of National Statistics, 2006. Abortion Statistics

13 Fiala, Dr Christian (2006) Improving Medical Abortion. Research presented at the 4th Abortion Providers Conference in Wellington, 31 March - 1 April 2006

Sexuality education at school is where students most often get information about sexual health and related issues. The Youth2000 survey showed more than 90% of young people get sexual health information at school. Friends, family, TV and magazines are also common sources of information.[14]

Many submissions noted that the provision of sexuality education varies greatly from school to school, and is a neglected area for some schools. Submissions highlighted a lack of trained teachers who feel comfortable teaching the subject, so that it is frequently taught by teachers who feel uncomfortable with the material, sexuality or talking about sex. The New Zealand Association for Adolescent Health and Development (NZAAHD) submission highlighted that schools often opt for external agencies to teach sexuality education, which can be problematic as these agencies may provide their own viewpoints on sexuality and sexual health. This is not monitored, and external agencies are not required to be registered with anyone.

The Southland DHB submission highlighted the need for better collaboration between the Ministries of Health and Education at a national level, and DHBs, schools and Primary Health Organisations (PHOs) at the local level, to tackle issues around sexual health education.

The evaluation of the government-funded National Youth Sexual Health Awareness Campaign showed some young people have significant gaps in their knowledge about sexual health issues.[15]

Sexual health service delivery

Sexual health care in New Zealand is delivered by a number of providers, including sexual health clinics, Family Planning Association clinics, GPs, and student/youth health clinics.

Several submissions highlighted the lack of government priority given to sexual and reproductive health, which impacts on the level of priority and allocation of resources at DHB and community level.

Furthermore, there is no national coordination of sexual health services, which means the quality of sexual health care and health promotion is variable, and there is no consistency of approach to management of STIs and other sexually associated conditions.

A number of submissions also noted workforce issues. More sexual health specialist positions are essential to advocate for and act as champions for sexual health, to train and support primary care providers as well as provide appropriate secondary and tertiary care services, and to conduct relevant research into sexual health issues. In addition, the New Zealand Nurses Organisation recommends a deliberate recruitment and investment strategy be undertaken in schools to encourage nurses to work in this important area of health.

14 Youth2000 survey

15 Ministry of Health, 2005 Safer Sex Evaluation Summary
http://www.moh.govt.nz/moh.nsf/0/936FD8EE8E88F4C9CC2570070012A990/$File/safersexevaluationsummary.doc

Access to sexual health services

The Youth2000 survey found that about half of all students (males 45.9% and females 50.3%) identified barriers to obtaining health care. These included:

- "Not wanting to make a fuss"
- "Can't be bothered"
- "Too expensive"
- "Don't feel comfortable"
- "Too scared"
- "Worried that it won't be kept private".

Submissions also highlighted that there are particular barriers for young people accessing services in rural areas, including transport and access during out of school hours. Privacy is also an important issue in small rural towns where young people may be seen entering the health clinic, and there is usually no choice of alternative services.

Long waiting times were also identified as an issue. Most young people prefer drop-in clinics to appointment clinics, but they can often wait up to two hours to be seen.

Several submissions noted particular issues for young men accessing sexual health services.

Young Maori

There are some clear disparities in sexual and reproductive health between young Maori and their European counterparts.

- Maori youth are more likely to be sexually active and less likely to always use contraceptives.[16]
- Maori women are over represented among teenage birth rates. Between 2000-2002 the fertility rate for Maori teenagers was 70 per 1,000.[17]
- Maori women are more likely to have abortions than European women. From 2000 to 2002, the abortion rate for European teenagers was 21 per 1,000. The Maori teenage abortion rate was 30.[18]
- Young Maori have higher rates of STIs than those of European ethnicity, especially for chlamydia and gonorrhoea. The 2005 annual surveillance report from Environmental Science & Research (ESR) showed that Maori are twice as likely to have concurrent infections.[19]

These statistics are linked to generations of disparity and disadvantage for Maori, with lower life expectancy, poorer education and health outcomes, and lower levels of participation in employment, higher education and training. However, these gaps are closing.

The Te Puawai Tapu Trust's submission noted that recent research with Maori sexual and reproductive health providers shows there is anecdotal evidence that the disparity in health outcomes is continuing to increase. The Trust predicts a worst-case scenario of an infertility crisis for Maori in the coming years.

The Trust also highlighted that Maori communities are deeply concerned with the stigmatising and problematising of teen pregnancies once young women have become pregnant.

Young Maori need access to culturally appropriate sexual and reproductive health information and education, and culturally appropriate and accessible services.

16 Clark, T 2004, Sexual and Reproductive Health, Te Ara Whakapiki Taitamariki, Maori Specific Findings of Youth2000, A National Secondary School Youth Health Survey p 55 - 64, University of Auckland

17 Statistics New Zealand, 2003. Teenage Fertility

18 Ibid

19 Population and Environmental Health Group, Institute of Environmental Science and Research Ltd (ESR), 2005. Sexually Transmitted Infections in New Zealand Annual Surveillance Report 2005

Young Pacific people

- Rates of STIs and teenage fertility are disproportionately high among young Pacific people. STI surveillance figures for 2005[20] show Pacific people had higher rates of chlamydia and gonorrhoea than those of European ethnicity. Pacific people were three times more likely than Europeans to be diagnosed with concurrent infections.
- Pacific teenagers' fertility rate (48 per 1,000), although lower than that for Maori, was 50% higher than the national level, and more than twice the European rate in 2000-2002 (22 per 1,000).[21] From 2000 to 2002, the abortion rate for Pacific teenagers was 26 per 1,000.[22]

Pacific cultures have different concepts and constructs about sexual health and reproduction and it is important that these values and ideas are part of young people's learning. Young Pacific people need access to culturally appropriate sexual and reproductive health information and education, and culturally appropriate and accessible services.

Young people with diverse sexualities and genders

- In the Youth2000 survey, 7.8% of respondents identified that they were attracted to the same sex, both sexes, neither sex, or were unsure.
- Only 30% of those who said they were attracted to the same sex or both sexes had "come out".[23]
- A 2003 University of Otago study reported that only 5% of more than 800 students and 7% of more than 400 staff believed gay/lesbian/bisexual students would feel safe at their school.

Both the NZAAHD and OUT THERE! submissions identified safety in school as an important issue, particularly around bullying and inadequate access to support.

The submissions also highlighted that young people with diverse sexualities and genders face high rates of depression and suicide. The New Zealand Suicide Prevention Strategy[24] acknowledges a growing body of evidence pointing to a connection between self-harm and sexual orientation.

20 Population and Environmental Health Group, Institute of Environmental Science and Research Ltd (ESR), 2005. Sexually Transmitted Infections in New Zealand Annual Surveillance Report 2005

21 Statistics New Zealand, 2003. Teenage Fertility

22 Ibid

23 Youth2000 survey

24 Ministry of Health, 2006. New Zealand Suicide Prevention Strategy

Sexual assault

- The Youth2000 survey found that 11.3% of males and 22.2% of females under 18 reported being touched in a sexual way or forced to do sexual things that they didn't want to do. However, this figure increased to one third in relation to non-heterosexual students.[25]
- Furthermore, a randomised New Zealand community study[26] found that:
  - 32% of girls reported some form of sexual abuse before the age of 16, with 20% of these describing genital contact, or attempted or actual penetration;
  - 20% of the sample had experienced some form of sexual abuse before the age of 12; and
  - 16% of these had experienced abuse to the level of genital contact, attempted penetration or penetration.

The Rape Prevention Education submission noted that such experiences have been found to have profound effects on young people's mental, physical and sexual health, including depression, low self-esteem, difficult interpersonal relationships, self injurious and suicidal behaviour, chronic pelvic pain, pre-menstrual syndrome, infertility and a history of complicated pregnancies. They also reported that other possible effects include criminal behaviour and increased chance of becoming involved in sex work.

Submissions noted that the prevention of sexual violence is not covered in depth within the health curriculum, and that many staff at high schools have stated that they do not feel comfortable addressing issues around sexual violence with their students.

Rape Prevention Education also highlighted issues such as lack of services for young people, particularly counselling, due to restrictions in transport, finances and privacy. Furthermore, they reported that crisis services in Auckland do not cater for males over 15, and many ACC registered counsellors do not work with males.

Young parents

The existence of young parents is frequently cited as evidence of ill health in society, which in turn alienates these young people and tarnishes them with a negative label, exacerbating their feelings of alienation and deprivation.

Poverty is a major issue for teenage parents as little or no benefits are available until they reach 18. While some young parents do well, they and their children are vulnerable to negative health, social and economic outcomes.

Anecdotal evidence from one submission shows that young mothers have been encouraged to leave school when pregnant because they are considered to be a bad example.

The New Zealand College of Midwives emphasised the importance of continuity of care by a midwife for all young women in pregnancy. Midwifery care has been shown to be effective in reduction of adverse neonatal events and improved contraception use in teenage mothers.[27] The College also noted the importance of supporting young mothers to breastfeed.

25 Youth2000 survey

26 Anderson, J., Martin, J., Mullen, P., Romans, S., & Herbison, P. (1993). 'Prevalence of childhood sexual experiences in a community sample of women'. Journal of the American Academy of Child and Adolescent Psychiatry, 32:911 - 919

27 Quinlivan, J.A., Box, H., Evans, S.F. (2003). Postnatal home visits in teenage mothers: a randomised controlled trial. The Lancet 361 (893-900)

Environmental factors and youth development

Young people are at a particular stage of human development characterised by trying new things, taking risks and learning to care for their health themselves. Many of the submissions emphasised the influence that alcohol and drug misuse, peer pressure and the media have on young people's decision-making processes. Binge drinking leading to unprotected sexual intercourse is a common scenario. Poor self-esteem was also identified as an issue.

The NZAAHD submission argued that a strengths-based and positive approach to youth sexuality is needed. Though there are poor sexual health statistics, the framing of youth sexuality as problematic only worsens the situation.

Parents and family/whanau

Several submissions emphasised the importance of parents and whanau in determining adolescent behaviour. Both the Counties Manukau DHB and the New Zealand Medical Association submissions noted that the lack of a good relationship with at least one adult was a known risk factor for poor adolescent sexual and reproductive health. The Office of the Children's Commissioner said while most young people report that they believe their parents care about them, schools are the main source of information about sexuality. This indicates that many parents do not talk easily with their young adults about this important aspect of development. The Family Education Network highlighted that the education of parents needs greater development.

There is evidence that shows that young people who are able to speak to their parents about sex are likely to delay their first sexual activity and use contraception when they do become sexually active.

What is working now?

The submissions referenced a number of national and local policies and initiatives that are helping to address the issues around youth sexual and reproductive health, but highlighted that more is needed. Submitters acknowledged that there are strategies in place, but argued that government needs a joined up approach in implementing the strategies.

The New Zealand Sexual and Reproductive Health Strategy was welcomed in many submissions, but it was recognised that DHBs have responded in various ways to the Strategy. Some DHBs have implemented sexual and reproductive health initiatives while others have not.

The Youth Development Strategy Aotearoa was praised as it recognises the specific needs of young people and can be used as a model for building more effective strategies for youth participation in services. However, the Strategy has not been fully implemented, and further investment is needed in youth programmes and more youth workers need to be trained in youth development.

The Health and Physical Education Curriculum was welcomed by many submissions, although there is significant work still to be done in this area as sexuality education is inconsistent across schools. The implementation of the Health and Physical Education Curriculum still appears to be delivering variable sexual and reproductive health information to secondary school students in terms of both quality and quantity.

The 2004/05 national public information 'Hubba Hubba' campaign was generally supported. The Activate Youth Advisory Group welcomed the campaign, and noted that the advert and materials had successfully reached young people. The group said the campaign needed to be ongoing, but had "just disappeared".

There needs to be sustained campaigns targeting different groups in society.

There was also support for the current legal framework which allows young people to consent to medical services, including abortion and contraception, without parental consent or notification.

Submissions included information about projects being initiated locally by NGOs and DHBs. Some examples are:

- **SS4Q (Safe Schools for Queers):** a nationwide informal network of teachers, students, and allies who support school-wide action to address sexual orientation prejudice. Examples of things schools can do include: reviewing Equal Employment Opportunities (EEO) and sexuality education, establishing policies for addressing homophobic bullying, offering gender neutral uniform options, improving library resources, implementing inclusive peer education programmes, and running anti-discrimination campaigns.
- **BodySafe (run by Rape Prevention Education):** delivers workshops in high schools in the greater Auckland region, equipping young people with tools to take responsibility for their sexual safety - 90% of students who have participated in BodySafe report they would now think or act differently in high risk situations.
- **Sexual Health 4 You (Bay of Plenty):** a sexual health coalition that was set up in 2004 to help address high rates of STIs and teenage pregnancy. The coalition allows for a coordinated community approach, and has monthly meetings which provide an opportunity for networking, professional development, identification of local issues and policy development.

Many submissions also highlighted the success of local school-based programmes where nurses and doctors provide sexual and reproductive health services in schools, one-stop community services and other outreach services.

Several submissions noted that other OECD countries with better sexual and reproductive health outcomes for their young people share particular characteristics, including:

- social openness in attitudes to discussing sex and sexuality
- comprehensive sexuality education that is age-appropriate, includes relationship skills such as communication and negotiation, and is taught by trained teachers
- accessible, high quality, confidential and youth friendly sexual and reproductive health services.

What needs to change?

Submitters identified a range of areas where New Zealand needs to do better in relation to youth sexual and reproductive health. To fully address the issues of youth sexual and reproductive health in New Zealand, a multidisciplinary and cross-government approach is needed. Furthermore, it is vital that young people are part of the solutions and are consulted on issues such as education and health services.

The NZPPD recommendations can be grouped under the following themes:

- Prioritisation
- Education
- Service provision
- Youth development
- Young Pacific people
- Young people with diverse sexualities and genders
- Joined up activity
- Information
- Workforce
- Young Maori
- Teenage parents

Prioritisation

Sexual and reproductive health must become a priority health goal with specific targets and indicators for reducing STIs, including HIV, and unplanned pregnancies. Until this happens, there is no incentive for DHBs to implement the Sexual and Reproductive Health Strategy.

The sexual and reproductive health of young people in New Zealand is being threatened by high rates of bacterial STIs. There will be long-term increased costs to the health care system with complications of pelvic inflammatory disease, ectopic pregnancy, sub-fertility and the increased risk of HIV transmission.

Recommendation 1: **The Ministry of Health must prioritise sexual and reproductive health, and it is essential that it becomes one of the key population health objectives of the New Zealand Health Strategy.**

New Zealand needs an effective sexual and reproductive health strategy that aims to ensure that all New Zealanders enjoy good sexual and reproductive health. The strategy needs to be backed up with specific policy and funding.

Recommendation 2: **The Sexual and Reproductive Health Strategy and HIV/AIDS Action Plan must be fully implemented and resourced.**

Joined up activity

New Zealand has the second highest rate of teenage pregnancy in the OECD. We note the experiences of the UK government in addressing the issue of teenage pregnancy. A government-wide approach is needed in New Zealand and we support the establishment of a cross-agency teenage pregnancy strategy. The strategy will need to have a multidisciplinary approach and work across the relevant Ministries including Health, Education, Social Development and Youth Development; and it must be adequately resourced. The government should set realistic targets to reduce teenage pregnancy. The strategy should include wider sexual and reproductive health issues such as STIs and sexual abuse. It should also consider other issues key to teenage parents such as housing, educational opportunities and other support.

Recommendation 3: **Develop a cross-agency teenage pregnancy strategy.**

An independent multi-disciplinary sexual and reproductive health advisory group should be established to provide advice to the government and to monitor and ensure action is taken on implementing all strategies to improve sexual and reproductive health. It is important that the relevant groups and organisations are brought together in an advisory group to ensure that all strategies and policies are joined up and implemented in parallel.

Initial key areas for the group should be to:

1. develop a comprehensive process for STI surveillance

2. establish a national chlamydia screening programme
3. monitor the antenatal HIV screening programme rollout over the next three years
4. monitor the development of a teenage pregnancy strategy, and
5. monitor incidents of sexual abuse, assault and rape to ensure services are adequately resourced.

Recommendation 4: **Establish a sexual and reproductive health advisory group.**

As referred to above, a key area for future policy is the development of a comprehensive process for STI surveillance. To ensure New Zealand has accurate data to inform targeted strategies, STIs should be notifiable anonymously through all laboratories, and laboratories must have contractual obligations to provide STI data.

Recommendation 5: **Develop a comprehensive database of STI surveillance through Environmental Science and Research (ESR).**

There are already excellent youth health and education initiatives in place at both national and local level which should be evaluated and replicated across the country. For example, there are a number of 'one-stop shops' which provide a variety of services and amenities for young people. These services should be available in all communities around New Zealand.

Recommendation 6: **Evaluate all current youth sexual and reproductive health and education initiatives to develop a consistent nationwide programme.**

Education

While it is encouraging that young people are receiving sexuality education at school through the Health and Physical Education Curriculum, there is inconsistency in the messages being delivered by schools due to the lack of a prescribed sexuality curriculum.

Young people need comprehensive, good quality sexuality and relationships education before they become sexually active to enable them to make informed decisions about their sexual and reproductive health. This needs to be age-appropriate, and cover sexual orientation, sexual decision-making including delaying sexual activity, safer sex practices, contraceptive and condom use, personal identity, gender and culture, and relationship skills. Personal development, life skills and self-esteem should be an integral part of sexuality education. Effective education can improve knowledge, skills and attitudes, resulting in more informed decisions and a reduction in risky behaviour. It is also vital that young people receive information about confidential and accessible support services.

Sexuality education needs to be taught by trained professionals, and there needs to be better and more consistent teacher training and professional development on sexuality education. Furthermore, teacher training should include youth development. Where external agencies provide sexuality education sessions in schools, there must be a nationwide approval or monitoring system to ensure they provide comprehensive and non-judgmental sexuality education.

A number of submissions highlighted the important role of peer educators, but recognised they need support and training. Peer educators need to be ethnically and culturally appropriate for the students they are mentoring. There should be national funding to support peer education models in all secondary schools, and other non-educational settings for young people, particularly those at risk.

Sexuality education needs to address the needs of all young people, including young people with a disability, Maori and Pacific young people, and young people with diverse sexualities and genders. There also need to be targeted strategies for young men.

The NZPPD welcomes the Ministry of Women's Affairs commissioning of the Education Review Office (ERO) to undertake a review of sexuality education for Year 7 to 13 students. The ERO findings, due in the first quarter of 2007, should be used in conjunction with this report to improve sexuality education for young people.

Recommendation 7: **Young people need consistent and comprehensive sexuality and relationships education in both schools and non-educational settings, delivered by trained specialist teachers or facilitators. Government must prioritise sexuality and relationships education, and ensure that all schools deliver comprehensive programmes.**

Many parents feel ill-prepared to talk to their children about sex. A number of submissions recommended that there should be more support and information available to parents about youth sexual and reproductive health, and support available to them in talking with their children around sexuality, sexual orientation and safer sex.

The UK Family Planning Association's Speakeasy project is a community-based education programme that provides parents with the skills and confidence needed to talk to their children about sex. Courses are run in selected areas of high teenage pregnancy. Although there are specific course outcomes, the content is needs-led and parents actively influence and shape the sessions.

Recommendation 8: **Consider a similar approach as the UK Speakeasy programme, for parent groups in the Strategies with Kids, Information for Parents (SKIP) programme and other parent education/support programmes.**

Information

There need to be ongoing national information campaigns such as 'Hubba Hubba', targeted at young people to raise awareness of sexuality and relationship issues including negotiating sexual activity, contraception, delaying sexual activity until you are ready, sexual violence, and the impact of alcohol and drugs on behaviour.

The campaigns need to be comprehensive, marketed using a range of media outlets and technology, and target places where young people congregate, including school and community settings. Resources must be readily available and in a range of languages and formats to attract all young people. A public campaign targeting young men in particular is needed.

It is vital that campaigns and information are developed with young people, and that they are linked to accessible, confidential services for young people.

Such campaigns could reduce the stigma of accessing sexual health services and stimulate discussion among the general public.

Recommendation 9: **Develop effective and positive education awareness strategies for all young people, accounting for ethnic and sexual diversity. Campaigns must be consistent, ongoing and developed with young people.**

Service provision

Young people need better access to confidential, non-judgemental, youth-friendly and free sexual health services. Services need to be well located, be open out of school hours and be well publicised. It is vital there is an emphasis that youth services are confidential.

Young people need to be able to access services in a range of locations to enable them to choose the most appropriate point of access. Recommendations include the expansion of the current 'one-stop-shop' model of service delivery into more areas in the community or encouraging schools to provide school-based sexual health services in partnership with local sexual health services, the Family Planning Association or Primary Health Organisations.

Several submissions said that all high schools should have at least a registered nurse trained to deliver sexual and reproductive health care. Youth providers working with high risk groups should also provide contraception and STI health care and treatment. Access to rural sexual health services must be given urgent attention, as should the creation of mobile health clinics. Clinics for young men staffed by men should also be considered.

Several submissions recommended the further development of nurse-led services such as sexual health screening and assessment, standing orders for emergency contraception, and other sexual health medication. Every consultation in primary care should consider the need for sexual health screening. For example, a health professional could ask a simple lead question: "Are you, or have you ever been, sexually active?"

Services need to address the needs of all young people, including young people with disabilities, Maori and Pacific young people, young people with diverse sexualities and genders, and young men. Young people should be involved in the development of sexual and reproductive health services.

Recommendation 10: **Develop and fund an Integrated Youth Health Service Model to include school-based services, community services and mobile services. Every school should have a paid nurse able to offer sexual and reproductive health services.**

Young people need access to the full range of contraceptive methods. All contraception methods should be made available without charge or with a nominal charge. In addition, emergency contraceptive pills should be available without charge from any pharmacy without prescription.

Recommendation 11: **As a minimum, condoms and emergency contraception should be free, and accessible services for dispensing need to be developed, particularly in rural locations.**

Sexual assault care must be adequately funded and resourced. Current services are variably funded and some areas have no provision of sexual assault care. There needs to be an increase in youth-focused service provision for counselling and related services to deal with the long-term effects of sexual violence. A nationwide database of counsellors who work with young people, particularly young men and youth of different cultures, should be developed. Comprehensive prevention programmes are also needed.

Recommendation 12: **Sexual assault care must be adequately funded and resourced. A database of counsellors and related services for young people should be developed.**

There were a number of recommendations around abortion services, including ensuring abortion occurs as early as possible in the pregnancy and improved access to abortion services, particularly early medical abortions, outside the main centres. Submitters recommended that the current abortion law be reviewed as the present system of two certifying consultants is overly bureaucratic and expensive, creating barriers to prompt and efficient access to abortion. Furthermore, with the advances in early medical abortions, the definition of licensed institutions should be re-examined with consideration of the second stage of medical abortion to take place at home. Young women need access to free and unbiased counselling before and after abortion, with appropriate support and follow-up services.

Recommendation 13: **Introduce a target to reduce the number of abortions carried out in the second trimester, and make safe medical methods of abortion available as an option for women. Review the current legal framework (Contraception, Sterilisation, and Abortion Act 1977), particularly around clinical guidelines and licensed institutions, as there have been advances in abortion procedures since the legislation was introduced.**

Workforce

There is currently a shortage of sexual health physician positions, and they are unevenly distributed throughout the country. An urgent review of specialist requirements and expansion of consultant posts is therefore needed. More specialists are essential to advocate and provide leadership for sexual health, to train and support primary care providers, as well as provide appropriate secondary and tertiary care services, and to conduct relevant research into sexual health issues. A recruitment and investment strategy is needed to encourage doctors and nurses to work in sexual and reproductive health.

Recommendation 14: **Develop a workforce plan to deliver sexual and reproductive health services.**

Health professionals, particularly GPs and primary care nurses, should be trained in delivering sexual and reproductive health services to young people. Other health professionals would benefit from an increased awareness of sexual and reproductive health issues, so that they feel comfortable raising the issue opportunistically when young people have contact with them.

Recommendation 15: **Implement training in sexual and reproductive health for primary care practitioners.**

Youth development

The government needs to invest in the Youth Development Strategy Aotearoa, particularly to provide good, comprehensive youth development programmes and introduce youth development training for teachers and other professionals. Investing in youth development means young people feel better supported and more able to make good decisions in all areas of their lives including sex and sexuality, and drug and alcohol use. All people who work with young people would greatly learn from a strengths-based youth development approach.

Recommendation 16: **Adequately invest in youth development programmes to fully implement the Youth Development Strategy and introduce youth development training for teachers and other professionals.**

Young Maori

Maori culture has different concepts and constructs about sexual health and reproduction and it is important that these values and ideas are part of young people's learning.

Multiple strategies are needed to address the complexities of sexual and reproductive health, for example sexual, physical and mental abuse; alcohol and drug misuse; education and health promotion; and socio-economic status.

There also needs to be a coordinated whanau approach to sexual and reproductive health services which sits alongside 'by Maori, for Maori' clinical services. Providers need access to kaupapa Maori sexual and reproductive health training and information.

Maori providers need to be given the opportunity to provide input into the national sexual and reproductive health strategy, setting priority areas and implementing regional strategies.

Recommendation 17: **Multiple strategies are needed to improve the sexual and reproductive health of young Maori, including a government-wide approach, increased 'by Maori, for Maori' clinical services, and better access to kaupapa Maori sexual and reproductive health training and information.**

Young Pacific people

Pacific cultures have different concepts and constructs about sexual health and reproduction and it is important that these values and ideas are part of young people's learning. Pacific views on sexual health issues, and fa'a Samoa and other Pacific-specific ways of working, need to be incorporated into policy development on sexual and reproductive health services.

Pacific young people need access to culturally appropriate services which are friendly, youth focused, confidential and accessible. There must be sufficient funding for programme development and delivery to Pacific youth and their communities.

Parents and caregivers need access to resources and support to address sexual health issues with their children. Resources must be specific for Pacific communities and available in Pacific languages.

Recommendation 18: **Pacific views on sexual health issues, and fa'a Samoa and other Pacific-specific ways of working, need to be incorporated into policy development on sexual and reproductive health services. Young Pacific people need access to culturally appropriate sexuality and relationships education and information, and sexual and reproductive health services.**

Teenage parents

Young parents need a range of support including assistance and financial incentives to stay at school and continue their education, and increased benefit levels and extended assistance at a younger age. Improvements in the rates of exclusive breastfeeding beyond six weeks of age could be supported with the development and implementation of strategies to provide information on the benefits of breastfeeding, relevant to young women, and supportive environments, such as mum-friendly schools.

Recommendation 19: **A range of support for young parents is needed, including teen parent units, financial assistance and incentives to continue their education, and increased benefit levels and extended assistance at a younger age.**

Young people with diverse sexualities and genders

A whole-school approach is needed to address sexual and reproductive health issues for young people with diverse sexualities and genders, including homophobia and bullying. The Health and Physical Education Curriculum should provide appropriate education and information for all young people, and should be taught in a non-judgmental and supportive learning environment. Furthermore, it should cover anti-homophobia education.

Schools and youth services need to be safe environments for all young people. They should have explicit anti-bullying and homophobia policies. All documents need to be written with inclusive language.

Young gay, lesbian, transgender, bisexual, takataapui, fa'afafine and intersex people require non-judgemental and safe health care that meets their particular sexual health needs.

Recommendation 20: **Ensure that young people with diverse sexualities and genders have safe and supportive school and youth service settings. Both the Health and Physical Education Curriculum and sexual health services must fully address the needs of young people with diverse sexualities and genders.**

Conclusion

The NZPPD *Open Hearing on Youth Sexual and Reproductive Health* has raised awareness among Parliamentarians and participants, and provides a base and opportunity for understanding and developing policy to address youth sexual and reproductive health issues in New Zealand.

There are already good programmes and services meeting the needs of young people, but on a small scale. They must be replicated and adequately resourced. The government has sound policies and strategies in place, but commitment and funding is required to support and implement them fully. Youth sexual and reproductive health is complex and wide reaching, and needs a whole of government approach.

Youth Sexual Health: "Our Health, Our Issue" will be used to inform and influence government, parliamentarians, public servants and other interested parties. NZPPD members will discuss the report with key Ministers to develop an action plan for taking forward the recommendations.

It will also be a key resource for sharing information and useful approaches with the Pacific Parliamentary Assembly on Population and Development (PPAPD) and within the Asian Forum of Parliamentarians on Population and Development (AFPPD) network.

Appendix one - Aotearoa New Zealand background

Aotearoa New Zealand health legal framework

Young people under 16 have a legal right to access confidential medical services, including sexual and reproductive health services, without parental consent. Relevant legislation is as follows:

Venereal Diseases Regulations 1982

The Regulations require practitioners to notify the parent or guardian of any person under the age of 16 if they are suffering from a venereal disease (STI), unless they think that it would not be in the best interest of the young person.

However under the Code of Health and Disability Services Consumers' Rights 1996 and the Health Information Privacy Act 1994 (see below) the rights of the young person to privacy of their health information could take precedence over this regulation.

Contraception, Sterilisation and Abortion Act 1977, as amended 1990

In 1990, Parliament repealed section 3 of the 1977 Act which restricted the sale or disposal of contraceptives to any person under the age of 16. The amendment means that there is no longer any statute law restricting any health provider giving information or advice on the use of contraceptives or prescribing contraceptives to people of any age. Young people under 16 can consent to their own medical treatment in relation to receiving contraceptive advice, services and termination of pregnancy.

Health Information Privacy Code (1994)

A patient is entitled to complete confidentiality irrespective of age. However, there are exceptions to confidentiality which include:

- when the patient authorises it, or
- when disclosure is necessary to prevent or lessen a serious and imminent threat to public health or safety, or the life or health of an individual.

Where a child has the necessary capacity to consent to his or her own medical treatment, all health information disclosed to the health practitioner should be kept confidential. Parents are not entitled to be given confidential information without patient agreement.

The only situation where disclosure of health information is allowable is if the patient is unable to consent to medical treatments on his or her own behalf.

Code of Health and Disability Service Consumers' Rights (1996)

The Code contains a presumption of competence and the recognition that a consumer retains the right to consent to the extent appropriate to his or her level of competence.

Right 7, "Right to Make an Informed Choice and Give Informed Consent", does not have an age-based threshold upon which competence is measured. The focus is on the competence of each individual. Subsection (2) of Right 7 states: *Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.*

Subsection (3) adds: *Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence*. Furthermore Subsection (2) of Right 5 states: *Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively*.

This recognises that in some circumstances it is beneficial for minors to see a health provider without their parents' presence in order to enable effective communication.

Care of Children Act 2004

Section 36 states that the consent of a child of, or over, 16 years of age has the same effect as if the child was of full age. Notwithstanding the cut-off age of 16 years, health practitioners should involve children in

the decision-making process as to whether care should be provided. The views of those children who have the maturity and understanding to be able to make an informed decision should be considered and not automatically discounted because a child has not reached the age of 16 years. Section 38 specifically states that a female of any age can give or withhold consent for abortion.

Aotearoa New Zealand youth sexual and reproductive health policy framework

The New Zealand government has implemented a number of policy initiatives to address sexual and reproductive health issues for young New Zealanders.

The New Zealand Health Strategy (2000)

The New Zealand Health Strategy published in 2000 set out the government's plan of action on health and identified 13 key population health objectives for the Ministry of Health and District Health Boards to focus on in the short to medium term. The population health objectives are:

- Reducing smoking
- Improving nutrition
- Reducing obesity
- Increasing physical activity
- Reducing suicides and suicide attempts
- Minimising the harm caused by alcohol, drug and illicit drug use
- Reducing the incidence and impact of cancer
- Reducing the incidence and impact of heart disease
- Reducing the impact and incidence of diabetes
- Improving oral health
- Reducing violence
- Improving the health status of people with severe mental illness
- Improving access to health services including well child, family health care and immunisation.

Sexual and reproductive health is not included, although it is clearly linked to a number of the priority areas such as reducing suicides and attempted suicide attempts, reducing violence, reducing the incidence and impact of cancer, and minimising the harm caused by alcohol, drug and illicit drug use.

Sexual and Reproductive Health Strategy (2001)

The Sexual and Reproductive Health Strategy released in October 2001, followed a similar strategy in 1997 and signalled identification by the government of sexual and reproductive health as a priority area of health.

Phase One of the Strategy set out the overarching vision and strategic directions for sexual health in New Zealand. It aimed to provide the health sector, including the Ministry of Health, District Health Boards and other organisations, with the basis from which to develop service-specific plans and funding decisions.

The Strategy identified the government's key concerns in sexual and reproductive health as:

1. New Zealand's increasing number of STIs, particularly chlamydia, gonorrhoea, and HIV. This was considered particularly significant given the potential lifelong consequences of STIs and the disproportionate rates of STIs among some population groups, for example youth, Maori and Pacific people.
2. New Zealand's high rates of unintended/unwanted pregnancy relative to comparable countries. The Strategy recognised the impact of teenage pregnancy on both mother and child, including social and economic problems, and increased risk of the child having "poor outcomes in education, health and welfare".

The principles of the Strategy are derived from the New Zealand Health Strategy and include:

- sexual and reproductive health services as a public health service
- a comprehensive, free, specialist sexual and reproductive health service close to the community
- STI control to ensure that at-risk groups have access to effective education programmes
- disease control of HIV as an STI
- an emphasis on effective and available services for Maori, Pacific people, and young people.

The Strategy identified four strategic directions:

1. Societal attitudes, values and behaviour - increase the awareness and understanding of all members of society about the complex nature of sexuality, sexual behaviour and motivation
2. Personal knowledge, skills and behaviour - increase individuals' understanding and skills and teach them to value themselves (personal identity and self worth)
3. Services - ensure sector development and that the necessary number and range of interventions and services are working together regionally and nationally to improve sexual and reproductive health and provide consistent messages
4. Information - increase the evidence base.

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

In 2003, as part of the second phase of the Sexual and Reproductive Health Strategy, the Ministry of Health released this resource book. It was designed to help DHBs and PHOs by providing guidance on comprehensive and effective approaches to maintaining good sexual and reproductive health, improving the population's uptake of effective contraception and safer sex practices, and responding effectively to the threat of HIV and AIDS. The resource book contained a wide range of possible activities, but without indication of priorities; many of them have not been implemented. An exception is the 'Hubba Hubba' national public health campaign launched in Novermber 2004, which aimed to reduce high rates of STIs in sexually active young people by encouraging them to use a condom every time they have sex.

HIV/AIDS Action Plan: Sexual and Reproductive Health Strategy (2003)

In 2003, the Ministry of Health released the HIV/AIDS Action Plan, which provides a review and update of New Zealand's response to HIV and AIDS, and sets out a comprehensive set of actions including a key objective to: *ensure HIV awareness and prevention training is a key component of sexual and reproductive health education and promotion programmes, particularly those targeting young people.*

Furthermore, the Plan recognises that effective nationwide programmes should take into account the need to raise awareness and knowledge of HIV prevention and care among the general population, especially the young. The Plan says that young people need to have the knowledge and skills to make safe choices and to have access to youth-friendly services that include sexual and reproductive health services and access to condoms. Special attention should be paid to vulnerable young people and those at high risk. Successful youth targeted programmes and services involve young people in their design and work with young people to promote their participation.

Aotearoa New Zealand sexuality education policy

Health and Physical Education Curriculum (2001)

Under the Education Standards Act 2001 all state and state-integrated schools are required to implement the Health and Physical Education curriculum. Sexuality education is a key area of learning in the curriculum, so is required to be incorporated in programmes for all students at both primary and secondary levels to the end of year 10.

Beyond year 10 there are no mandated components to the New Zealand curriculum. Schools may choose to offer sexuality education as part of a senior health education programme designed to meet the requirements of NCEA at levels 1, 2 and 3.

The Board of Trustees of every state school is required by the legislation to meet at least once every two years, in order to (after consultation with the school community, which includes parents) adopt a statement on the delivery of the health curriculum. The Board may adopt any method for the consultation.

Parents and guardians retain the right to withdraw their child from attending sexuality education lessons; this should be done in writing to the principal. On receipt of this the school principal must ensure the student is excluded from any specific parts of the health education curriculum relating to sexuality education, and is supervised during this time. However, principals are not required to ensure the student is excluded at any other time while a teacher deals with a question raised by another student, which relates to the sex education part of the curriculum.

In 2002 the Ministry of Education published *Sexuality Education - Revised Guide for Principals, Boards of Trustees, and Teachers*, which provides links between the curriculum and the implementation of classroom sexuality programmes. The guide does not specify particular teaching, learning or assessment activities. It provides guidance on consulting the school community about the health curriculum.

Aotearoa New Zealand youth-focused policy

Youth Development Strategy Aotearoa (2002)

The Ministry of Youth Affairs launched the Youth Development Strategy in 2002. The Strategy promotes the application of a youth development approach as a way of understanding what needs to happen for, around and with young people in New Zealand. It focuses on how government and society can support young women and men aged 12 to 24 years. It's about how they develop the skills and attitudes they need to take a positive part in society, now and in the future. However, there is little specific reference to sexual and reproductive health in the Youth Development Strategy Aotearoa.

Youth Health: A Guide to Action (2002)

Youth Health: A Guide to Action was published by the Ministry of Health in September 2002 and proposed a plan for action to improve the health of 12 to 24 year olds, and set out the goals, objectives, and specific actions to do this. The 10 key goals identified were:

1. A safer, more supportive environment for New Zealand's young people
2. A measurable improvement in young people's mental health
3. A measurable improvement in young people's physical health
4. Young people influencing health policy and programme development
5. A higher knowledge about youth health and youth health services
6. High-quality, youth-friendly, accessible health services
7. A measurable improvement in the health of *rangatahi* (Maori youth)
8. A measurable improvement in the health of Pacific young people
9. A measurable improvement in the health of disabled youth and chronically ill young people
10. Better health outcomes for young people with multiple disadvantages.

The Guide specifically recognised that young people have disproportionate rates of STIs in comparison to other groups in the population. The Guide identified STIs and unplanned pregnancy as being among the specific health risks for young people.

Specific actions were identified for different settings including family, school, community, primary care, hospitals and specialist health services, and District Health Boards. Some of the key actions that relate to youth sexual and reproductive health are:

Family and whanau setting	• Promote the extension of parent education programmes to provide knowledge and support for families and whanau in dealing with young people's developmental needs, particularly in the areas of mental health, sexual and reproductive health, and alcohol and drug abuse.
School setting	• Acknowledge and respond to the needs of young people who are perceived as different because of their sexual orientation. • Look at the feasibility of establishing or extending school health clinics in collaboration with schools, GPs, public health services and DHBs.
Community setting	• Support the development of community-based youth health centres.
Primary care setting	• Actively involve young people in designing primary health care services for young people. • Explore ways of reaching out to those young people who don't use existing health services, through: - youth-specific health services - mobile clinics at sports events, marae, dance parties, central city and rural locations - extending the role/reach of public health services and practice nurses - supporting Maori and other communities to develop their own services. • Encourage family health clinics to look at how they could become more youth focused – taking account of young people's expressed desire for privacy and confidentiality, and look at how user friendly they are for Maori and Pacific young people, and from the perspective of disabled and deaf young people. • Support the extension of school-based health clinics, particularly for schools in low-income communities.
Hospitals and specialist health services setting	• Look at how hospital-based and specialist health services could become more youth focused.
DHB setting	• Actively involve young people in developing policies and health services for young people. • Consider innovative approaches to taking health care services to young people who don't use GPs. • Explore, together with schools and GPs, the feasibility of extending school based health centres, particularly in low-decile schools.

Appendix two - international background

The international human rights framework

In response to atrocities committed during World War II, the UN General Assembly adopted the Universal Declaration on Human Rights (the Declaration) in 1948. International treaties have since transformed the principles asserted in the Declaration into legally binding obligations for nations that ratify the treaties.

Sexual and reproductive rights are central to human rights. They derive from the recognition of the basic right of all individuals and couples to make decisions about their sexuality and reproduction free of discrimination, coercion or violence. They include the right to the highest attainable standard of health and the right to determine the number, timing and spacing of children.

International treaties and agreements provide a framework for addressing sexual and reproductive health from a human rights perspective; some of the key treaties and agreements are outlined in the table below:

Treaty	Date adopted	Purpose
International Covenant on Civil and Political Rights	1966	Guarantees right to life, liberty, marry and found a family, freedom from inhuman treatment, and freedom of thought and expression
International Covenant on Economic, Social, and Cultural Rights	1966	Guarantees right to health, education, work, adequate standard of living, and benefits of scientific progress
International Conference on Human Rights (Teheran)	1968	The first global meeting on human rights reviewed the progress made in the 20 years since the adoption of the Universal Declaration of Human Rights and formulated an agenda for the future. Included in the Proclamation of Terehan was the declaration that parents have a human right to family planning.
Convention on the Elimination of all Forms of Discrimination Against Women	1979	Eliminates discrimination against women in civil, political, economic, social, and cultural areas
Convention on the Rights of the Child	1989	Defines and guarantees civil, political, economic, social, and cultural rights of children under age 18 and their parents
United Nations Commission on Human Rights	2004	Explicitly recognised women's sexual rights as essential to combating violence and promoting gender equity.

Source: Outlook. A rights based approach to reproductive health. Volume 40 Number 4 Path. UNFPA December 2003

The international policy framework

The United Nations Population Fund (UNFPA) defines young people as those aged 10-24 years. Currently half of the world's population is under the age of 25.

Since the 1990s, many international agreements and fora have brought more attention to the sexual and reproductive health needs of young people. These are supported by the international human rights framework.

International Conference on Population and Development (ICPD)

New Zealand was one of 179 countries that signed up to the ICPD Programme of Action in 1994. The 20-year Programme of Action sets goals to be achieved by 2015 including:

- universal access to reproductive and sexual health services, including family planning
- universal education
- a reduction in infant, child and maternal mortality.

The Programme of Action set out clear objectives for young people around access to sexual health education and information, and access to private and confidential health services. Key objectives include:

- to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV and AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group (para 7.44)
- countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse.....these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents (para 7.45)

- countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies (para 7.46)
- governments, in collaboration with non-governmental organisations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention (para 7.47)
- sexually active adolescents will require special family planning information, counselling and services, and those who become pregnant will require special support from their families and community during pregnancy and early child care (para 7.47)
- adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities (para 7.47).

Progress in the first five years of implementing the ICPD programme was the focus of a special session of the United Nations General Assembly (ICPD+5) in June 1999. The session identified further actions including around young people and HIV:

- Governments, with assistance from UNAIDS and donors, should, by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counselling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 per cent (para 70).

Beijing Platform for Action

In 1995 at the Fourth World Conference on Women, New Zealand signed up to a Platform of Action, which included objectives to address the needs of young people. These included to:

- prepare and disseminate accessible information, through public health campaigns, the media, reliable counselling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction (para 108e)
- give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality (para 109k).

Commission on the Status of Women

The resolution adopted by the Commission on the Status of Women at its 42nd Session in 1998 stated that action should be taken by governments, civil society and the United Nations system to:

- make widely available information and counselling to adolescent girls and boys, especially on human relationships, reproductive and sexual health, sexually transmitted diseases and adolescent pregnancy, that are confidential and easily accessible and emphasise the equal responsibility of girls and boys
- improve the health care for adolescent girls by health personnel and provide the latter with appropriate training, and encourage health care staff to work with girls to understand their special needs
- recognise and protect from discrimination pregnant adolescents and young mothers and support their continued access to information, health care, nutrition, education and training
- support the activities of non-governmental organisations in the area of reproductive health and health orientation centres for girls (chapter IV - The Girl Child).

International case study: England's Teenage Pregnancy Strategy

England has seen a marked reduction in the rate of teenage fertility since the introduction of its Teenage Pregnancy Strategy in 1999. Teenage pregnancy rates are at their lowest for 20 years; since the introduction of the Strategy, under-18 conceptions are down by 11.1% and under-16 conceptions are down by 15.2%.

The Teenage Pregnancy Strategy was launched by the Prime Minister in June 1999 following a report from the Cabinet Office's Social Exclusion Unit (SEU) on teenage pregnancy. The report and Strategy took into account the scale of teenage pregnancies and the impact on outcomes for teenage parents and their children, as well as drawing international comparisons.

The SEU identified a number of factors that increased a teenager's risk of becoming pregnant. These were:

- poverty
- being in care (for example being in fostering arrangements or children's homes)
- being children of teenage mothers
- educational problems
- no education, training or work after 16 years old
- sexual abuse
- mental health problems.

Furthermore, they identified three key factors that stood out in terms of their impact on teenage pregnancy rates, which were:

- low expectations, particularly of education or the job market
- ignorance or a lack of knowledge about contraception and safer sex
- mixed messages. One part of the adult world (i.e. the media) bombards teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. Another part, including many parents and most public institutions, is at best embarrassed and at worst silent, hoping that if sex isn't talked about, it won't happen.

The Strategy set two national targets, to:

- halve the under 18 conception rate in England by 2010 (with an interim reduction target of 15% by 2004)
- increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long term social exclusion.

It recommended four strands of activity to achieve the national targets:

- media campaign
- joined up activity
- better prevention
- support for teenage parents.

Media campaign

Initially the media campaign focused on messages around ignorance, for example beliefs among young people that "you can't get pregnant the first time you have sex". More recently there have also been campaigns to encourage young people to delay sexual activity and also to use condoms as being part of mutual respect. Although the focus was on teenage pregnancy, it has also included information about STIs.

Joined up activity

Teenage Pregnancy Unit

The Teenage Pregnancy Unit is a cross-government unit based in the Department for Education and Skills, but is funded by Education, Department of Health, Department for Communities and Local Government, Department for Work and Pensions, and the Home Office.

The objectives of the Teenage Pregnancy Unit are to:

- oversee the implementation of the government's teenage pregnancy strategy
- co-ordinate activity at national level
- provide support for local activity.

At a local level, each top tier local authority in England has its own teenage pregnancy strategy, which draws together expertise and input from a variety of local partners, including health services. Local teenage pregnancy coordinators have also been appointed, who aim to ensure that there is joined up activity at a local level and ensure progress on local implementation.

Independent Advisory Group (IAG)

The Group was established in 2000 to provide advice to the government and to monitor the overall implementation of the Teenage Pregnancy Strategy. The IAG publishes an annual report, which the government must respond to. The most recent annual report, published in September 2006, welcomed the government's focus on social exclusion but recommended more be done on 'the basics' to reduce the number of pregnancies. The IAG called for Personal, Social and Health Education to be made statutory and recommended that teenagers should be able to access the full range of contraceptive methods, including long-acting ones, and in more accessible locations, including shops, sports facilities and further education colleges.

Better prevention

Sex and relationships education

Following the publication of the Teenage Pregnancy Strategy, the Department for Education and Skills issued new guidance to schools on sex and relationships education. This set out for schools and parents what had to be provided by law, but also what should be included to provide a comprehensive programme, including addressing controversial issues such as abortion and homosexuality. Some aspects of Personal, Social and Health Education have a statutory basis in secondary schools, including contraception and HIV. All schools must have a sex and relationships education policy. The sex and relationships education policy should be developed in consultation with parents and made available to them. It is possible for parents to withdraw their children from the sex and relationships education related aspects of Personal, Social and Health Education, although not from statutory science lessons.

Confidentiality

In 2004, following the publication of the Sexual Offences Act 2003, the Department of Health issued revised guidance for healthcare professionals confirming the rights of young people under the age of 16 to access confidential advice and treatment, without parental consent, including those under 13. The guidance recommends that young people should be encouraged to tell their parents or another adult if possible.

This confirmed the House of Lords' ruling in 1985 in the case of *Gillick v West Norfolk and Wisbech Area Health Authority*. The Lords ruled that a young person under the age of 16 can consent to contraceptive advice and treatment, including abortion, without parental consent, providing certain criteria are met, including that the young person will understand the professional's advice and the young person cannot be persuaded to inform their parents.

Improved services

Attempts have been made to increase access for young people, including those under 16, to sexual health and contraceptive services. Best practice commissioning guidance was issued that included consideration of the locations and times when services are available, the provision of youth-friendly services and the display of publicity where young people met.

Support for teenage parents

Initiatives include tailored maternity services, financial support for childcare for those in education and training, and help to access supported accommodation.

Evaluation of the Teenage Pregnancy Strategy

While England's teenage pregnancy rates are at their lowest for 20 years, progress around the country has been varied.

The Teenage Pregnancy Unit undertook a "Deep Dive" exercise in 2005 to identify the key issues affecting progress. They compared geographic areas that were doing well with areas that had similar demographic and socio-economic features that were doing badly.

The key factors for success were found to be:

- **a prompt start, a senior champion and all key partners contributing to the Strategy**
- **strong delivery of sex and relationships education/Personal, Social and Health Education by schools**
- **accessible, confidential and well known contraceptive services plus outreach work**
- **workforce training on sex and relationships education within mainstream partner agencies**
- **targeted work with at risk groups**
- **active and well resourced youth services.**

In terms of identifying those young people most at risk of teenage pregnancy, the Deep Dive found that improvements in educational attainment over the period of the strategy had an overriding influence. When areas with similar levels of deprivation were compared, the teenage birth rate was lower in those where larger numbers of young people were now receiving good exam results.

New guidance has now been issued to primary care trusts and local authorities highlighting these factors and encouraging the worst performing areas to learn the lessons from those that are doing well.

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