

Sexual and Reproductive Health

**A resource book for New Zealand
health care organisations**

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Contents

Message from the Minister	v
Section One: Background Information	1
Introduction	1
New Zealand's sexual and reproductive health statistics	2
Section Two: Designing Services	9
Approaches that work	9
Things to consider in planning services	14
Section Three: Strategies for Action	17
Community-wide action	17
Personal knowledge and skills	20
Programmes and services	22
Information and data collection	26
Section Four: Strategies for Māori	29
Introduction	29
Community-wide action	30
Personal knowledge and skills	33
Programmes and services	35
Information and data collection	37



Section Five: Strategies for Pacific Peoples	39
Introduction	39
Community-wide action	42
Personal knowledge, skills and behaviour	44
Programmes and services	45
Information and data collection	46
Appendices	47
Appendix 1: Unintended and Unwanted Pregnancies	47
Appendix 2: Sexually Transmitted Infections	53
Appendix 3: HIV and AIDS	57
References	67

List of Tables

Table 1: Number and rate of abortions by age of woman, 2002	3
Table 2: Confirmed sexually transmitted infection rates and age comparisons at sexual health clinics, 2001	5
Table 3: Number and rate of abortions by age of woman, 2002	49

List of Figures

Figure 1: Annual number of confirmed sexually transmitted infection cases reported by sexual health clinics, 1995–2000	4
Figure 2: Annual number of people newly diagnosed HIV-positive, 1985–2002	6
Figure 3: Number of people newly diagnosed with HIV infection by year of diagnosis and likely mode of infection, New Zealand, 1985–2002	58
Figure 4: Annual number of people newly diagnosed HIV-positive, 1985–2002	59
Figure 5: Ethnicity of people diagnosed HIV-positive from 1 January 1996 to 31 December 2002	60
Figure 6: Regional distribution of people diagnosed HIV-positive from 1 January 1996 to 31 December 2002	60



Message from the Minister

In 2001 I released the Sexual and Reproductive Health Strategy, which indicated the overall direction the Government wished to take to achieve positive and improved sexual and reproductive health for all New Zealanders. In this second phase of the strategy, we are focusing on District Health Boards and Primary Health Organisations and the role they can play in improving the sexual and reproductive health of their communities.

We know New Zealanders can be reticent about discussing sexual health issues. Most of us take for granted that we will be sexually active and be able to choose if and when we will have children.

This is the ideal, but it is not the reality for many New Zealanders. Among young New Zealanders, and rangatahi Māori particularly, unplanned pregnancies, abortion and sexually transmitted infections are becoming more common – with potential long-term consequences for their health and their fertility.

We have to do better in the area of contraception. Research tells us that up to 60 percent of pregnancies in New Zealand may be unplanned. That means some babies do not have an optimal start to life. And babies born to very young women and into families that are already finding it hard to cope are not having the best start to their lives either. Increasing abortions is not the best solution.

New Zealand also has high rates of sexually transmitted infections. Part of the problem is that infections like chlamydia often have no symptoms. That means they can be passed on unwittingly. Untreated, chlamydia can have long-term effects. It can be transmitted from mother to newborn child; it can cause infertility; and it can make people more susceptible to HIV infection.



Hon Annette King
MINISTER OF HEALTH



These issues are of concern to us all, as individuals, as family and whānau members, and as a community. Sexual and reproductive health is an area where major inequalities exist between Māori and non-Māori.

We know many of the influences on our sexual and reproductive health lie outside the health sector. However, we in the health sector have the opportunity and the responsibility – particularly in respect of young people— to make sure they have ready access to advice and care on sexual health matters.

At the same time we need to encourage all people to take responsibility for contraception and to make sexual and reproductive health check-ups a normal part of their health care routines. This is one area where new Primary Health Organisations can take a lead.

The reference groups who helped compile this resource book proposed a goal:

A society where individuals have the knowledge, skills and confidence to enjoy their sexuality, to choose when or if to have children, and to keep themselves safe from harm.

This is a society I want to be a part of.

Hon Annette King
MINISTER OF HEALTH



INTRODUCTION

The Ministry of Health has developed this resource book to support the Minister of Health's Sexual and Reproductive Health Strategy. Improved sexual and reproductive health is one of the objectives of the New Zealand Health Strategy.

This book and the accompanying document, *HIV/AIDS Action Plan*, are designed to help District Health Boards (DHBs) and Primary Health Organisations find ways of improving their populations' uptake of effective contraception and safer sex practices. It suggests some practical steps organisations can take to:

- encourage and maintain good sexual health in the general population as part of a healthy lifestyle
- reach young people, Māori, and Pacific peoples who may not have ready access to services
- make services more user-friendly for young people, Māori and Pacific peoples
- increase individuals' knowledge and skills – from negotiating relationships to knowing which contraception method works best for them.

While the resource book is intended as a guide primarily for DHBs and primary health care providers, there are ways in which the whole community can contribute to improving our sexual and reproductive health statistics:

- local government can involve and constructively engage young people in the life and development of their communities
- school management and school trustees can create health-promoting schools, and support students (and parents) through the different stages of the curriculum's sexuality education
- community organisations can explore new ways of promoting good sexual and reproductive health among their members
- families, whānau and individuals can acquire knowledge to support their young people, and practise safer sex.





New Zealand's sexual and reproductive health statistics

Unintended/unwanted pregnancies

Research studies and abortion statistics indicate that a high number of pregnancies occurring each year in New Zealand are unintended or unwanted.

- A Dunedin Multidisciplinary Health and Development Study (Dickson et al 2002)¹ reported that out of its participants 60 percent of pregnancies to women aged under 25 were unintended.²
- In both the Dunedin study and a Christchurch study about 30 percent of pregnancies ended in abortion.
- New Zealand has high rates of abortion compared with other countries, as well as high ratios of abortions to known pregnancies,³ particularly among Māori and Asian women (Statistics New Zealand 2003).

Teen pregnancy

New Zealand also has a comparatively high rate of births to teenagers (UNICEF 2001). Young Māori women have a particularly high birth rate. While many teenage pregnancies are intended and wanted, many occur to young women who are not able to support or care for a child adequately.

New Zealand's teenage birth rate (27.3 per 1,000 women aged 15–19) is third highest of 28 countries, behind the United States (52.1) and the United Kingdom (30.8). Among Māori women aged 15–19, the birth rate is 74 births per 1,000 women. At the lower end of the teenage birth rates are countries such as Korea (2.9 per 1,000 women), Japan (4.6), Switzerland (5.5), the Netherlands (6.2), Sweden (6.5), Italy (6.6) and Spain (7.9).

Abortion data

In comparison with many European countries, New Zealand's abortion rate (in 2002, 20 per 1,000 women aged 15–44) is at the higher end of the scale, along with the United States, Australia and Sweden. At the lower end of the scale are the Netherlands (7.4 per 1,000), Germany (8.0) and Finland (10.5).

In New Zealand in 2001:

- Asian women had the highest ratio of abortions to known pregnancies (364 per 1,000), followed by Māori women (280), Pacific women (255) and European women (207)
- of the women who had abortions 8,728 (54 percent) had one or more children already
- of the women who had abortions 5,580 (34 percent) had previously had one or more abortions.

In 2002, women aged 20–24 had the most abortions (5,124) and the highest abortion rate (38.9 per 1,000). Women aged 15–19 had the second highest number of abortions (3,602), followed by women aged 25–29 (3,450) (see Table 1).

¹This study examined the circumstances of wanted and unwanted pregnancies in a cohort of New Zealanders born in Dunedin in 1972/73.

²Note that the Dunedin data participants were aged up to 25 years and the Christchurch participants were aged up to 21 years.

³Twenty-three percent of known pregnancies (excluding miscarriages) ended in abortion in 2002 (Statistics New Zealand 2003).



Table 1: Number and rate of abortions by age of woman, 2002

Age	Number of abortions	Rate*
11–14	78	0.6
15–19	3,602	25.7
20–24	5,124	38.9
25–29	3,450	26.6
30–34	2,676	17.5
35–39	1,715	10.9
40–44	686	4.4
45 and over	49	0.4
Total	17,380	

*Per 1,000 females in each age group.

Source: Statistics New Zealand 2003

Current developments

Several major projects in the area of sexual and reproductive health are planned or are under way:

- Sexual and Reproductive Health Behaviours Survey:** This survey of New Zealanders' sexual and reproductive health behaviour is to become a regular component of the Ministry of Health's National Population Survey Programme. The first survey will be undertaken in early 2004.
- Māori sexual and reproductive health:** A research project is under way to develop a kaupapa Māori framework for action and intervention in sexual and reproductive health. The project is being undertaken by Te Puawai Tapu and is being funded by the Health Research Council.
- Access to abortion:** Service specifications are being developed so women are assured of more equitable access to abortion services around the country.
- Teen pregnancy:** Reducing teen pregnancy has been incorporated into the Government's Sustainable Development Strategy work programme in the area of investing in child and youth development.
- Long-term contraception:** A trial of the contraceptive Mirena as an alternative to sterilisation for some women is under way in Auckland.
- Azithromycin:** Pharmac is evaluating the implications of making Azithromycin treatment for chlamydia more accessible through practitioner supply orders.
- Gay Auckland Periodic Sex Survey (GAPSS):** This survey is to be repeated in 2003/2004.
- Safer Sex public health campaign:** This campaign is being planned as a part of the Ministry of Health's focus on sexual and reproductive health in 2003/2004.
- Low-cost access to health care for school age students enrolled** in PHOs is being introduced from October 2003.



Sexually transmitted infections

Sexually transmitted infections (STIs) are among the main preventable causes of ill health among young people in New Zealand. Untreated, they can have life-long consequences, increasing the risk of infertility, sub-fertility, ectopic pregnancy, cancer and other chronic diseases. The presence of a sexually transmitted infection can increase the risk of HIV transmission and, if untreated, may be passed on by a mother to her baby at birth.

Despite chlamydia and gonorrhoea being relatively easy to prevent, treat and cure, rates of chlamydia and gonorrhoea have increased significantly in the last few years. Laboratory data suggest the incidence of chlamydia in the New Zealand population is considerably higher than that in Canada, Australia and the United Kingdom (ESR 2002).

Rangatahi Māori continue to experience significantly higher rates of STIs than non-Māori. Many young people may be infected without realising it.

Most common sexually transmitted infections

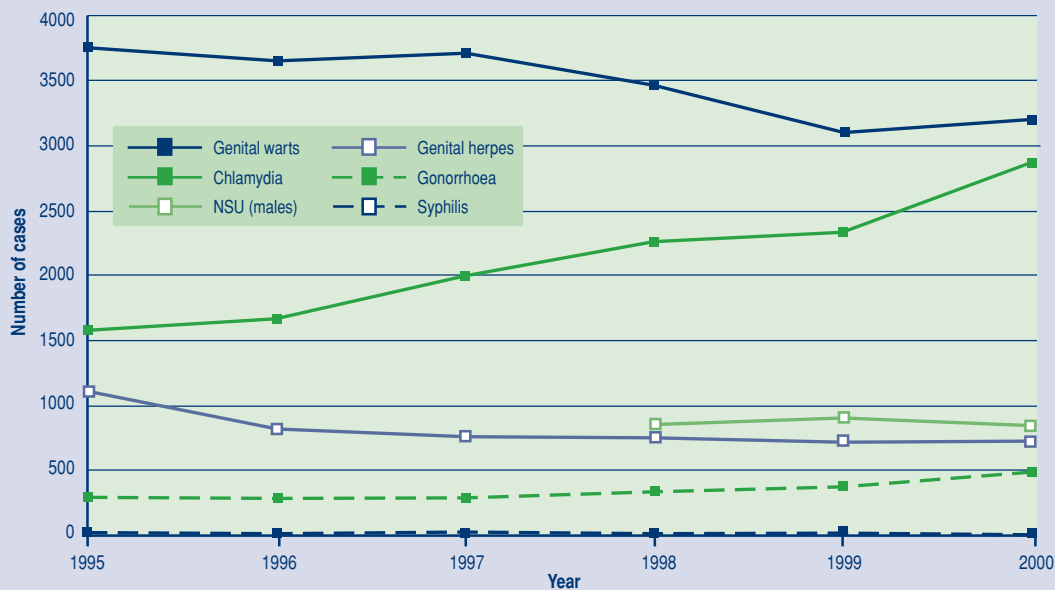
The STIs most frequently diagnosed in New Zealand are chlamydia, genital warts, non-specific urethritis (NSU) in males, genital herpes and gonorrhoea.

Genital chlamydia is the most commonly diagnosed STI at sexual health clinics. The number of confirmed cases of chlamydia presenting in sexual health clinics has risen by more than 100 percent from 1995 to 2000 (see Figure 1). While the move to more sensitive nucleic acid amplification tests (NAATs) is a factor in this increase, the number of chlamydia cases has also increased at sexual health clinics not using NAATs.

Chlamydia predominantly affects those aged 15–24 (see Table 2), and is more common among Māori than non-Māori.

Data from laboratories in the Waikato and Bay of Plenty suggest the incidence of chlamydia in the New Zealand population is four times higher than that in Canada and over five times higher than in the Australian states that use laboratory data for STI surveillance.

Figure 1: Annual number of confirmed sexually transmitted infection cases reported by sexual health clinics, 1995–2000



* NSU annualised, based on July–December 1998 data. Source: ESR 2001



Table 2: Confirmed sexually transmitted infection rates and age comparisons at sexual health clinics, 2001

Infection	Cases	Rate*(%)	Mean age	Median age	Age range
Chlamydia	3238	3.8	22.5	21	13–69
Genital herpes	638	0.8	28.9	27	15–64
Genital warts	3304	4.3	24.8	22	13–81
Gonorrhoea	533	0.7	24.6	22	13–60
NSU (males only)	1053	3.4	29.6	27	13–66
Syphilis	18	0.0	36.2	34	22–72
Other	29				
Total	8785	11.5	24.8	23	13–81

*Number of cases as a proportion of the total number of clinic visits (76,257). For NSU, number of male cases as a proportion of the number of male clinic visits (31,039).

Source: ESR 2002

HIV/AIDS

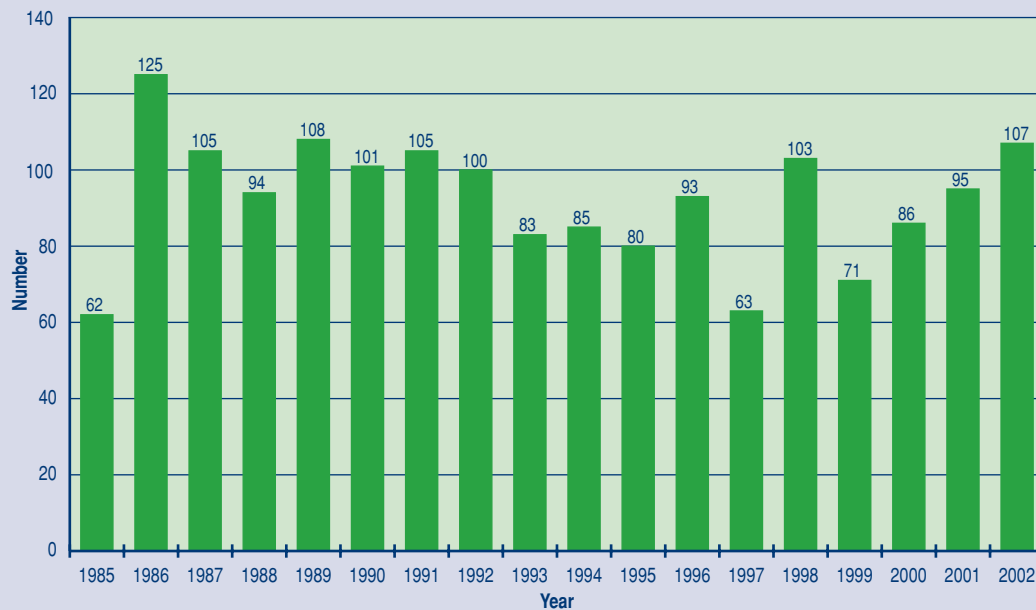
In the year ending December 2002, 136 people were diagnosed HIV positive; 112 were male and 24 female.

The World Health Organization classifies New Zealand as a ‘low prevalence’ country for HIV and AIDS. However, the speed with which HIV can spread through communities leaves no room for complacency. Shifts in the characteristics of New Zealand’s HIV-positive population and changes in the pattern of migration can alter the risk level significantly.

Figure 2 shows how the annual total numbers of people newly diagnosed HIV positive have fluctuated since reporting began in 1985. There were 107 people newly diagnosed in 2002, which is higher than in the previous three years. Although it is too early to tell whether this will be an ongoing trend, it underlines the need for prevention programmes to continue.



Figure 2: Annual number of people newly diagnosed HIV-positive, 1985–2002



Source: NZ AIDS Epidemiology Group 2003

The total number of men diagnosed (1,410) since 1985 is still significantly more than women (237), but women are increasingly making up a greater proportion of the annual numbers diagnosed. A 2000 study of New Zealand's HIV-positive population under active care concluded that the increasing numbers of women under care required new strategies to be developed to prevent perinatal HIV transmission.



Recent research findings

The following are findings from the *New Zealand National Secondary School Youth Health Survey 2001* (Adolescent Health Research Group 2003).

- Just over 20 percent of students report being currently sexually active. Of those 17 years or over, one-third are sexually active.
- Seventy-six percent of sexually active male students and 69 percent of sexually active female students report using condoms the last time they had sex.
- School is the main source of information about sexual health for school students, followed by friends, and then parents, magazines, books and television.
- Female students are more likely than male students to get sexual health information from a nurse or doctor (27 percent of females compared with 14 percent of males).
- Males are more likely to get information from the Internet than females (22 percent of males compared with 8 percent of females).
- More than a third of all students report an episode of binge drinking (five or more alcoholic drinks in four hours) in the last four weeks.

Trends in Sexual Risk Behaviours among US High School Students 1991–2001 (CDC 2002) found the following.

- Thirty-three percent of US high school students report being currently sexually active (compared with 21 percent of New Zealand students). This percentage has stayed constant over the decade.
- Between 1991 and 2001, the percentage of high school students who reported ever having had sexual intercourse decreased (from 54 percent to 45 percent) and the percentage of sexually active students who used a condom at last sexual intercourse increased.
- Between 1991 and 2001, the percentage of students who reported using alcohol or drugs before sexual intercourse increased.

Shafer et al (2002) found the following.

- Results from randomised clinical trials of a systems approach to improving screening for chlamydia among sexually active adolescents found significant increases in screening rates with an intervention that incorporated:
 - engagement of the practice's leaders
 - demonstration of the gap between best practice and current practice
 - a project champion
 - identification of the barriers to screening
 - development of solutions with the involvement of the whole practice
 - frequent monitoring of progress.

Approaches that work

There is growing evidence to support the effectiveness of particular approaches to improving sexual and reproductive health. Most of the research (and most programmes) focus on young people.

Youth-focused approach

For young people, a youth-focused approach is important. Evidence shows that young people often do not seek health care when they need it. Over 40 percent of a sample of New Zealand school students in 2001 (Adolescent Health Research Group 2003) reported barriers to getting health care for reasons that included:

- worries about privacy and lack of confidentiality
- not feeling comfortable with the person they were consulting
- not wanting to make a fuss
- cost.

Health care services for young people need to recognise these concerns and be more responsive to them.

Evidence suggests that the most effective approach to improving young people's sexual

health is multi-pronged and combines:

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

The evidence also suggests that short-term programmes are not as effective as longer-term approaches in reducing STIs and unwanted pregnancies.

Two recent studies (Di Censo et al 2002; Wight et al 2002) have found that most short-term interventions aimed at school-aged students (over and above the standard sexual health curriculum) showed little additional benefit for participants when compared with control groups receiving standard sexuality education.

This confirms other findings that efforts to improve sexual health need to take a wider, longer-term approach.





School and community-based health centres

There is sufficient evidence to conclude that school- and community-based youth health centres effectively increase young people's access to health care, particularly among young people from disadvantaged backgrounds (Matthias 2002).

Evidence for effectiveness is anecdotal. Schools where health centres have been established say there are many benefits to having comprehensive health care services on the school site, for example:

- improved access to health care for the whole school community, including increased use by boys
- fewer unwanted pregnancies
- more students practise safer sex
- the impact of health problems on learning is reduced

- the school environment becomes safer
- parents use the service to support their children's health.

Factors contributing to the success of school health clinics include:

- youth involvement in service establishment and design
- a high level of management support for the service
- professional support from local general medical practices
- community support for the service.

Although schools and families carry the major responsibility for sexuality education, Primary Health Organisations can reinforce this learning by linking their health promotion campaigns with curriculum topics and by promoting 'well teen' checks.

Since 1999, New Zealand schools have had a new curriculum document, *Health and Physical Education*, that includes a guide for teaching and learning in the area of sexuality education. The curriculum is compulsory to Year 10, but is also designed to provide the basis for programme planning in the senior secondary school (Ministry of Education 1999).

'Sexuality education is a lifelong process. It provides students with the knowledge, understanding and skills to develop positive attitudes towards sexuality, to take care of their sexual health, and to enhance their interpersonal relationships, now and in the future'

(Health and Physical Education in New Zealand Curriculum).



Sexual health ‘warrants of fitness’

Sexual health ‘warrants of fitness’ are offered by some practices. It is a way of offering chlamydia screening to younger clients who are traditionally harder to reach.

Involving young people in programme design

Many well-intentioned (and apparently well-designed) programmes targeted at young people often fail to make much difference in young people’s behaviour. This may be because young people have not been involved in planning or designing the programmes.

A recent analysis of 26 programmes designed to reduce unintended pregnancies observed

that ‘few sexual health interventions are designed with help from adolescents’ (Di Censo et al 2002).

The importance of actively involving young people in finding solutions to sexual and reproductive health issues that affect them is reinforced by studies that show that young people often have different views from health sector professionals about what is likely to work (Chambers et al 2002). According to the studies, professionals tend to medicalise the problems and emphasise service-based solutions, whereas young people think more creatively and focus on young people’s preferences and need for good information. Evidence about ‘what works’ makes it clear that combining both perspectives is most likely to lead to better sexual health.

Young people’s views on reducing STIs and unwanted pregnancies

Young people have suggested the following ways to reduce STIs and unwanted pregnancies:

- more advertisements about places teenagers can go for help
- young people-friendly health services
- drop-in services at school and in the community where young people can call in and chat about how they are
- clinics with staff who are young or on the same wavelength, and who do not judge
- confidential advice from youth workers, school counsellors, nurses and teachers
- peer supporters who are trained and can provide good information
- help to say ‘no’ to peer pressure
- more help for boys, in and out of school
- more privacy at doctors’ surgeries
- more information from general practitioners on the options
- regular columns about sex in teenage magazines
- more posters and leaflets in schools
- leaflets in toilets and messages on toilet paper
- more colourful leaflets and posters with cartoons
- posters about sex in places where teenagers go
- useful internet websites that have short addresses.

Collated from Chambers 2002; Le Lievre 1999.



Effective primary health care practices

In general practice and other primary health care settings, consistent increases in condom and contraceptive use are associated with four key elements of a clinic or health centre's practice:

- one-on-one discussions with the client about their sexual health
- readily available information about the options for managing fertility and safer sex – including delaying having sex – as well as information on contraceptive methods and condom use
- clear messages about the risks around sexual activity and the importance of using condoms or contraceptives
- direct provision of condoms or contraceptives (Kirby 2001).

Effective sexual and reproductive health services

Quality sexual and reproductive health services are likely to be:

- **accessible**, in respect of location, physical accessibility, travelling distance and opening hours
- **affordable**, so those whose need is greatest (young people; low income families) are encouraged to seek advice or treatment
- **well publicised**, so everyone who needs them knows where and when they can be accessed
- **connected**, so staff make links between, for example, contraception issues and STIs or pregnancy testing
- **welcoming** to all people of all ethnicities, all sexualities and both genders
- **responsible**, offering counselling for those who may need it
- **supportive** of community development in sexual and reproductive health
- **acceptable**, particularly in terms of confidentiality and privacy.

What works for Māori

Health services that work for Māori are likely to be based on the five principles identified by Mason Durie (1995) as being associated with successful outcomes:

- **choice**, ensuring mainstream and kaupapa Māori options are available for Māori consumers
- **relevance**, providing services that address needs and are culturally meaningful
- **integration**, ensuring health services are connected and there are links with other sectors in line with an holistic approach to health
- **quality**, providing high-quality care and evidence-based treatment linked with good outcomes
- **cost-effectiveness**, economies of scale and value for money.



Effective sexuality education programmes

Research (cited in Kirby 2001) has identified 10 characteristics of effective sexuality education programmes (see the shaded box below). Programmes that have all or most of these characteristics have been shown to increase knowledge and increase the frequency of safer sex practices.

Ten characteristics of effective sex and HIV education programmes

The most effective sex and HIV education programmes share 10 common characteristics. These programmes:

1. Focus on changing one or more sexual behaviours that lead to unintended pregnancy or HIV/STI infection (eg, delaying the initiation of intercourse; improving the use of condoms).
2. Take an intervention logic approach, identifying beliefs, behaviours, attitudes, confidence, skills that affect the target group's sexual behaviour, and focus on changing these.
3. Deliver and reinforce consistently clear messages about sexual activity and condoms or contraception use: 'Unprotected sex is an undesirable choice'. This appears to be one of the most important characteristics that distinguishes effective from ineffective programmes.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STIs.
5. Include activities that address social pressures that influence sexual behaviour (eg, discuss situations that might lead to sex; provide data that shows that many youth do not have sex; or do use condoms).
6. Demonstrate and practise communication, negotiation and refusal skills.
7. Employ teaching methods designed to involve participants and have them personalise the information (eg, role playing; brainstorming; visiting family planning clinics).
8. Incorporate behavioural goals, teaching methods and materials that are appropriate to the age, sexual experience and culture of the students.
9. Select teachers or peer leaders who believe in the programme and provide them with adequate training.
10. Last a sufficient length of time. (Fourteen hours' instruction time is considered to be the minimum.) Generally, short-term programmes do not have a measurable effect on the behaviour of teens.



Things to consider in planning services

A multi-pronged approach

International evidence makes it clear that action to improve sexual and reproductive health needs to be taken on several fronts at once. Focusing solely on the presenting problem is unlikely to have a lasting effect.

A multi-pronged approach

Countries that have comparatively good sexual health outcomes – particularly for young people – tend to have several common characteristics:

- they are 'inclusive societies' – as judged by income equality and the proportion of older teenagers in education and training
- there is open, honest discussion about sex and sexuality at all levels of society
- most have consistent, long-term public education campaigns focusing on safety and pleasure, where the media is a partner, not part of the problem
- there is respect for young people, who are valued, rather than seen as problems
- they have a research-based approach to policy and programme development
- there is access to free or low-cost contraception
- they carefully work through the issues arising from cultural diversity and differing values (Hubermann 2001).

Reducing inequalities

The Government is committed to reducing health inequalities that exist between different population groups. DHBs are required by law to tackle health inequalities. The disparities in sexual and reproductive health that exist between Māori and non-Māori are indicators of the wider disparities that exist between Māori and non-Māori in overall health status and on many other measures of social and economic wellbeing. Māori experience comparatively high rates of unemployment, education system failure and poverty. They also have unequal access to health services. Taking steps to reduce inequalities in all of these areas is part of the Government's commitment to Māori and is a necessary part of the wider actions necessary to improve Māori sexual health.



Socioeconomic influences

UNICEF has linked two indicators of an inclusive society (income equality and percentage of 15–19-year-olds in education) with teenage birth rates (UNICEF 2001). New Zealand, the United Kingdom and the United States are at the bottom of the UNICEF league table, with the greatest income inequality, the lowest percentage of 15–19-year-olds in education, and the highest teenage birth rates.

‘Motivation’ is as important as ‘means’

UNICEF identifies both ‘motive’ and ‘means’ as influences on teenage birth rates. The *means* to avoid early pregnancy comes from being well prepared and well equipped to cope in a highly sexualised society; the *motivation* to avoid early pregnancy comes from a sense of self-worth, a sense of connectedness, and having life options that are more attractive than early parenthood. Both motivation and means are influenced by social and economic factors.

Influence of societal attitudes and values

Community attitudes, social and cultural values, social support and media representations can have a significant positive or negative effect on individuals’ sexual behaviour. Some cultures are reticent about discussing personal and intimate matters. In many communities there is still prejudice and ignorance in relation to gay or lesbian people. People at risk from or living with HIV and AIDS can suffer discrimination or stigmatisation. And in today’s highly sexualised society, many young people may feel they are getting mixed messages about sex from the media, the community, and their families. Finding ways to help communities and families understand and talk about sex and sexuality is a priority in this action plan.

Individual commitment

Good sexual health requires a commitment by each individual to practise safer sex. The connection between having sex and becoming pregnant (or catching a sexually transmitted infection) needs to be understood. Individuals need to appreciate that condoms and contraceptives must be used every time they have sex. Individuals may need to learn the negotiating skills to give them sufficient confidence to be safe in their sexual relationships.

Responsive programmes and services

Ready access to sexual health services across the country is important. ‘User friendliness’ of the services is also important. Bearing in mind that many people are uncomfortable discussing sexual health issues, and that young people especially need privacy and confidentiality, primary health care practices need to provide regular training for staff, and check that their practices are sensitive to their clients’ needs.

Good data and research

Good data and research make for effective policy and well-designed services.



Risk and protective factors influencing teenage sexual behaviour

(+ signifies a protective factor; – signifies a risk factor)

(From Kirby 2001)

Community

Community advantage and organisation

- + High level of education
- High unemployment rate
- + High income level
- High crime rate

Family

Structure and economic advantage of teens' family

- + Two (vs one) parents
- Changes in parental marital status
- + High level of parents' education
- + High parental income

Positive family dynamics

- + Parental support and family connectedness
- + Sufficient parental supervision and monitoring

Family attitudes about and modelling of sexual risk-taking and early childbearing

- Mother's early age at first sex and first birth
- Single mother's dating and cohabitation
- + Conservative parental attitudes about premarital sex or teen sex
- + Positive parental attitudes about contraception
- Older siblings' early sexual behaviour

Peers

Peer attitude and behaviour

- + High grades among friends
- Peers' substance use and delinquent behaviour
- Sexually active peers (or perception thereof)
- + Positive peer norms or support for condom or contraceptive use

Partner

Partner attitudes and behaviour

- + Partner support for contraception

Teen

Biological antecedents

- Older age and greater physical maturity
- Higher hormone levels

Attachment to and success in school

- + Good school performance
- + Educational aspirations and plans for the future

Attachment to religious institutions

- + Frequent religious attendance

Problem or risk-taking behaviours

- Alcohol or drug use
- Problem behaviour or delinquency
- Other risk behaviours

Emotional distress

- Higher level of stress
- Depression
- Suicide ideation

Characteristics of relationship with partners

- Early and frequent dating
- Going steady, having a close relationship
- Having a partner three or more years older

Sexual abuse

- History of prior sexual coercion or abuse

Sexual beliefs, attitudes, and skills

- + Conservative attitudes to premarital sex
- + Greater perceived susceptibility to pregnancy; STIs/HIV
- + Importance of avoiding pregnancy, childbearing and STIs
- + Greater knowledge about contraception
- + More positive attitudes about contraception
- + Greater perceived self efficacy in using condoms or contraception



Community-wide action

Goal

Communities where people are comfortable with their sexuality and enjoy good sexual and reproductive health, and where there is understanding and acceptance of differences in sexual expression.

Suggested strategies

- Develop a good understanding of each key population's sexual and reproductive health issues, and the factors influencing attitudes and behaviour.
- Actively involve the key populations in devising solutions to sexual and reproductive health problems.
- Be aware of the wider economic, social and cultural influences on sexual and reproductive health and integrate health initiatives with other community development initiatives whenever possible.
- Piggy-back onto international, national and local campaigns to raise public awareness of sexual health issues.
- Engage with the sexual health promoters working in the DHB public health units; they are experienced in sexual health promotion *and* working with youth.

- Work with community leaders to tackle the stigma and discrimination often directed to people because of their sexual orientation or HIV/AIDS status.

Ways to progress these strategies

Develop a good understanding of each key population's sexual and reproductive health issues, and the factors influencing attitudes and behaviour.

When the data has been gathered on the relative sexual health status of the region's populations, tap into the local knowledge of people who are working in the area of sexual and reproductive health to identify where the focus of attention should be.





Actively involve the key populations in devising solutions to sexual and reproductive health problems.

In most regions, there will be groups and individuals who are already working in the area of sexual and reproductive health. Tap into the expertise that already exists. Engage with the sexual health promoters working in the DHB public health units. Māori sexual health promoters are active in several regions and can provide links into the Māori community. There are also Pacific public health nurses in several regions, and their experience should be drawn on to find ways to work effectively with Pacific communities.

The Ministry of Youth Affairs has produced a resource book, *Keepin' it Real*, to help and encourage organisations to involve young people in service planning and development (Ministry of Youth Affairs 2003). Along with this, organisations can draw on the experience of people in the community who are already working successfully with young people. Talking with young people about the forms of participation that work for them is a useful first step.

Be aware of the wider economic, social and cultural influences on sexual and reproductive health and integrate health initiatives with other community development initiatives whenever possible.

Many of the factors contributing to poor sexual health lie outside the health sector's reach. However, health professionals are often in a position to influence community development and community responses.

Teen pregnancy, for example, is strongly associated with detachment from school, lack of training or work opportunities, and the absence of meaningful prospects for the future. Some of the most successful strategies for reducing teen pregnancy have taken a youth and community development approach. One such approach involves young people in voluntary community work, coupled with structured time for preparation, discussion and feedback. Programmes like this encourage and build on young people's strengths rather than focusing on the negative aspects of their behaviour.

Take the opportunities wherever they present in the community to encourage a more collaborative policy approach to improving young people's wellbeing.

Find ways to connect different social service initiatives, for example, by linking:

- the initiatives for reducing family violence and partner abuse with initiatives for reducing unwanted pregnancies
- sexual and reproductive health outreach services with other initiatives aimed at supporting the most at risk families, for example, Family Start.

The Ministry of Health's *Reducing Inequalities Framework* provides a useful guide to determining where effective interventions can be made. The newly developed Health Equity Assessment Tool ('HEAT') provides a checklist to assist service funders considering whether proposed programmes and services are likely to reduce or increase health inequalities.



Piggy-back onto national campaigns to raise public awareness of sexual health issues.

International events like World AIDS Day and national campaigns like Condom Week or National Penis Day can provide ‘hooks’ for local events.

Over the next year the Ministry of Health will be developing a public health campaign to raise awareness of sexual health issues. At a regional level, there will be opportunities to develop local initiatives that can be linked to the broader national messages.

Part of the national campaign will focus on ‘starting conversations’ – helping families broach topics that can often be difficult to raise. Workshops for parents on sexual and reproductive health issues could be timed to coincide with the nationwide campaign.

Raising awareness is likely to create an increased demand for advice on and treatment for sexual health matters. Primary health care practices should consider additional training and professional education for both administrative and clinical staff. Research suggests many people are self-conscious and often hesitant about seeking advice and help in sexual health matters, and health care professionals may be equally uncomfortable.



Work with community leaders to tackle the stigma and discrimination often directed at people because of their sexual orientation or HIV/AIDS status.

There is still a considerable amount of ignorance around HIV and AIDS, and this can lead to fear and rejection of individuals who are or are assumed to be infected.

Encourage sexual health promoters to work with community leaders – particularly in migrant and refugee communities – so that key people are in a position to share accurate information about how to avoid HIV transmission, and how to support any community members who may have already contracted AIDS.

Work alongside those living with HIV/AIDS and other affected populations to identify areas where they face discrimination.

Ensure health promotional material – particularly that directed at young people, Māori and Pacific peoples – includes information on the need to reduce stigma and discrimination surrounding HIV/AIDS.

Young people whose sexual orientation is different from that of their peers are often subjected to bullying. Health care workers (and school staff) need to be alert to early warning signs of this occurring among the young people in their practice or their schools.



Personal knowledge and skills

Goal

Individuals with the knowledge, skills and confidence to enjoy their sexuality, to choose when or if to have children, and to keep themselves safe from harm.

Suggested strategies

- Make sure people in your region know how to access sexual health and family planning advice and services.
- Promote the full range of options available to prevent pregnancy and STIs.
- Encourage young people to incorporate sexual health check-ups as a part of their general health checks.
- Encourage the tracing of contacts of people diagnosed with STIs.
- Ensure there is support in contraceptive planning and other sexual health issues for people with disabilities.

Ways to progress these strategies

Make sure people in your region know how to access sexual health and family planning advice and services.

Many young people say they do not know where to go to get sexual health advice. They have suggested it would be helpful to have local directories listing the services available in each community. This information could also be made available through websites and other media targeted at young people.

There is also a wider audience for this information which could be put into leaflets, local telephone directories, buses, taxis, doctors' waiting rooms and toilets in bars and

clubs. It may be useful to collaborate with the IPAs and the Family Planning Association who have begun to take similar initiatives. Having the information available in a range of Pacific and Asian languages is also important.

Local media may be willing to promote sexual and reproductive health care messages as a part of their community service broadcasting.



Promote the full range of options available to prevent pregnancy and STIs.

Research suggests many people do not have enough information about the range of prevention and protection options available to them at different stages of their reproductive life. Having posters and leaflets that provide information about the range of products currently available is one way of raising awareness. Providing opportunities for general practitioners to update their knowledge is another.

It is important to find the most effective ways of providing this information to the various target groups. It is likely to vary among the groups.

Programmes for parents, updating them on current options, may be useful in helping parents support their teenagers to make safer sex choices.

Encourage young people to incorporate sexual health checkups as a part of their general health checks.

Normalising sexual and reproductive health check-ups, and encouraging young people to have regular check-ups as an integral part of a healthy lifestyle tie in with messages they will be getting through the school health and physical education curriculum. Using youth role models and promoting similar messages through local media are ways of 'keeping it real'.

To reduce the transmission of asymptomatic infections like chlamydia, opportunistic testing

for chlamydia is recommended for:

- sexually active people under the age of 25
- women presenting for pregnancy testing
- women attending antenatal clinics
- women seeking termination of pregnancy.

The development of a urine-based test means that testing is non-invasive and hence more user friendly.

Target young men with messages about chlamydia that make it clear how easy it is to test and treat.

Encourage the tracing of contacts of people diagnosed with STIs.

Take active steps to limit the transmission of STIs by encouraging people who have positive diagnoses to tell their partners about the risk of infection and the need for testing.

Practices should offer to do the follow-up if the patient is reluctant to do this. The *Australasian Contact Tracing Manual* (Sydney Sexual Health Centre 2002) is a very useful guide to dealing with different situations where the need for contact tracing may arise. (Copies are available from the Ministry of Health.)

Consider using public health nurses to do contact tracing. They have the skills appropriate to this sensitive task.



Ensure that there is support in contraception planning and sex- and sexuality-related matters for people with disabilities.

People with disabilities often need support to enable them to make choices about their relationships, sexuality and reproductive potential.

There are nurses, educators and health promoters who are specially trained to advise

young people with disabilities on sexual health issues. Draw on their expertise to train more health professionals in supporting people with disabilities and in helping parents and caregivers to provide advice and support on sexuality issues.

Programmes and services

Goal

Accessible, effective programmes and services working together regionally and nationally to reduce the incidence of HIV, AIDS, STIs and unintended/unwanted pregnancies, particularly among the most vulnerable populations.

Suggested strategies

- Agree on indicators for sexual and reproductive health in the region or practice.
- Look at a range of ways to improve access to sexual and reproductive health advice and care for the most vulnerable populations.
- Make existing services more user-friendly.
- Encourage the development of sexual and reproductive health service provision by Māori for Māori.
- Encourage professional development and further education among the sexual and reproductive health workforce.



Ways to progress these strategies

Agree on indicators for sexual and reproductive health in the region or practice.

Establish baseline data on the incidence of abortions and STIs in your area. Designate a 'champion' for sexual health – someone who has the interest (and capacity) to inspire action.⁴

Work out what is feasible to achieve in the area and focus on this. Organise any training and/or information sharing that may be necessary to achieve the objective.

Look at a range of ways to improve access to sexual and reproductive health advice and care for the most vulnerable populations.

Map the current provision of sexual health services in the area and identify any gaps. Check the service coverage for key populations, for example young people (particularly those not in school or tertiary training); Māori, Pacific peoples and migrant and low-income groups. Are there barriers to access such as distance or lack of transport?

Would it make sense to set up mobile clinics to reach those who have difficulty getting access

to sexual health services? For example:

- people in rural areas
- people in factories and other workplaces
- young people in alternative education
- young people in custodial care.

Could better coverage be achieved by making more frequent and more effective use of nurses to deliver sexual and reproductive health advice and screening?

Bearing in mind that some people – young people in particular – are often reluctant to consult their family doctor about sexual health matters. Ensure, wherever feasible, that advice on sexual and reproductive health can be accessed through other avenues, such as school health centres, the Family Planning Association, specialist sexual health services, youth 'one-stop shops' or Māori and Pacific health services.

Having clear pathways of care for sexual and reproductive health is important.

Each region should look at developing guidelines to make sure health care professionals work together to establish effective local protocols for testing, managing and following up STI/HIV-positive cases that are identified through screening.

⁴Significant increases in screening for chlamydia in adolescents is achievable with a multifaceted systems level approach that is championed by a practice leader (Shafer et al 2002.)



Make existing services more 'user-friendly'.

The most effective way to make services more user-friendly is to involve consumers in the service design.

Understanding and being sensitive to cultural differences should be a starting point in developing 'user-friendly' practices. Invite representatives of the ethnic and cultural groups represented in the region or practice to talk to staff about the best ways of approaching sexual health issues.

Many practices have developed strategies for making clients feel comfortable and overcoming the embarrassment factor that often accompanies consultation on sexual health issues.

For young people, privacy and confidentiality are major concerns. Empathy of the health professional is important, too. Tips for making the practice more youth friendly can be found in the shaded box (on page 25).

Holding school-based clinics is an effective way of reaching adolescents. (Consultation with the school and the school community is an important first step, though.⁵)

Encourage the development of sexual health service provision by Māori for Māori.

Māori are entitled to the same quality of service provision that is available to the rest of the population. Increase the capacity of 'by Māori for Māori' sexual and reproductive health services so that Māori can access sexual and reproductive health services from local Māori service providers. It is important that 'by Māori for Māori' provider groups have the same opportunities for training and upskilling as other health professionals.

It may be appropriate to develop incentives to attract Māori with the necessary skills into the area of sexual and reproductive health.

⁵Refer to the Ministry of Health's *Guide to Setting up School-based Health Services* (2003).



General practices can take some simple steps to check the youth-friendliness of their services . . .

- **Organise a whole team practice meeting to look at ways to improve the ‘teen friendliness’ of the practice.** Everyone needs to be on board – GPs, practice nurses and receptionists. When young people are asked what is important to them, confidentiality and friendliness rate highest.
- **Involve your teen patients** in suggesting ways the practice could become more user-friendly.
- **Identify the characteristics of the 10–18-year-olds in your practice.** What percentage has been seen in the past year? What for? Are they representative of the practice’s community?
- **Train appropriate practice members in contraception,** including emergency contraception. GPs, nurses and receptionists all need to be trained in their interaction with teenagers coming in for contraception or other sexual health advice. Be sensitive to their embarrassment; they will not give you a second chance to get it right.
- **Inform young people about what the practice provides.** Have posters showing the services provided. Develop a special Practice Information booklet for teenagers.
- **Make confidentiality a priority practice issue.** Make sure every member of the practice is signed up to a confidentiality code of practice. Reassure young people about confidentiality during face-to-face consultations.
- **Offer advice and support for teenagers who get pregnant.** Make sure they are given non-judgemental support and help in deciding whether to continue with the pregnancy or have a termination.
- **Make sure practice advice is directed to young men** as well as young women. Let young men know they are welcome too. Aim to include free condoms and advice about emergency contraception and STIs. Have posters in the waiting room aimed directly at young men.

Adapted from McPherson et al (2002).



Encourage professional development and further education among the sexual health workforce.

Many health professionals say they would benefit from more professional development in the area of sexual and reproductive health. Interactive small group seminars are an effective way of raising awareness of HIV and other STIs. These could be organised on a regional basis. (Māori providers might need support to release their staff for these seminars.)

Try to arrange regular product-oriented seminars to enable GPs and pharmacists to keep up with the range of products available for preventing pregnancy and for treating STIs.

Information and data collection

Goal

A sufficient information and evidence base to enhance policy, clinical, service and personal decision making in the area of sexual and reproductive health.

Suggested strategies

- Ensure data collection is sufficient to provide a clear picture of changes to and inequalities in sexual and reproductive health.
- Provide regular updates to the community on service availability and service quality.



Ways to progress these strategies

Ensure data collection is sufficient to provide a clear picture of changes to and inequalities in sexual and reproductive health.

Identify areas where current data is inadequate for assessing disparities between Māori and non Māori and take the necessary steps to improve data collection and quality. It is important that accurate ethnicity data is collected. The Ministry of Health is developing *Ethnicity Data Protocols* to assist in the improvement in quality of ethnicity data.

Monitor the data for Pacific and Asian peoples in your region/practice.

PHOs could consider the practicalities of collecting data that is comparable with that which DHBs' and Family Planning sexual health clinics collect, and combining this with ESR data to obtain a more complete picture for their region.

Provide regular updates to the community on service availability and service quality.

Compile a map and database of sexual and reproductive health and family planning services by region. Link in with sexual health promoters working in the DHB public health units.

Whenever feasible, build in programme and service evaluations.

Conduct or commission effectiveness audits of selected reproductive health services.

Survey Māori uptake of sexual and reproductive health services.

Assess consumer satisfaction with services.



INTRODUCTION

With a Māori population that is relatively young and growing in number greater emphasis needs to be placed on ensuring the health of rangatahi Māori – for the health of the whānau and for the health of future generations of Māori.

Sexually transmitted infections and unwanted pregnancies have long-term consequences. Chlamydia, for example, can cause infertility if it is not treated. Because chlamydia does not have obvious symptoms, young men and young women can unwittingly carry and spread this infection. Unwanted pregnancies put families under stress, and very often limit the future opportunities of both mother and child.

Currently, rangatahi Māori experience disproportionately high rates of sexual and reproductive ill health:

- Māori women experience higher rates of sickness and death from cervical cancer than non-Māori women (Ministry of Health 2002).
- Rates of chlamydia and gonorrhoea are highest among young people and Māori (ESR 2003).
- Teenage pregnancy is significantly higher among Māori than non-Māori (UNICEF 2001).
- A study of 654 14-year-olds in Hawke's Bay found Māori were nearly three times more likely than non-Māori to be sexually active (Fenwicke and Purdie 2000).
- In 2001 Māori women had higher rates of abortion than the national average.

The Government is committed to reducing health inequalities. It has a particular responsibility to Māori – as Treaty of Waitangi partners and as citizens. This means tackling the wider issues that impact on health. It means actively promoting whānau wellbeing through quality education, suitable housing and employment opportunities. It means putting into practice the Treaty principles of partnership, participation and protection.





At DHB level, this means:

- working in partnership with iwi, hapū, whānau and Māori communities to develop strategies to improve Māori sexual and reproductive health
- involving Māori at all levels of the sector, in decision-making, developing and delivering health and disability services
- working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices
- assisting the development of Māori provider capacity, capability and quality
- improving access to and responsiveness of services for Māori.

In the next section a range of ways are suggested in which DHBs, primary health care providers, health professionals and whānau can contribute to improving Māori sexual and reproductive health.

Community-wide action

Goal

A community where people are comfortable with their sexuality and enjoy good sexual and reproductive health, and where there is understanding and acceptance of differences in sexual expression.

Suggested strategies

- Develop a good understanding of Māori sexual and reproductive health issues, and the factors influencing attitudes and behaviour.
- Actively involve Māori in devising solutions to sexual and reproductive health problems.
- Be aware of the wider economic, social and cultural influences on Māori sexual and reproductive health and integrate health initiatives with other community development initiatives whenever possible.
- Piggy-back onto national campaigns to raise Māori awareness of sexual and reproductive health issues.
- Work with Māori community leaders to tackle the stigma and discrimination often directed at people because of their sexual orientation or HIV/AIDS status.



Ways to progress these strategies

Develop a good understanding of Māori sexual and reproductive health issues, and the factors influencing attitudes and behaviour.

Use existing data to draw a clear picture of Māori sexual health status in the region. Bring together Māori who are working in the area of sexual and reproductive health to help identify where the focus of attention should be.

Actively involve Māori in devising solutions to sexual and reproductive health problems.

Tap into the expertise that already exists. For example, 'by Māori, for Māori' providers working in sexual and reproductive health, and Māori sexual health promoters who are working in many regions can provide links into the Māori community.

Actively involve young Māori. The Ministry of Youth Affairs' resource book, *Keepin' it Real*, suggests different ways to involve young people in programme and service development. Draw on the experience of people in the community who are already working successfully with young Māori. Talking with young people about the forms of participation that work for them is a useful first step.

Be aware of the wider economic, social and cultural influences on Māori sexual and reproductive health and integrate health initiatives with other community development initiatives whenever possible.

Consider forming a Māori-led intersectoral working group to link health-oriented initiatives with other social service initiatives. There may be opportunities, for example, to link:

- the initiatives for reducing family violence and partner abuse with initiatives for reducing unwanted pregnancies
- sexual and reproductive health outreach services with other initiatives aimed at supporting the most disadvantaged families, for example, Family Start.

The Ministry of Health's *Reducing Inequalities Framework* provides a useful guide to determining where effective interventions can be made.

The Health and Equity Assessment Tool provides a checklist to assist service funders considering whether proposed programmes and services are likely to reduce or increase inequalities in health between Māori and non-Māori.



Piggy-back onto national campaigns to raise Māori awareness of sexual and reproductive health issues.

During 2003/2004 the Ministry of Health will be developing a national public health campaign to raise awareness of sexual and reproductive health issues. At a regional level, there will be opportunities to develop local initiatives that can be linked to the broader messages.

It is important Māori are involved in devising advertising and health promotional material that is targeted to Māori. It is also important to remember there are a diversity of Māori communities. Promotional campaigns that work for young urban Māori may miss the mark entirely for a more conservative rural community.



Provide Māori with the opportunities to develop their own health promotional resources.

Work with Māori community leaders to tackle the stigma and discrimination often directed at people because of their sexual orientation or HIV/AIDS status.

There is still a considerable amount of ignorance around HIV and AIDS, and this can lead to fear and rejection of individuals who are or are assumed to be infected.

Encourage sexual health promoters to work with community leaders, so key people are in a position to share accurate information about how to avoid HIV transmission, and how to support any community members who may have already contracted AIDS.

Work alongside those living with HIV/AIDS and other affected populations to identify areas where they face discrimination.

Ensure health promotional material – particularly that directed at young people – includes information on the need to reduce stigma and discrimination surrounding HIV/AIDS.

Young people whose sexual orientation is different from that of their peers are often subjected to bullying. Health care workers (and school staff) need to be alert to early warning signs of this occurring among the young people in their practice or their schools.



Personal knowledge and skills

Goal

Māori with the knowledge, skills and confidence to enable them to choose their sexual and reproductive pathways, and to maintain good sexual and reproductive health throughout their lives.

Suggested strategies

- Make sure Māori in the region know how to access sexual health advice and services.
- Promote the full range of options available to prevent pregnancy and STIs.
- Encourage rangatahi to incorporate sexual health check-ups as a part of their general health checks.
- Encourage the tracing of contacts of Māori diagnosed with STIs.
- Ensure there is support in sex- and sexuality-related matters for Māori with disabilities.

Ways to progress these strategies

Make sure Māori in the region know how to access sexual health advice and services.

Ensure regional directories of sexual and reproductive health services identify 'by Māori for Māori' services.

Print posters and leaflets in te reo Māori. Get advice on the best places to put such information. Work with Māori radio and television and other Māori media to promote sexual and reproductive health care messages.

Promote the full range of options available to prevent pregnancy and STIs.

Find out what Māori want and need to know more about. Take advice on the most effective means of providing this information.

Programmes for parents, updating them on current options, may be useful in helping parents support their teenagers to make safer sex choices. Contact local 'by Māori for Māori' sexual and reproductive health providers to enquire about school and community-based sexuality education programmes for rangatahi Māori and sexuality education programmes for Māori parents and caregivers.



Encourage rangatahi to incorporate sexual health checkups as a part of their general health checks.

Normalising sexual and reproductive health checkups, and encouraging rangatahi to have regular check-ups as an integral part of a healthy lifestyle tie in with messages they will be getting through the school health and physical education curriculum. Using Māori role models and promoting similar messages through local media are ways of 'keeping it real'.

To reduce the transmission of asymptomatic infections like chlamydia, opportunistic testing for chlamydia is recommended for:

- sexually active people under the age of 25
- women presenting for pregnancy testing
- women attending antenatal clinics
- women seeking termination of pregnancy.

Encourage the tracing of contacts of Māori diagnosed with STIs.

Take active steps to limit the transmission of STIs by encouraging people who have positive diagnoses to tell their partners about the risk of infection and the need for testing.

Practices should offer to do the follow-up if the patient is reluctant to do this. The *Australasian Contact Tracing Manual* developed by the Sydney Sexual Health Centre (2002) is a very useful guide to dealing with different situations where the need for contact tracing may arise. (Copies are available from the Ministry of Health.)

Consider using public health nurses to do contact tracing. They have the skills appropriate to this sensitive task.

Ensure there is support in contraception planning and sex- and sexuality-related matters for Māori with disabilities.

People with disabilities often need support to enable them to make choices about their relationships, sexuality and reproductive potential.

There are nurses, educators and health promoters who are specially trained to advise young people with disabilities on sexual health issues. Draw on their expertise to train more health professionals in supporting people with disabilities and in helping parents and caregivers to provide advice and support on sexuality issues.



Programmes and services

Goal

Accessible, effective programmes and services working together regionally and nationally to reduce the incidence of HIV/AIDS/STIs and unintended/unwanted pregnancies among Māori.

Suggested strategies

- Agree on indicators for sexual and reproductive health for Māori in your region or practice.
- Look at a range of ways to improve access to sexual and reproductive health advice and care for Māori.
- Make existing services more user-friendly for Māori.
- Encourage the development of sexual health service provision by Māori for Māori.

Ways to progress these strategies

Agree on indicators for sexual and reproductive health for Māori in your area.



Establish baseline data on the rates of abortion and STIs among Māori in your area.

Work out what is feasible to achieve, and focus on this. Organise any training and/or information sharing necessary to achieve the objective.



Look at a range of ways to improve access to sexual and reproductive health advice and care for Māori.

Check the service coverage for Māori. Are there barriers to access such as distance or lack of transport?

Would it make sense to set up mobile clinics to reach those who have difficulty getting access to sexual health services? For example, Māori in:

- rural areas
- factories and other workplaces
- alternative education
- care and in prisons.

Could better coverage be achieved by making more frequent and more effective use of marae-based health services and other 'by Māori for Māori' providers to deliver sexual health advice and screening?

Bearing in mind that some people, young people in particular, are often reluctant to consult their family doctor about sexual health matters, ensure – wherever feasible – that advice on sexual and reproductive health can be accessed through other avenues, such as 'by Māori for Māori' services, school health centres, the Family Planning Association, specialist sexual health services or youth 'one-stop shops'.

Make existing services more user-friendly for Māori.

The most effective way to make services more user-friendly for Māori is to involve Māori in the planning, development and delivery of sexual and reproductive health services.

The importance of understanding and being sensitive to cultural differences should not be underestimated. A Māori advisory committee will be able to suggest someone who can work with primary health care practices to find the best ways of approaching sexual health issues with Māori clients.

Encourage the development of quality sexual and reproductive health service provision by Māori for Māori.

Māori are entitled to the same quality of service provision that is available to the rest of the population. Increasing the capacity of 'by Māori for Māori' sexual and reproductive health services will enable Māori to access sexual and reproductive health services from local Māori service providers. It is important that by Māori for Māori provider groups have the same opportunities for training and upskilling as other health professionals.

Develop incentives to attract Māori with the necessary skills into the area of sexual and reproductive health.



Information and data collection

Goal

Sufficient information and evidence to improve Māori sexual and reproductive health and reduce inequalities between Māori and non-Māori.

Suggested strategies

- Ensure data collection is sufficient to provide a clear picture of changes to Māori sexual and reproductive health and inequalities between Māori and non-Māori.
- Provide regular updates to Māori on service availability and service quality.

Ways to progress these strategies

Ensure data collection is sufficient to provide a clear picture of changes to Māori sexual and reproductive health and inequalities between Māori and non-Māori.

Identify areas where current data is inadequate for assessing disparities between Māori and non-Māori and take the necessary steps to improve data collection and quality. It is important that accurate ethnicity data is collected. The Ministry of Health is developing Ethnicity Data Protocols to assist in the improvement in quality of ethnicity data.

Provide regular updates to Māori on service availability and service quality.

Whenever feasible, build in programme and service evaluations.

Conduct or commission effectiveness audits of selected reproductive health services for Māori.

Survey Māori uptake of sexual and reproductive health services.

Assess Māori consumer satisfaction with services.

Strategies for Pacific Peoples

INTRODUCTION

Pacific peoples are amongst the most dynamic part of a slow-growing, rapidly ageing New Zealand population. Fertility, immigration, and intermarriage are the three engines of growth of this community.

The current median age of the Pacific community is just 20 years, well under the 32 years of the population in total.

Despite the tendency to consider the Pacific population as one entity, Pacific peoples are a diverse group. There are seven main Pacific communities represented in New Zealand: Tuvalu, Tonga, Niue, Tokelau, Cook Islands, Fiji and Samoa.

The youthfulness of the Pacific population reinforces the importance of focusing on Pacific sexual and reproductive health. Currently Pacific young people have relatively high rates of sexually transmitted infections and Pacific women have a higher ratio of abortion to live births than European women (although lower than Asian women and Māori).

The Pacific Health and Disability Action Plan (2002) has already identified sexual and reproductive health as one of the areas for specific focus for Pacific youth.

For more information on that plan and Pacific health issues, visit the Ministry of Health's Pacific website: www.moh.govt.nz/pacific

Sexual and reproductive health issues for Pacific peoples

As with most migrant groups, Pacific people face having to reconcile the often conflicting attitudes and values of their traditional culture with those of their adopted culture. In the area of sexual health, this is compounded by a reticence that many people share when discussing matters relating to sex.





Traditional values

A newly reported study⁶ of contraceptive practices among 1,300 Pacific mothers (average age 27) who had babies in 2000 found that 60 percent had had unplanned pregnancies. Among the women whose pregnancies were unplanned, non-use of contraception was significantly more likely to be associated with those who:

- had a strong alignment with Pacific way of life and customs
- had no post-school qualifications.

Generation gap

Many Pacific young people report having difficulty talking to their parents about sexuality:⁷

'In our culture, it's rude to talk to parents about these things. You want to open up, but you can't.'

'Parents are strict and don't talk about these things. It makes you think that there's something wrong with sex because you're not getting any good advice from your parents'

Cross cultural relationships

In addition to the generation gap, different stresses are often brought to bear as a result of cross-cultural relationships. While these create new family links, they may also generate tensions by bringing new expectations and patterns of behaviour into Pacific family structures.

⁶ Paterson J 2003 (personal communication)

⁷University of Auckland. 1999. Evaluation of the Pacific Island Sexual Health Project: Family Life Education Pasifika

Socioeconomic pressures

The reality is that for many Pacific families, dealing with contraception issues is often a low in priority when faced with the demands of surviving on low incomes, working long hours, supporting extended families, and maintaining obligations in relation to church and faith.

What DHBs and PHOs can do

In the seven DHBs that have relatively high numbers of Pacific peoples – Auckland, Waitemata, Counties Manukau, Waikato, Hutt, Capital and Coast, and Canterbury – there are already a number of programmes and services with a focus on Pacific young people and Pacific adults. Identifying and building on existing successful initiatives will be a natural starting point.

One of the most successful existing programmes is Family Life Education Pasifika (FLEP) which works among Pacific peoples in the Auckland region. An evaluation of its programme in 1999 highlighted some important elements of a successful programme:

- Building networks and developing linkages with existing providers.
- Ensuring community ownership of the issue and community involvement in the development of activities.
- Establishing safe environments – eg, small, culturally and gender-specific discussion groups where people feel they can safely talk about the issues.
- Dealing with wider issues – religious influences, financial pressures, gender roles – before focusing specifically on contraception.
- Being sensitive to, and reflecting the perspectives of, all Pacific cultures.



Points for DHBs and PHOs to note

Pacific communities can be defined in a number of ways

There is no generic 'Pacific community' but rather Pacific peoples who align themselves variously, and at different times, along ethnic, geographic, church, family, school, age/gender-based, youth/elders, island-born/New Zealand born, occupational lines, or a combination of these. It is important that these various contexts of 'Pacific communities' are clearly recognised and defined in any process involving consultation, training, programme development and service delivery.

There is a diversity of views among the different ethnic groups

It needs to be recognised that while Pacific groups have many similar beliefs and attitudes towards sexuality and reproduction, there are also differences between groups. To understand the diversity of views and concepts that underpin values and beliefs, engagement needs to occur in the language that the ethnic group is most fluent in, and in which they are best able to express their cultural world views and their perceptions.

There are protocols and etiquette to be observed

In most families across the six major ethnic specific communities, there are protocols and etiquette, which define appropriate behaviour and discussion between people – particularly on issues such as sex, sexuality and reproduction. While there are exceptions, a simple approach to arranging groups for

discussion is by gender and age. Depending on the group's level of adherence to or relaxing of their protocols and etiquette, other relational arrangements that may be viewed to be inappropriate to have within the same group may be required to be taken into account. These may include:

- older and younger siblings, cousins, relatives
- mothers and, for example, daughters and nieces; fathers, and for example, sons and nephews
- church leaders and non-church leaders
- various levels of traditional leaders and non traditional leaders.

There is a special sister–brother relationship, with its own protocols

Within Pacific families, the relationship that holds significant value is that between a brother and his sister. The protocols and etiquette that define behaviour and language within this relationship vary between the ethnic-specific groups. The role of the sister as being central to the brother–sister relationship is a consistent value across the seven major Pacific population groups. Discussions on sexuality and reproduction in the presence of both brother and sister, male and female relatives, is highly inappropriate and will often cause offence.

The codes of behaviour, which govern the brother–sister relationship as a general rule extends into relationships between males and females.



There needs to be a reinforcing environment if new learning is to be practised

The development and implementation of programmes for Pacific youth needs to bear in mind that the message is reinforced if the immediate environment of young people supports and reflects back to them positive behaviour and attitudes.

Many young Pacific people face identity issues

It is often assumed that the values, beliefs, and experiences of island-born young people will differ from their New Zealand-born peers. That is not always the case. There are island-born youth who are more relaxed in their values and beliefs. And some of their New Zealand-born

counterparts may uphold traditional values and beliefs.

The question of identity for young Pacific people is a significant one. This is more so now with third- and fourth-generation New Zealand-born Pacific youth. The challenge for the wider community is to understand and support their preferences for how they relate to their communities and society.

More research is needed to profile the Pacific youth population and to identify and explore existing and future issues.

In the next section, a range of ways are drawn together in which DHBs, primary health care providers, health professionals and health promoters can contribute to improving sexual and reproductive health among the Pacific population.

Community-wide action

Goal

A community where people are comfortable with their sexuality, enjoy good sexual and reproductive health, and where there is understanding and acceptance of differences in sexual expression.

Suggested strategies

- Develop a good understanding of what the ethnic-specific sexual and reproductive health issues are for the Pacific peoples in your area and the factors that influence their attitudes and behaviour.
- Actively involve Pacific peoples and Pacific youth in devising solutions to sexual and reproductive health issues.
- Use opportunities to participate in national campaigns to raise and promote awareness of sexual health issues for Pacific peoples and Pacific youth.



Ways to progress these strategies

Develop a good understanding of what the ethnic-specific sexual and reproductive health issues are for the Pacific peoples in your area and the factors that influence their attitudes and behaviour.

In conjunction with Pacific youth, and Pacific and non-Pacific researchers, identify:

- local and regional information on the sexual and reproductive health status for Pacific youth – STIs; HIV/AIDS; unplanned pregnancies; abortions
- the perceived religious, social and cultural issues for Pacific females
- the perceived religious, social and cultural issues for Pacific males
- what research and studies have been undertaken in your region on the status and needs of Pacific youth.

Actively involve Pacific peoples and Pacific youth in devising solutions to sexual and reproductive health issues.

In conjunction with local Pacific and non-Pacific expertise and using appropriate means:

- proactively involve Pacific youth in consultations on youth issues in your region
- identify existing and develop new Pacific youth to represent their populations in decision-making forums on areas related to young people
- train, develop and mentor Pacific youth in policy development processes and design and delivery of service programmes.

Use opportunities that arise to participate in national campaigns to raise and promote awareness of sexual and reproductive health issues for Pacific peoples and Pacific youth.

During 2003/2004 the Ministry of Health will be developing a national public health campaign to raise awareness of sexual health issues. At a regional level, there will be opportunities to develop some local initiatives, which can be linked with the broader messages.

- Support and resource Pacific youth initiatives within their communities and their region.
- Establish local and regional networking, advocacy, support group and fono opportunities for young Pacific people.
- Train, develop and mentor Pacific youth in the skills of lobbying and advocacy.



Personal knowledge, skills and behaviour

Goal

Pacific peoples with the knowledge, skills and confidence in their sexuality to enable them to choose their own sexual and reproductive health pathways, and to maintain good sexual health throughout their lives.

Suggested strategies

- Make sure that Pacific peoples have access to good information about sexual and reproductive health.
- Make use of peer groups to promote sexual and reproductive health.

Ways to progress these strategies

Make sure that Pacific peoples have access to good information.

Identify the most appropriate ways of communicating information to Pacific youth and families, eg, via radio, music, performance and drama.

Actively involve Pacific youth in developing the content and range of education and health promotion resources.

Publicise where Pacific peoples can go for advice and information that is confidential and which protects their interests and wellbeing.

Utilise peer groups to promote sexual and reproductive health.

In conjunction with qualified Pacific and non-Pacific health promoters and educators with clinical expertise in sexually contracted infections and disease, train, develop and mentor Pacific youth as health promoters and educators in sexual and reproductive health.

Training should reflect Pacific values and beliefs, Pacific youth issues and context of family.

Recruitment needs to take into account gender, peer group and ethnic-specific settings.



Programmes and services

Goal

Accessible, effective programmes and services that are working together to empower Pacific youth and their families to reduce the incidence of STIs, HIV/AIDS and unintended pregnancies among Pacific youth.

Suggested strategies

- Look at a range of ways of improving access to sexual and reproductive health services for Pacific peoples and of making existing services more 'user-friendly'.
- Encourage the development of a Pacific sexual and reproductive health workforce.

Ways to progress these strategies

Look at a range of ways of improving access to sexual and reproductive health services for Pacific peoples, and of making existing services more 'user-friendly'.

Identify and promote awareness of the barriers that exist for Pacific peoples in accessing sexual and reproductive services and primary health care services.

Develop and implement standards and competency guidelines for those working with Pacific peoples in the area of sexual and reproductive health.

Identify and promote effective initiatives for Pacific youth in youth-friendly settings and environments.

Promote the use of models of health promotion that work for Pacific youth and young Pacific parents.

Encourage the development of a Pacific sexual and reproductive health workforce.

An essential component of a quality service is a workforce that has the skills and competencies to provide a service that is responsive, professional and innovative.

- Be proactive in recruiting and training Pacific peoples at all levels of your organisation.
- Ensure there is appropriate training and support for non-Pacific staff to develop cultural competencies.



Information and data collection

Goal

Sufficient information and evidence to improve Pacific peoples' sexual and reproductive health and reduce inequalities between the Pacific and non-Pacific populations.

Suggested strategies

- Ensure data collection is sufficient to provide a clear picture of changes to Pacific peoples' sexual and reproductive health and inequalities between Pacific and non-Pacific populations.
- Provide regular updates to Pacific peoples on service availability and service quality.

Ways to progress these strategies

Ensure data collection is sufficient to provide a clear picture of changes to Pacific peoples' sexual and reproductive health and inequalities between Pacific and non-Pacific populations.

Identify areas where current data is inadequate for assessing disparities between Pacific and non-Pacific populations and take the necessary steps to improve data collection and quality.

Provide regular updates to Pacific peoples on service availability and service quality.

Whenever feasible, build in programme and service evaluations.

Conduct or commission effectiveness audits of selected reproductive health services for Pacific peoples.

Survey Pacific uptake of sexual and reproductive health services.

Assess Pacific consumer satisfaction with services.



Unintended and Unwanted Pregnancies

INTRODUCTION

The terms 'unintended' and 'unwanted' are often used interchangeably in discussions about pregnancy. However, the terms have quite different meanings and connotations, and several researchers are now distinguishing between 'unintended' (unplanned or mistimed) and 'unwanted' (where the pregnancy is not desired by and/or is undesirable for the mother, father, family or wider society (Brown and Eisenberg 1995; Fischer et al 1999)).

Unintended pregnancies are not necessarily unwanted. An American study estimated that 35 percent of unintended pregnancies were simply 'mistimed' and ended – not in terminations – but with the birth of a wanted child (Poole and Forrest 1995). Another study of 110 women receiving prenatal care found that only 35 percent of the pregnancies were planned, but 91 percent were wanted (Rosenfeld and Everett 1996).

Studies suggest that what is happening in the mother's life when the pregnancy occurs determines the 'wantedness' of the pregnancy – regardless of whether the pregnancy was intended or unintended (Rosenfeld and Everett

1996; Fischer et al 1999). The conflicting pressures that come to bear on women contemplating pregnancy are reflected in the ambivalence many women feel about becoming pregnant and go some way to explaining why the rate of unintended pregnancies is so high.

However, unintended pregnancies – whether simply mistimed or unwanted – present some risk to the health of mother and child.

Research studies and abortion statistics indicate that many pregnancies that occur each year in New Zealand are unintended and/or unwanted.





- A Dunedin Multidisciplinary Health and Development Study (Dickson et al 2002)⁸ reported that out of its participants, 60 percent of pregnancies to women aged under 25 were unintended.⁹
- New Zealand has high rates of abortion compared with other countries, as well as high ratios of abortions to known pregnancies,¹⁰ particularly among Māori and Asian women (Statistics New Zealand 2003).

New Zealand also has a comparatively high rate of births to teenagers (UNICEF 2001). Young Māori women have a particularly high birth rate. While many teenage pregnancies are both intended and wanted, many occur to young women who find it difficult to adequately support or care for a child without significant amounts of assistance from family and social service agencies.

Consequences of unintended/unwanted pregnancies

While many unintended pregnancies become wanted pregnancies, they still carry some risk for the child and the family. With an unintended pregnancy:

- **Couples do not have the chance to benefit from the growing field of preconception risk identification.** The opportunity to optimise the mother's health and nutrition diet is reduced, including supplementing the diet where necessary with folic acid.¹¹
- **There are reduced opportunities for women to seek care at an early stage.** American studies indicate that many women with unintended pregnancies do not seek or receive care until after the first trimester.

- **The foetus may be unwittingly exposed to harmful substances** (such as tobacco and alcohol).
- **Unanticipated financial burdens** may be placed on families and increase the stress that families are under (Brown and Eisenberg 1995).

About a fifth of all pregnancies among New Zealand women end in abortion,¹² which, while usually having few long-term consequences for women's physical or psychological health, is often associated with short-term emotional and psychological stress for the women and their families.

Unintended and unwanted pregnancies that go to full term pose the greatest risk – to the mother, the child, the family and the community. Several studies have documented the negative effects of unintended and unwanted pregnancies:

- When the pregnancy is unintended and unwanted, the infant is at greater risk of having a low birth weight, dying in its first year, being abused, and not receiving enough resources for healthy development (Brown and Eisenberg 1995).

⁸ This study examined the circumstances of wanted and unwanted pregnancies in a cohort of New Zealanders born in Dunedin in 1972/73.

⁹ Note that the Dunedin data participants were aged to 25 years and the Christchurch participants were aged up to 21 years.

¹⁰ Twenty-three percent of known pregnancies (excluding miscarriages) ended in abortion in 2002 (Statistics New Zealand 2003).

¹¹ Evidence suggests that taking folic acid as a supplement can reduce the incidence of neural tube defects, including spina bifida. The Ministry of Health recommends that women considering pregnancy should take a supplement of 0.8†mg of folic acid from four weeks before conception.

¹² Derived from 2001 New Zealand abortion and birth statistics (Statistics New Zealand).



- Women with unwanted pregnancies are more likely to be abused by their partners (Fergusson et al 1986).
- For teenagers, such pregnancies are strongly associated with subsequent disadvantage, including educational underachievement, unemployment and poverty (UNICEF 2001).
- Children of teenage mothers are more likely to repeat the cycle of teenage parenthood (UNICEF 2001).
- Women living on a very low income have more unintended and unwanted pregnancies than women who are more affluent, and more of these [the unintended ones?] pregnancies end in live births (Brown and Eisenberg 1995).

Who is most likely to have an unintended/unwanted pregnancy?

Unintended and unwanted pregnancies occur among the whole range of women of childbearing age. Women with one or more children are as likely to seek abortions as women facing their first pregnancy.

Research indicates, however, that there are higher rates of unintended and unwanted pregnancies among some population groups: the most socially and economically disadvantaged groups; Māori; and young Asian women.

Abortion data

In New Zealand in 2001:

- Asian women had the highest ratio of abortions to known pregnancies (364 per 1,000), followed by Māori women (280), Pacific women (255) and European women (207)
- of the women who had abortions, 8,728 (54 percent) had one or more children already
- of the women who had abortions 5,580 (34 percent) had previously had one or more abortions.

According to 2002 statistics, women aged 20–25 had the most abortions (5,124) and the highest abortion rate (38.9 per 1,000). Women aged 15–19 had the second highest number of abortions (3,602), but the third highest rate (25.7) (Statistics New Zealand 2002) (see Table 3).

Table 3: Number and rate of abortions by age of woman, 2002

Age	Number of abortions	Rate*
11–14	78	0.6
15–19	3,602	25.7
11–14	78	0.6
15–19	3,602	25.7
20–24	5,124	38.9
25–29	3,450	26.6
30–34	2,676	17.5
35–39	1,715	10.9
40–44	686	4.4
45 and over	49	0.4
Total	17,380	

*Per 1,000 females in each age group.

Source: Statistics New Zealand 2003



Research

Of the 188 pregnancies that were reported by women aged up to 21 in the Christchurch Health and Development Study,¹³ 32 percent ended in termination (Woodward et al 2001). Among this cohort, Māori were more likely to have become pregnant than non-Māori.

There was some indication that women with better educational and occupational prospects were more likely to terminate their pregnancy than their lower-achieving peers, and that non-Māori women were more likely to terminate their pregnancy than Māori women. (This is supported by national abortion data in 1997 that showed that only a quarter of Māori teen pregnancies ended in abortion compared with half of European/Pākehā teen pregnancies (Dickson et al 2000).) (Non-Māori and European/Pākehā are different groups.)

The Christchurch study also found that young women who became pregnant and kept their children were significantly more likely than those who became pregnant and terminated their pregnancies to have:

- left school without qualifications
- a mother who had been a teenage parent
- been born into a low socioeconomic status single-parent family
- experienced family instability.

Analysis of pregnancies among the participants in the Dunedin Multidisciplinary Health and Development Study¹⁴ found that 60 percent of all pregnancies that occurred to women by age 25 were reported as being 'unwanted' (Dickson et al 2002).¹⁵

Other significant findings from this study are:

- by the age of 25, about a quarter of the participants (men and women) had

experienced or caused at least one unintended/unwanted pregnancy

- pregnancies were more likely to be unwanted in the group aged under 19
- there were more unintended/unwanted pregnancies among the group aged 20–24 than among teenagers
- 'length of relationship' was more highly correlated than 'age of the mother' with the pregnancy being both 'unwanted' and the mother being unhappy at the time: the shorter the relationship, the more likely the pregnancy was to be unwanted
- the most unwanted pregnancies were those in which there was no ongoing relationship with the partner.

There are limitations to this study, as there are to the Christchurch study: Māori are underrepresented in the cohort (7.5 percent compared with 16.2 percent in the general population), and the analysis is restricted by the overall age of the cohort to pregnancies before age 25.

American studies show a high proportion (75 percent) of unintended and unwanted pregnancies among **women over the age of 40**, and that 60 percent of births to **low income women** are unintended and unwanted (Brown

¹³ A longitudinal study of a cohort of children born in the Christchurch urban region during mid-1977. The sample size for this particular study was 533 women.

¹⁴ A longitudinal study of a cohort born in Dunedin between 1 April 1972 and 31 March 1973. The sample size for this particular study was 966 – 477 women and 489 men.

¹⁵ The question asked in this study was, 'Did you want to get pregnant when you did?'. All those who had been pregnant were then asked how happy they had felt when it occurred.



and Eisenberg 1995). Given that the American studies indicate a similar rate to New Zealand of unintended pregnancies in the younger age groups, it is probably reasonable to assume that the similar rates apply in the older age groups and among the most disadvantaged.

Influences on pregnancy ‘wantedness’

Studies suggest that what is happening in the mother’s life when the pregnancy occurs determines the ‘wantedness’ of the pregnancy – regardless of whether the pregnancy was intended or unintended (Poole et al 1994; Rosenfeld and Everitt 1996; Fischer et al 1999).

Many women report being ambivalent about becoming pregnant, with conflicting pressures coming from a need to secure job or career prospects, continue with education, meet the expectations of the family or partner, manage a primary relationship, and manage financially. However little research has been done to determine the relative impact of these factors on the ‘wantedness’ of pregnancies.

Length of the relationship was found to be closely associated with the wantedness of pregnancies in Dickson’s study of a cohort of young New Zealanders. The shorter the relationship, the less the pregnancy was wanted (Dickson et al 2002).

The male partner’s attitude to the pregnancy was prominent in determining how women defined their pregnancies in Fischer’s study. Having a partner who was excited about the pregnancy was highly associated with defining the pregnancy as ‘wanted’. For some women, the partner’s enthusiasm overcame other reservations they may have had about continuing with the pregnancy (Farley 2001).

Comparison with other countries

New Zealand’s teenage birth rate (27.3 per 1,000 women aged 15–19) is third highest of 28 countries, behind the United States (52.1) and the United Kingdom (30.8).

Among young Māori women aged 15–19, the birth rate is 74 births per 1,000 women.

At the lower end of the teenage births are countries such as Korea (2.9 per 1,000 women), Japan (4.6), Switzerland (5.5) the Netherlands (6.2), Sweden (6.5), Italy (6.6) and Spain (7.9).

In comparison with many European countries, New Zealand’s abortion rate (19 per 1,000 women aged 15–44) is at the higher end of the scale. At the lower end are the Netherlands (7.4 per 1,000), Germany (8.0) and Finland (10.5).

Societal influences on pregnancy

In most industrialised societies there are several conflicting pressures on individuals and communities in relation to childbearing (UNICEF 2001). Chief among these is the conflict between workforce pressures and the desire to have children. Participation in the paid workforce is necessary for economic survival for most people. This may contribute to the ambivalence that many women feel about pregnancy and childbearing, particularly in a relatively low-income society like New Zealand,¹⁶ where taking time off to have a child may compromise a family’s economic viability.

New Zealand follows international trends, with its indigenous people and its ethnic minority groups having higher birth rates than the population of the country as a whole. These

¹⁶In OECD terms.



differences partially reflect traditional values favouring early marriage and childbearing, but also reflect the impact of colonisation and the social and economic disadvantage experienced by these communities.

Social attitudes to sex and sexuality also influence unintended pregnancy rates. Many researchers have commented on the low rates of pregnancy and STI in some European countries and have contrasted those countries more open attitudes to sex and sexuality with New Zealand's (and the United Kingdom's and United States') relatively conservative approaches to sexuality education and to sexual and reproductive health issues generally (Hubermann 2001; UNICEF 2001).

Disparity between Māori and non-Māori

The disparities between Māori and non-Māori rates of unintended/unwanted pregnancy are indicators of the wider disparities between Māori and non-Māori in overall health status and many other measures of social and economic wellbeing. Māori experience comparatively high rates of unemployment, education system failure and poverty. They also have unequal access to health services. Reducing inequalities in all of these areas is a Government priority.

Socioeconomic influences

UNICEF (2001) has linked two indicators of an inclusive society (income equality and the proportion of 15–19-year-olds in education) with teenage birth rates. New Zealand, the United Kingdom and the United States are at the bottom of this table, with the greatest income inequality, the lowest proportion of 15–19-year-olds in education, and the highest teenage birth rates. The greatest disparity is experienced by Māori.

UNICEF identifies both 'motive' and 'means' as influences on teenage birth rates. The *means* to avoid early pregnancy comes from being well prepared and well equipped to cope in a highly sexualised society; the *motive* to avoid early pregnancy comes from a sense of self-worth, a sense of connectedness, and life options that are more attractive than early parenthood.

Both motive and means are influenced by social and economic factors.



Sexually Transmitted Infections

INTRODUCTION

Sexually transmitted infections (STIs) are among the main preventable causes of ill health among young people in New Zealand. Untreated, they can have life-long consequences, increasing the risk of infertility, sub-fertility, ectopic pregnancy, cancer and other chronic diseases.

The presence of an STI can increase the risk of HIV transmission, and, if untreated, may be passed on by a mother to her baby at birth.

Despite chlamydia and gonorrhoea being relatively easy to prevent, treat and cure, rates of chlamydia and gonorrhoea have increased significantly in the last few years. Laboratory data suggest that the incidence of chlamydia in the New Zealand population is considerably higher than that in Canada, Australia and the United Kingdom (ESR 2002).

Of particular concern is that rangatahi Māori continue to experience significantly higher rates of STIs than non-Māori, and that many young people may be infected without realising it.

Most common sexually transmitted infections

The STIs most frequently diagnosed in New Zealand are chlamydia, genital warts, NSU in males, genital herpes and gonorrhoea.

Chlamydia and gonorrhoea are bacterial infections. Once diagnosed, they can be treated and cured quickly. However, for many people infected with chlamydia, there may be no symptoms. It is estimated that up to 80 percent of females and 45 percent of males who have this infection have no symptoms. This means there is a sizeable pool of untreated people to sustain the disease in the community. Therefore, partner notification and treatment are crucial to reducing these infections.





If undiagnosed and untreated, chlamydia can cause pelvic inflammatory disease and ectopic pregnancy, and lead to long-term infertility. The presence of chlamydia or gonorrhoea can enhance HIV transmission.

Both chlamydia and gonorrhoea can be passed on to infants at birth and may cause infant pneumonia and/or blindness.

Genital warts and genital herpes are viral infections. There is no cure for these infections, but the symptoms – which are recurrent blisters or warts – can be managed.

Genital herpes can infect infants at birth. Some types of genital warts are associated with genital cancer.

Who can get them?

Sexually transmitted infections are no respecters of age or socioeconomic status, gender, sexual orientation or ethnicity. They can affect anyone who is sexually active. Young people are most vulnerable, because they are more sexually active and are likely to have more partners than other age groups.

Rates of the bacterial STIs (chlamydia and gonorrhoea) are higher among Māori and Pacific peoples than among Europeans/Pākehā. Lack of access to appropriate primary health care is a large part of the reason for this (Fairley et al 1997; Plummer and Forrest 1999; Connor et al 1997). This emphasises the importance of ensuring appropriate and affordable treatment (as well as knowledge about how to prevent infection) is available within communities where health care needs are high.

Rates of the viral STIs are more commonly diagnosed in the European/Pākehā population than the Māori or Pacific populations.

Vulnerable populations

Within the general population there are groups who are more vulnerable to STIs than others: 16–24-year-olds; men who have sex with men; rangatahi Māori; and young Pacific people.

12–24-year-olds

The majority of those infected with STIs are young people. Over 60 percent of the diagnosed cases of gonorrhoea, chlamydia and genital warts occur in people aged under 25. Young people are at higher risk of acquiring STIs, because:

- they are more likely to be having sex
- they tend not to have access to sexual health services, nor, particularly, to condoms and contraceptives.

Sex workers

While sex workers have been particularly effective in preventing the transmission of STIs, there are particular groups of sex workers who remain vulnerable to STI transmission.

Plumridge (2000: 371) noted that fewer than half of sex workers who have a GP disclosed to their GP that they were sex workers. This means effective information of relevance to their sexual health may not be communicated to them. The majority of sex workers are under 25, and 30 percent of the participants in Plumridge's study were under 21 ($n = 303$, $< 21 = 30\%$; $22–29 = 38\%$; $\leq 30 = 33\%$).

People entering the sex industry are even more vulnerable, and are often pressured by clients to have unsafe sex. UNAIDS reports that 'laws, policies, and policing methods that perpetuate poor working conditions for sex workers and encourage unscrupulous behaviour by third parties are common' (UNAIDS 2002).



Furthermore, New Zealand has sex workers who migrate from other countries to work in the New Zealand sex industry for short periods, and ‘migrant prostitutes often come from countries with a higher STI/HIV prevalence than the countries of destination’ (UNAIDS 2002).

In regards to the clients of sex workers, several massage parlours are licensed to serve alcohol and offer a full bar service. ‘Alcohol also increases the amount of time it takes a man to reach climax, and this slower response time could increase the amount of vaginal or anal abrasion that occurs in unprotected sex with insufficient lubrication. Such abrasions are open portals for the transmission of HIV’ (UNAIDS 2002). Such practices also increase the risk of STI transmission.

Many younger sex workers are highly mobile, and mainstream youth targeted initiatives would not be accessible to them.

Men who have sex with men (MSM)

The New Zealand AIDS Foundation’s Project Male Call has provided the first detailed examination of sexual behaviour among many New Zealand men who have sex with men (MSM). The research found that, overall, MSM have accepted the importance of condom use for anal sex as the primary method of prevention of STIs, but a sufficiently large minority continues to engage in highly unsafe sex. ‘Unsafe sex’ was characterised in the research as failure to maintain condom use in relationships after about two years, and having unprotected casual sex. Men having unprotected casual sex tended to have lower incomes, be non-gay community attached, and to have a greater number of sexual partners.

Rangatahi Māori

Rangatahi Māori suffer higher rates of ill health than non-Māori youth. The causes are complex. Māori are overrepresented in the lower socioeconomic groups, and are less likely to have access to health care than non-Māori. Restoring and maintaining Māori health – including sexual health – requires a multifaceted approach that tackles employment, housing and education issues, and involves Māori in a driving role. Many promising models for this approach already exist and are becoming well established, but they need to be complemented by more responsive mainstream initiatives that reach young Māori who are not connected to traditional Māori organisations.

Pacific peoples

Pacific peoples experience higher levels of sexual and reproductive ill health than the non-Pacific population. This is partly because Pacific peoples are more likely to be clustered in the lower socioeconomic groups than their non-Pacific counterparts, with more restricted access to primary health care. It is also partly because there are cultural and social barriers to open discussion about sexual and reproductive health matters in Pacific families. Working with Pacific church and community groups to develop health messages and raise awareness of sexual health issues is an approach that is advocated by Pacific community health workers. Some Pacific young people who are in co-education schools have said they would prefer to have the sexual health curriculum taught in segregated classes. In developing any new approaches to sexual and reproductive health education, it is important the views of the Pacific community and their young people are sought and they are involved in service design.

INTRODUCTION

HIV (human immunodeficiency virus) is a virus that causes a lifelong infection that damages the body's immune system. AIDS (acquired immune deficiency syndrome) is a late consequence of HIV infection. AIDS-defining conditions (serious infections or cancers indicating a severely damaged immune system) occur on average about 10 years after a person becomes HIV-positive. However, the time from infection to the development of AIDS may range from one and to more than 20 years. Treatment extends the period before AIDS develops and may keep people well indefinitely. However, HIV can develop resistance to one or more treatments as a result of continual mutation and this resistance can result in treatment failure (Grierson et al 2002).

HIV transmission

HIV is transmitted through the exchange of body fluids such as blood and semen. HIV is commonly transmitted by:

- having anal sex without a condom (both partners at risk)
- having vaginal intercourse without a condom (both partners at risk)
- sharing drug-injecting equipment
- an infected mother to her baby during pregnancy, at child birth or by breastfeeding.

HIV is rarely transmitted by:

- vaginal or anal intercourse with proper condom use
- oral sex without a condom (ejaculation increases the risk)
- fresh blood-contaminated sharp injuries or splashes, for example needle-stick injuries. HIV is rarely transmitted in this manner because there are relatively few needle-stick injuries, but it should be noted that the per episode risk for needle stick injuries is similar to the per episode risk for vaginal intercourse without a condom (Royce et al 1997).





In New Zealand, infection with HIV as a result of a transfusion of blood or blood products is unlikely because of comprehensive screening and testing procedures. Serologic testing for HIV in blood began in September 1985.

There is no evidence that HIV has ever been transmitted by: cuddling; massage; shaking hands; sharing knives, forks, cups or glasses; toilet seats; or mosquito bite.

Trends in HIV epidemiology in New Zealand

Over the last 15 years the number of people each year diagnosed with HIV has been greater than the number dying from AIDS. Although some people with HIV will no longer be in the country, it is likely there has been a steadily increasing number of people in New Zealand

with diagnosed HIV who require care. A study of New Zealand's HIV-positive population concluded that at the end of 2000 approximately 800 HIV-positive people were under active care.

The number of men (1,410) diagnosed with HIV since 1985 is significantly more than the number of women (237), but more recently women are making up a greater proportion of the annual numbers diagnosed (see Figure 3).

Figure 4 shows how the annual total numbers of people newly diagnosed with HIV infection has fluctuated since reporting began in 1985. There were 107 people newly diagnosed with HIV in 2002, which is higher than in the previous three years. Although it is too early to tell whether this will be an ongoing trend it emphasises that prevention programmes must continue.

Figure 3: Number of people newly diagnosed with HIV infection by year of diagnosis and likely mode of infection, New Zealand, 1985–2002

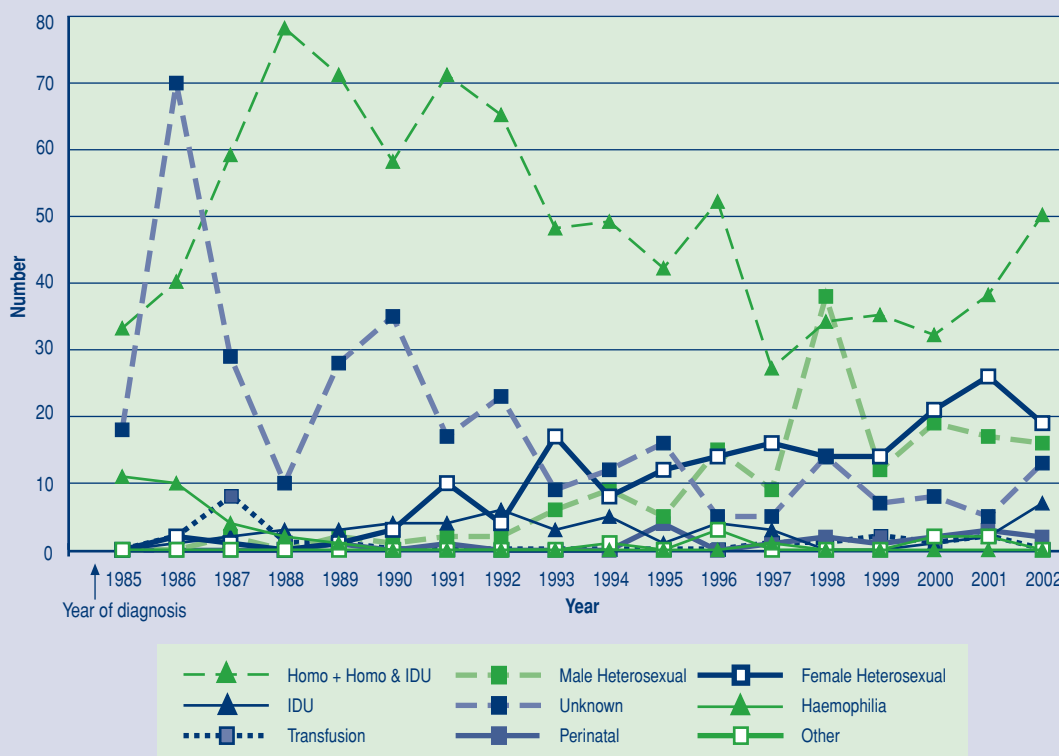
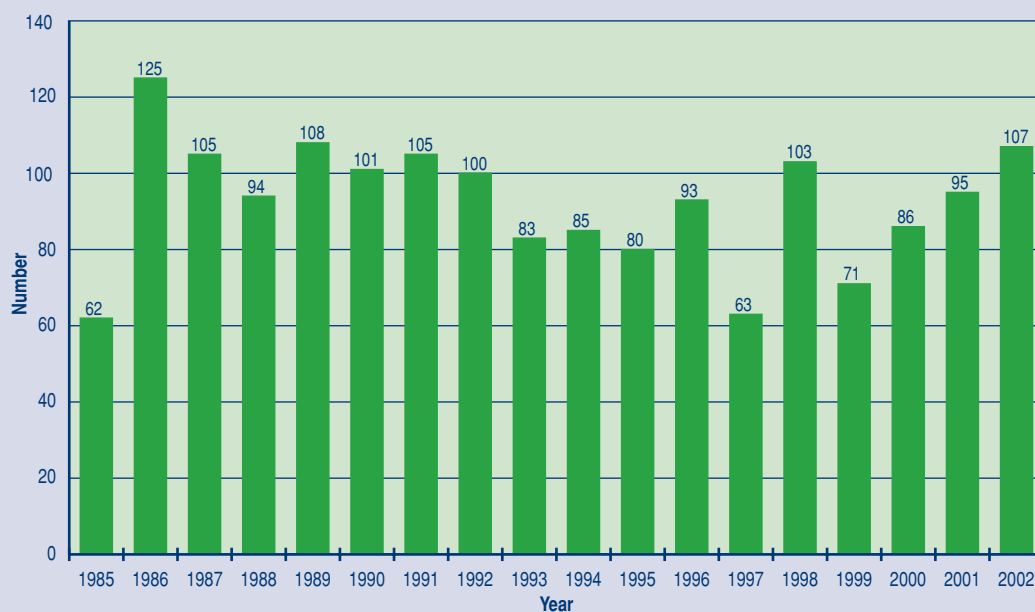


Figure 4: Annual number of people newly diagnosed HIV-positive, 1985–2002



Source: NZ AIDS Epidemiology Groups 2003

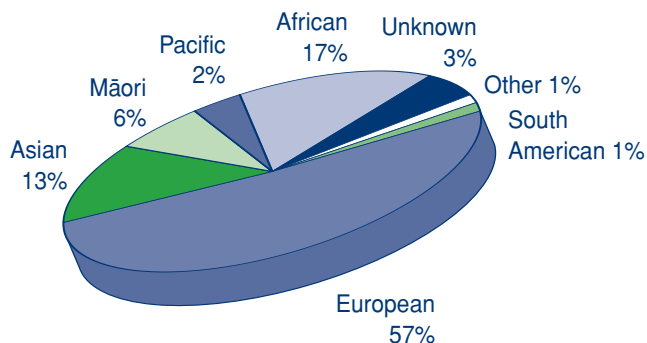
Figure 3 shows the changes in the likely mode of HIV transmission of people found to be HIV-positive since 1985. Early in the epidemic more than 80 percent of people found to be HIV-positive were men who reported having sex with men. In 2002 infection through heterosexual contact accounted for around a third of newly diagnosed HIV infections compared with 6 percent of newly diagnosed HIV infections in 1992. A factor that contributed to the peak in newly diagnosed males with heterosexually acquired HIV infections in 1998 was the large number of refugees (41) diagnosed with HIV infection through the Refugee Health Assessment in that year. Since reporting on HIV diagnosis as part of the refugee health assessment began in 1994, 107 refugees have been diagnosed which is around 13 percent of the total number (782) of people diagnosed,

between 1994 and 2002. Injecting drug use as a mode of transmission has maintained a low incidence, indicating that harm minimisation, including the Needle and Syringe Exchange Programme, has been successful and needs to continue.

Between 1996 and 2002, 618 people were reported to the NZ AIDS Epidemiology Group through HIV diagnostic tests and 222 people through viral load tests. Of these 840 people, 51 percent acquired their HIV infection through male homosexual contact and 34 percent through heterosexual contact. Nearly three-quarters of the heterosexually acquired HIV infections were as a result of unprotected sex in, or with a person, from a high prevalence area. Eight percent of the heterosexually acquired HIV infections were as a result of unprotected sex with a high-risk partner.



Figure 5: Ethnicity of people diagnosed HIV-positive from 1 January 1996 to 31 December 2002

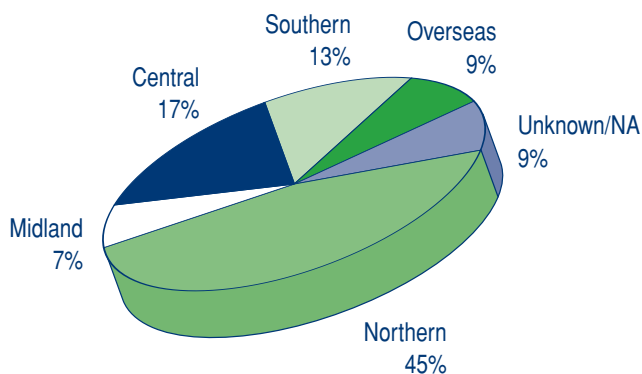


Source: NZ AIDS Epidemiology Group

As Figure 5 shows, the ethnicity of the diagnosed HIV-positive population is not representative of the general population profile. Africans at 0.2 percent of the general population, followed by Asians at 6.6 percent of the general population, are overrepresented. On the other hand, there are fewer Europeans, Māori and Pacific peoples than would be expected from their representation in the general population.

Figure 6 shows that the northern region, followed by the central region, is home to the majority of the diagnosed HIV-positive population. This reflects the underlying geographic distribution of population groups most vulnerable to HIV infection, in particular MSM and refugees and migrants from high prevalence countries. The northern, midland, central and southern region boundaries equate to the four Regional Health Authority boundaries of the mid- to late-1990s.

Figure 6: Regional distribution of people diagnosed HIV-positive from 1 January 1996 to 31 December 2002



Source: NZ AIDS Epidemiology Group



A study of New Zealand's HIV-positive population under active care during 2000 found a higher proportion of people under care from Africa, increasing numbers of females and an increase in the proportion of people with heterosexually acquired HIV infection (Mills et al 2002). The mean age for those aged over 14 was 41.2 years for men and 34.2 years for women. Although Africans account for less than 0.2 percent of New Zealand residents, they accounted for 13 percent of the sample and African women accounted for nearly a third of infected women. The commonest mode of transmission was male homosexual contact (56 percent) followed by heterosexual contact (28 percent). African men (89 percent) and Asian men (48 percent) were more likely than European men (7 percent) to have acquired their infections through heterosexual transmission.

AIDS in New Zealand

Trends in AIDS epidemiology may not reflect trends in HIV epidemiology. AIDS diagnoses peaked in 1989 and have generally declined since then, although rising temporarily in 1995 and 1996. The major factors in this decline were likely to have been the reduction in unprotected sex among MSM in the mid-1980s, and the effective prevention of epidemics in other population subgroups. Since the mid-1990s AIDS incidence has also reduced in part due to the availability of antiretroviral therapies that have delayed the progression of HIV infection. The epidemic also started later in New Zealand compared with other countries and this enabled an earlier proactive response at the political and community levels.

Target groups for HIV/AIDS initiatives

People living with HIV/AIDS

The study *HIV/AIDS Futures New Zealand* provided analysis of the clinical, social and cultural experiences of 226¹⁷ people living with HIV/AIDS (Grierson et al 2002). Of the 226 participants, 25 identified as Māori.

The study found that discrimination was a relatively common experience for people living with HIV/AIDS, indicating that societal attitudes towards these people need to be improved. The majority of people living with HIV/AIDS considered their HIV status to be an important part of their identity. Nearly half (47 percent) of the respondents were currently on a pension or benefit and the median income of respondents was \$330 per week. Paying for food, medical services and holidays was very difficult for 14 percent, 32 percent and 52 percent of respondents respectively.

Just over 80 percent were seeing an HIV specialist for management of their HIV and 64 percent were using antiretroviral (ARV) therapy. Most were concerned about the future efficacy of their treatment. HIV can develop resistance to one or more treatments as a result of its continual mutation and this resistance can result in treatment failure (Averitt and Thiemann 2001). Of those that took a treatment break (34 percent) the main reasons were lifestyle related (depression, travel or dosing problems) and clinically related (doctor's recommendation, side effects or drug resistance).

The study found that as well as HIV specialist services and GP services, respondents used a range of ancillary services. Significant

¹⁷Nearly 25 percent of the New Zealand HIV-positive population.



proportions used information and support/counselling services provided by the New Zealand AIDS Foundation. The non-HIV specific services most likely to be used related to pharmacy, financial advice and assistance, legal advice, housing assistance, employment, returning to work, drug and alcohol treatment, mental health, library, internet access, transport and paid carers.

Men who have sex with men

HIV and AIDS in New Zealand has primarily affected MSM. The 1996 New Zealand AIDS Foundation's *Project Male Call: Tane Ma Waea Mai* provided the first detailed examination of sexual behaviour and safer sex messages among 1,852 New Zealand MSM. The research found that, overall, MSM have accepted the importance of condom use for anal sex as the primary method of prevention. However, a large minority continue to engage in unsafe sex, and this has the effect of perpetuating the epidemic among this population group. Men having unprotected casual sex tended to be lower income, non-gay-community attached, and have greater numbers of sexual partners.

The 1996 research found several socio-sexual differences between Māori and non-Māori MSM. Compared with non-Māori MSM, Māori MSM were:

- more likely to be younger
- more likely to be on lower incomes and in semi-skilled work
- less likely to feel part of the gay community
- less likely to have had sex with casual partners or outside a regular relationship (Aspin et al 1998).

A proportion of MSM also have sex with women. Because many of these men identify as heterosexual, and because the stigma attached to male homosexual sex may prevent

such men from disclosing their sexual practices with men to their female partners, it is possible that such men and their female partners will be particularly vulnerable to HIV infection. Thus men who have sex with men and women may be at greater risk of acquiring HIV infection themselves, and, through their sexual practices with both MSM and women, may act as a 'bridging population' for passing HIV between high and low prevalence populations.

Refugees and migrants from high prevalence countries

Migrant populations, particularly those from high prevalence areas, may be at higher risk of HIV infection than the host population. Factors related to this include demographic and behavioural differences within the immigrant community; difficulties in interactions with, and integrating into, the host society; less access to medical services; the role of women in the migrant population and their ability to negotiate safer sex practices; and cultural, language and communication barriers when accessing health services in New Zealand.

Another compounding factor is that HIV-related stigma and shame is often greater in non-Western cultures. Migrants from some non-Western cultures may not have had access to HIV/AIDS education in their home country and HIV-positive individuals may be particularly fearful of disclosing their HIV status. Fear of disclosure has implications for HIV transmission, particularly for partners, and for access to HIV treatment and care services. All these factors create specific challenges for control strategies, clinicians and support services. Health professionals seeking more information can access *Refugee Health Care: A handbook for health professionals* (Ministry of Health 2001) through the Ministry of Health's website.



Injecting drug users

Injecting drug users (IDUs) are a vulnerable population because HIV can be readily transmitted through shared injecting equipment. However, injecting-drug-related HIV epidemics do not remain confined to IDU populations. Most IDUs are young, male and sexually active. They are likely to acquire or transmit HIV by sharing injecting equipment and by having unprotected sex. Injecting drug use often overlaps with being in the sex trade; users may buy or sell sex to finance their drug dependencies.

Preventing HIV in IDU populations requires a comprehensive primary prevention approach, including access to clean needles and syringes and condoms; drug-dependency treatment and rehabilitation; HIV/AIDS education; legal and social services; and voluntary HIV testing, counselling and psychosocial support.

There is strong evidence to show that effective and humane drug treatment not only reduces drug abuse, but diminishes HIV risk. It is important that drug control policies reduce, not augment, the HIV risk faced by IDUs, and HIV prevention activities must not inadvertently promote drug abuse.

Sex workers

Sex workers have largely adopted safer sex practices, but there are particular groups of sex workers who could be more at risk of coercion into unprotected sex and/or HIV transmission than other sex workers. While there is very little research in this area, anecdotal evidence suggests the most at-risk sex workers include street workers, transgendered sex workers, and younger, transient, Māori and migrant sex workers. Male and transgender sex workers are more likely to manage their own sex work activities as opposed to working for a third party from a venue.

Effective HIV prevention among sex workers addresses the social, economic and legal environments in which they live and work. Sex workers must be involved and empowered through programmes. Efforts must win the co-operation and support of control points in the sex industry, such as owners and managers of commercial sex venues, and the police. It is essential to tackle the prejudice that sex workers endure, and to weave other concerns into the programmes, such as care for their families and children.

The World Health Organization realises the necessity of protecting and promoting the rights of sex workers because of the important role sex workers can play in HIV prevention.

Implications of HIV/AIDS for other groups

HIV/AIDS has implications for a range of other groups in society.

People with sexually transmitted infections

Sexually transmitted infections (STIs) are risk indicators for HIV. The presence of STIs magnifies the risk of HIV transmission as much as ten-fold, since the infection creates additional entry points for the virus and facilitates viral replication. STIs that cause genital ulcers, such as Herpes Simplex Virus-2, increase the risk of transmission the most. STIs are also indicators of unprotected sex. Anal gonorrhoea in particular is a reliable predictor of unprotected sex among MSM.

A 1996/1997 HIV prevalence study of sexual health clinic attenders in Auckland and Christchurch found that 31 per 1,000 MSM



were HIV-positive. HIV prevalence in heterosexual men and women was found to be one per 1,000 for both groups.

Women

Women exposed to HIV during vaginal intercourse may be at greater risk of acquiring it than men exposed to HIV during vaginal intercourse. This is because the HIV viral load in vaginal fluid is generally less than the HIV viral load in semen (Shepard et al 2000) and women have a larger mucosal surface exposed to abrasions during vaginal intercourse that act as portals allowing entry of the virus to the bloodstream.

A 2000 study of New Zealand's HIV-positive population under active care concluded that the increasing numbers of women under care (about 19 percent) required the development of new strategies to prevent perinatal HIV transmission. Now that effective strategies can significantly reduce the risk of HIV transmission from mother to baby, the issue of screening and testing for HIV as part of antenatal care has been raised. The issues are discussed and guidance is provided in the Ministry of Health publication, *HIV in Pregnancy: Risk screening guidelines and information for health professionals*, (1997) (accessible at www.moh.govt.nz) and the 1999 publication, *HIV/AIDS: Information for health professionals*.

The National Health Committee is reviewing HIV screening in pregnancy and will be providing advice to the Minister of Health.

Young people

There are many reasons why young people are an important target group for action to prevent HIV/AIDS. Overseas in areas where HIV/AIDS is subsiding or declining, it is primarily because young men and women are being given the tools and incentives to adopt safe behaviours (UNICEF et al 2002). In New Zealand, young people have higher STI rates than older people. It makes sense for sexual and reproductive health promotion programmes (including STI and HIV prevention education) to target young people so they have good information about HIV and HIV risk factors and receive HIV prevention messages (WHO 2002).

Māori

There is minimal research data about Māori and HIV/AIDS, but several factors suggest Māori may be more at risk to HIV exposure than the general population: the youthful age structure of the Māori population; disproportionate numbers on low and very low incomes; trans-Tasman migration; lack of information; lack of access to culturally appropriate services; barriers in acquiring health skills; and access to health resources such as condoms (Te Puni Kōkiri 1994). Māori also experience disproportionately higher STI rates.

Pacific peoples

The youthful age structure of the Pacific population, Pacific youth's disproportionate STI rates and Pacific peoples' close social and economic ties with Pacific countries mean Pacific peoples, particularly Pacific young people, are an important target groups for HIV prevention strategies.



Prisoners

Removed and marginalised from society, prisoners can be at special risk of HIV infection, mainly through consensual or forced anal sex, injecting drug use, unsafe tattooing practices, and insufficient HIV prevention education and services. In New Zealand, 50 percent of the male prison population is Māori and nearly 60 percent of the female prison population is Māori. Any HIV prevention initiatives among New Zealand's prison population will need to take account of Māori prisoners' issues.

The Department of Corrections and the Ministry of Health have developed a communicable diseases policy that includes initiatives relevant to HIV prevention, offering HIV testing for inmates who self-identify as 'high risk', providing health kits that include condoms, and providing condoms on request. These initiatives are currently being trialled in selected prisons.

Uniformed services

The United Nations Declaration of Commitment on HIV/AIDS calls for inclusion, by 2003, of HIV/AIDS awareness and training into guidelines for defence force personnel involved in international peacekeeping operations. Several aspects of the military environment put its armed forces at risk. One of the most important factors is the practice of posting personnel away from their communities and families. This not only 'frees' soldiers from

the discipline they might be subject to in their own communities, it also removes them from their regular sexual partners. The resulting loneliness, stress and sexual tension can increase risk taking. A study of Dutch soldiers on a five-month peacekeeping mission in Cambodia found that 45 percent had sexual contact with sex workers or other members of the local community during their deployment.

The New Zealand Defence Force (NZDF) entrants are one of the serially tested low-risk populations included in the Hepatitis C surveillance programme; this includes HIV testing. NZDF also provides confidential counselling and voluntary testing before deploying personnel on peace keeping missions and on their return.

Travellers

New Zealanders need to be informed of the risks associated with having unprotected sex overseas and with visitors to New Zealand. Given that New Zealand's youth have a tradition of having an 'overseas experience', it will be important for them to be informed about the need to protect themselves from HIV and other STIs while overseas, including in the Pacific. Current practice is for health advice for international travellers to highlight the risk of HIV transmission through unsafe sexual behaviour and injecting drug use.

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