



**Primary Sexual Health Services for
young people**

in Capital & Coast DHB

March 2006

Table of contents

Acknowledgements	4
Executive Summary	5
Summary	5
Current situation	5
Recommendations: Accessible and Appropriate Services	5
Recommendations: Health Promotion and Information	6
Recommendations: Workforce	6
Purpose	7
Why Review Sexual Health Services for Young People?	7
Factors Supporting A Review Include:	8
Good News	8
Government Strategies	9
Youth Health: A Guide to Action	10
Evidence about young people in New Zealand	10
Sexual Activity	10
Sexually Transmitted Infection	11
Screening for STIs	11
Contraceptive Use	12
Access to Condoms and Contraceptives	13
Key Access Issues for Young People Accessing Health Services	13
Primary Care for Young People	14
Consultation	16
Young Men	16
Specific Issues for Māori and Pacific Services for Young People	16
Gay, Lesbian and Bisexual Young People	17
Access, Stigma, Non-Judgemental Services and Confidentiality	17
Knowledge and Variety of Services	17
Comments And Perception Of Current Services (Clinical And Public Health)	18
Analysis: Service Models and Ideas	19
Sexual Health Promotion	23
Characteristics Of Effective Sex Education Programmes:	23
Schools	23
Public Health Providers	24
Kaupapa Maori Services Providing Sexual Health Promotion	24
Pacific resources	25
National Sexual Health Campaign	25
How Were The Messages Promoted?	25
Commercials	26
Website	26
Campaign Evaluation	26
Knowledge of STIs	26
Main Findings	27
Awareness Of Advertising Increased	27
Key Messages	27
Conclusion	27
Sexual Health Consultations – Primary Care	28
PHO Enrolment	28
Information on Utilisation of Current Services	29
Wellington Independent Practitioners Association (WIPA) Practices	29
Porirua Union and Community Health Service	31
Ora Toa	33
Newtown Union Health Service	35
Karori Medical Centre	36

Summary of Primary Care Providers	36
Kapiti Youth Support	37
Evolve	38
Family Planning Association	40
School Health Clinics	41
Sexually Transmitted Infections (STIs)	43
Sexually Transmitted Infections In C&CDHB	43
Chlamydia	44
Gonorrhoea	45
Genital Herpes	45
Genital Warts	45
Hepatitis B	45
Teenage Pregnancy	46
C&CDHB	46
Termination of Pregnancy	47
References	50

Acknowledgements

This report has been developed with the assistance of several people. We would particularly like to thank Simon Harger-Forde, for work to hear the views of young people and provide a perspective from a national level. We would particularly like to thank the young people who shared their views and contributed to the review, including C&CDHB/Regional Public Health's Youth Health Advisory Group.

The work of Rebecca Rippon, Marnie Lanauze, Johanna Reidy and Lee Tan, (C&CDHB Planning & Funding) to obtain and analyse data is acknowledged. The primary care providers (GPs, nurses, school health clinics, youth health services, Maori, Pacific, Union Health services, Family Planning and pharmacists) continue to be the mainstay of sexual health service provision. This is supported by the specialist sexual health service in C&CDHB and by public health/health promotion providers, schools and other groups who work to promote positive sexual health.

The work of Dr Catherine Moor, public health physician and the sexual health service review in Counties Manukau DHB is acknowledged as a helpful starting point when considering C&CDHB's review.

Finally, we would like to acknowledge our DHB Board, providers, and staff for responding to youth representation with a focus on youth health and supporting a collaborative approach to ensuring best use of resources to optimise services

Executive Summary

This review is based on the results of consultation, discussion, data review and limited literature review.

Summary

Current situation

- A high proportion of young people are sexually active.
- Current health services are serving a large number of young people, mainly young women. On average, 94% of youth sexual health consultations are female clients.
- Pacific youth are less likely to have sexual health consultations than Maori or non-Maori non-Pacific youth.
- Sexual health consultations make up a high proportion of consultations at youth-specific providers.
- 15% of visits to secondary school health clinics were for sexual health.
- The most common services provided at sexual health consultations are contraception, sexually transmitted infection services and pregnancy tests.
- Some progress is being made in reducing teenage pregnancy.
- Sexually transmitted infections, especially chlamydia, are at unacceptably high levels.
- Genital warts and Chlamydia are the most common types of STI diagnosed at Capital and Coast sexual health service, family planning and student and youth health clinics.
- Teenage delivery rates in the district have decreased. Maori teenagers have a significantly higher delivery rate than the district average
- Maori, Pacific and Asian females are over-represented in termination of pregnancy statistics.

Recommendations: Accessible and Appropriate Services

- Sexual health services should be provided within a broad primary care/youth health service framework, and a diversity of service models and approaches is critical.
- Youth health services with young people involved in design and delivery are supported
- More accessible services for young people – good physical access, youth-friendly, information about service options in a range of formats
- Reduce barriers-more young staff, easier access to prescriptions, free services, transport.
- Opportunistic screening for Chlamydia and other STIs should be offered to all sexually active males and females at risk.
- Identified service gaps include: school outreach in Kapiti (and access to specialist sexual health services), non-school-based youth services in Porirua and school clinics in Wellington, health promotion capacity across a range of groups and sexual health issues.

- We need more services attractive to young men.
- Health services are needed that suit young people not in school.
- PHOs can enhance the use of youth health screening and health promotion within their organisations.
- For many young people, non ethnic-specific services are favoured to provide confidentiality and choice.
- More school clinics are supported.
- Specialist support for young people with disability or chronic illness.
- Gay friendly services – information to support and identify these services
- Opportunistic screening for Chlamydia for both young men and women
- Use nurses more - with some able to prescribe, after completing the appropriate training course or with GP support.

Recommendations: Health Promotion and Information

- School based sexuality education needs to include information about and links to youth-friendly health services.
- More support is needed for young people to make active choices about pregnancy and parenting.
- Young people need to know how to access relevant products and services and know what's free – this requires a range of communication strategies and innovative approaches –for instance text, free single phone number, web-based as well as information readily available on posters etc.
- We need more initiatives to encourage dialogue on sexual health issues, including support for young people that choose not to be sexually active.
- Ethnic-specific health promotion and disease prevention initiatives are supported.
- Utilise evidence about what works for young men and recognise the importance of targeted efforts to support positive attitudes in young men in reducing teenage pregnancy.
- Accessible sexual health and service information for parents and families
- Recognise the importance of youth workers and teachers' roles in brokering service access and providing basic information

Recommendations: Workforce

- Support primary care workforce development, in particular in the areas of youth health, screening for health issues in routine consultations, such as unmet contraceptive needs or STI screening
- Attract young people, particularly Maori, Pacific and members of the refugee communities into the health workforce.
- Train frontline staff and health professionals about youth-friendly service and offer service/environment 'audits'

Purpose

The purpose of this review is to improve the sexual and reproductive health of young people in the Wellington, Porirua and Kapiti Coast areas by identifying innovative, effective and free primary sexual and reproductive health services and partnering with providers to build on existing service.

Why Review Sexual Health Services for Young People?

Sexual health services for young people are part of general primary health care and sexual health is linked with many other factors that support 'healthy' young people.

Any discussion about sexual health needs to take into account all the influences on a young person including how young people are valued, how they feel about themselves, in their families, school, work, social settings; decisions being made about alcohol and other drugs, future prospects including education options and employment, their own values, resilience etc. While this review of primary sexual health services for young people in Capital & Coast DHB, focuses mainly on service access and acceptability, the significance of environmental factors in influencing health outcomes for youth is emphasised as a key background principle.

There is strong evidence to support the importance of youth resiliency and opportunities affecting health and particularly sexual health.

Common features of societies with relatively good sexual and reproductive health outcomes, include:

- An 'inclusive society'
- Relative income equality
- Good retention of young people in the education system
- Honesty and openness about sexuality at all levels of society
- Ongoing public education campaigns through the media about safety and pleasure
- Young people are valued in society rather than being seen as problems
- Policy and programmes are research-based
- Free or low cost contraception is accessible
- Issues arising from cultural diversity/differing values are carefully worked through¹

From a funding angle, there are particular services funded by the District Health Board as 'sexual health services'. Most current funding for sexual health services is through primary care (GPs, practice nurses), youth health services, school clinics, Family Planning and there are some health promotion services, mainly funded through the Ministry of Health (Public Health).

Several recent developments recently that prompted the DHB to have a look at how sexual health services are funded and how to support optimal access to services. It's also just part of our normal process to look at particular primary care services and think about how we can improve them.

Factors Supporting A Review Include:

- A major national campaign (“Hubba Hubba”) to support safe choices and safer sex has raised awareness. This needs to be supported by easy access to good information, support to discuss concerns and friendly, free services for sexual health.
- Wider understanding of and better evidence about what affects youth health including support for youth development approach²
- Rising levels of some sexually transmitted infections
- Relatively high levels of teenage pregnancy (which for some people reflects unintended pregnancy) and abortion rates
- More youth health services, school health clinics and other ‘youth-friendly’ initiatives developing.
- Multiple forms of contracting and criteria- C&CDHB funds primary care providers to provide free consultations to young people and others through a range of historical contracts: some fund people under 19, 19-24 year olds with community service cards and people over 24 with clinical signs and symptoms and ‘hardship’; others fund people under 25 years or over 25 with community service card. Other providers have contracts with the Ministry of Health (Family Planning). This variation makes communication about free options for young people very complicated!
- PHOs (Primary Health Organisations) provide more opportunities for health promotion and other ways to improve services for young people.
- Nurses can offer more services than previously, especially with the nurse practitioner role.
- The need to ensure a range of service options for young Maori and strengthen health promotion for rangatahi Maori, considering sexual health both within a whanau ora paradigm and a youth health context.
- For Pacific young people, to be supported in their own values and to ensure access to services they find comfortable.
- To meet the particular needs of young people who have moved to New Zealand as refugees.
- The need to overcome potential barriers such as cost, language, disability, income, sexual orientation and social issues that can make accessing services difficult.
- Recognising religious and social values in some communities that support abstinence and ensuring that young people making this choice feel supported.
- Easier ways to test for some sexually transmitted infections (like chlamydia) so we can improve screening and testing for these.
- With ECP available from pharmacies, condoms widely available from supermarkets etc, there’s more opportunity for self-care.

Good News

We have a lot of young people in C&C District Health Board area (see table)³

Table 1: C&C DHB population by age groups

Age group	0-14	15-24	25-44	45-64	65+
Population	50,703	36,222	81,996	51,285	25,245
Percentage	20.7%	14.8%	33.4%	20.9%	10.3%

Data source: Statistics New Zealand

- Most young people in the District are relatively healthy.
- For many young people, sexual health issues, decisions, information and health service requirements are being met within their homes, schools and normal health service contacts.
- Some indicators of youth health are improving already –in particular, teenage pregnancies.
- Evaluation of the “Hubba Hubba” campaign shows changes in awareness with most young people surveyed having heard the key message about safe sex and almost half saying the campaign had ‘definitely’ or ‘probably’ increased their likelihood of using condoms in the future.
- A range of different ‘models’ for services are already in place or developing.
- We have lots of good links with young people through our advisory group, youth health services, fono and other gatherings and they have given us good information on their views and experience.

In summary, this review is not attempting to address all sexual health issues comprehensively and is against a background of limited new funding. It does provide an opportunity to look at what’s already out there, reinforce the linkages to other influences on youth health and signal directions for the next 3-5 years.

The format of this document is as follows:

- Background –including government strategies, relevant recent research findings.
- Information gained from young people – previous research in New Zealand and in Wellington, information from focus groups facilitated by Simon Harger-Forde in early 2005, on behalf of C&CDHB.
- Local information about sexual health and utilisation of services follows.
- Main points in summary and recommendations.

Government Strategies

The Government’s Sexual and Reproductive Health Strategy-Phase One (2001)⁴ set out a overarching vision and strategic direction for sexual health, and identifies principles and obligations for sexual health service planning and delivery in New Zealand. The strategy’s guiding principles (which have been drawn from the New Zealand Health Strategy⁵) are:

- Sexual and reproductive health services as a public health service
- A comprehensive, free, specialist sexual health service close to the community
- Sexually transmitted disease control to ensure that at risk groups have access to effective education programmes
- Disease control of HIV/AIDS as a sexually transmitted infection (STI)
- An emphasis on effective and available services for Māori, Pacific peoples and young people.

The Strategy – “Phase One” highlights the need to reduce STIs and unwanted or unintended pregnancies, as well as maximise the health of youth, Maori and Pacific peoples.

The “Resource Book”¹ puts sexual health into a broader context, discussing the social and behavioural factors that influence sexual and reproductive health:

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

Influences on sexual and reproductive health that are discussed in this document include:

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

Youth Health: A Guide to Action

In September 2002, Government launched its plan for the health and wellbeing of young people – Youth Health: A Guide to Action.⁶ The plan identifies ten key goals for focus across sectors. Six of the goals focus on specific health service development and delivery and four focus on population specific health improvement.

Goals seven and eight seek a measurable improvement in the health of Māori and Pacific young people. Both goals refer to a ‘more effective range of services’ in a range of key areas including sexual and reproductive health.

Goal three seeks a measurable improvement in young people’s physical health. One of the key objectives is ‘a reduction in STIs and unintended pregnancies’. All of the recommended action points are mentioned further in this paper except the development of specific sexual health services for young people in correctional and residential facilities.

These and other strategic documents, with the evidence that supports them underpin the direction of C&CDHB’s sexual health services.^{7,8,9,10,11} Local planning, looking at what is already in place, listens to the views of youth, both locally and from previous consultations, takes into account the views of providers, the utilisation information etc to update current contracts and invest any additional funds where there are gaps.

Evidence about young people in New Zealand

Sexual Activity

Many young people are sexually active before they turn 18 years of age. A national study in 1995 found that 46% of a 20-24 year old sample had first had sexual intercourse by the age of 16 years, and 31% had first had sexual intercourse between the ages of 17 and 19 years of age.^{12,13} A Christchurch study found that, of the students who answered a questionnaire, 49% had

experienced sexual intercourse. The mean age of the sample was 16.7 years. 39% of sexually active participants had had one partner in their lifetime and 13% had had more than five partners.¹⁴

Sexually Transmitted Infection

New Zealand has a high (and increasing) rate of bacterial sexually transmitted infections (STIs). For example, the rates for Chlamydia and Gonorrhoea are five and two times higher respectively, than those reported in Australia. A disproportionately high rate of bacterial STIs occurred among people aged 25 years or younger, with approximately two-thirds of Chlamydia, Gonorrhoea and Genital Warts cases occurring in this age group.¹⁵

Chlamydia is the most common bacterial sexually transmitted infection in New Zealand, but those with the infection will often have no symptoms. Approximately 80 per cent of infected females, and 45 per cent of infected males will have no symptoms. Chlamydia infection can lead to infertility, ectopic pregnancy and chronic pain. Chlamydia also causes eye and lung infections in infants born to women with the STI.

The Institute of Environmental Science and Research (ESR) statistics show a steady increase in the number of confirmed chlamydia cases based on surveillance data from Family Planning, Sexual Health and Student and Youth Clinics. These findings are consistent with the laboratory surveillance data for the Waikato, Bay of Plenty and Auckland regions where rates of the STI have increased from about 350 per 100,000 to about 650 per 100,000 (1998-2003).¹⁶

- An audit undertaken in 2004 found that the rate of chlamydia infection in pregnancy is higher in women under 25 years. (12.2 per cent under 25 year olds compared to 2.3 per cent in pregnant women over 25 years).¹⁷
- A Christchurch study showed that 2.0% of sexually active senior high school students have asymptomatic *C. trachomatis* infections.¹⁴

New Zealand is classified by the World Health Organisation as a “low prevalence” country for HIV/AIDs. Gradual changes in the demographic composition of those being diagnosed with HIV in New Zealand have been occurring over recent years however, with increasing diagnosis of this condition in previously relatively uninvolved groups such as women.¹⁸ Rates of HIV/AIDs in New Zealand fluctuate but there was an increase in people newly diagnosed with HIV in 2002.

Screening for STIs

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

Screening initiatives amongst asymptomatic young people attending a contraceptive service in Britain found about 10% were infected with chlamydia.¹⁹ Selective screening of women with a combination of the risk factors of being under 25 years, reporting a change of sexual partner, non-condom use,

unintended pregnancy or an inflammatory cervical smear result has been promoted by some.²⁰ This can easily be achieved in the primary care or sexual or reproductive clinic setting, and has become more acceptable to patients with the advent of urine testing for chlamydia, rather than a need to take a cervical swab.

Improved access to screening for chlamydia and other STIs is an important goal. This requires better access to primary care services and primary care services taking the opportunity to offer screening to young people attending for other reasons.

Contraceptive Use

A South Auckland survey on contraceptive usage demonstrated that about half of South Auckland secondary school students reported using some form of contraception to prevent pregnancy every time they have sexual intercourse.²¹ Similar proportions reported using a condom as protection against sexually transmitted infections last time they had sexual intercourse. National data has found that women who first have sex at a relatively younger age are more likely to do so without using any form of contraception, than women who first have sex at a slightly older age. For example, 39% of those who first had sex at 16 years of age or less did not use any form of contraception on this occasion, compared with a lesser 27% of those who first had sex at 17-19 years of age.¹² In recent research amongst abortion clinic attendees, a lack of contraceptive use preceding presentation for termination of pregnancy was much more common in 2002 than it had been in 1995 and 1999.²²

In another study, published this year, half of the students surveyed were sexually active, and fewer than half used condoms on every occasion of sexual intercourse. Only 23 percent of participants said they felt vulnerable to acquiring an STI, with a quarter reporting not using condoms because they did not think that either they or their partner had an infection.²³

In the Christchurch study, cited above, 51% of males and 39% of females indicated that they always used condoms and 69% of males and 57% of females reported using a condom on the last occasion of sexual intercourse.¹⁰ This data suggests a need to markedly increase the proportion of sexually active young people using contraception to prevent pregnancy, and barrier contraception to prevent STIs.

A recent study assessed the association between sources of information and sexual behaviour among female adolescents. The authors observed that adolescents exposed to information about safer sexual practices among the primary individuals in their lives were more likely to be engaging in these behaviours themselves. Two primary sources of information on sex and contraceptive use for female adolescents were family and friends.

In the study, 892 female adolescents ages 15-18 who were part of a larger study and who reported prior sexual activity were selected and completed a paper-and-pencil survey designed to assess health status and risk behaviours. About 40% of participants had heard discussions about sexual intercourse, contraceptive use, or condom use among family members, and over 75% had heard such discussions among friends. Compared with participants who had first used condoms between ages 16 and 18, those who had never used condoms were less likely to have heard discussions about sexual intercourse among friends.

Participants who had delivered one child were less likely than those who had never had a child to have heard discussions about contraceptive use among friends. Importantly, no associations were observed between use of contraception at first or last intercourse or age at first intercourse and having heard discussions about sexual intercourse among family members or friends. A stronger association was observed between having had four or more partners and having heard discussions about condom use among family members or friends. Relative to participants who had never used condoms, those who had used them at least half the time were more likely to have heard discussion about condom use among family members or friends.²⁴

Overseas evidence shows that young men who have sex with significantly younger women are far less likely to use contraception and more likely to have a resultant pregnancy.²⁵

Access to Condoms and Contraceptives

Condoms and contraceptives are provided on site by some health care services, such as sexual health and FPA clinics, however this should become the norm in other primary care settings as well. Condoms are also available on a practitioner's supply order and could easily be provided to young people, in particular, within the practice setting.

The Wellington Sexual Health Service provides clinics at several sites (Wellington, Porirua) and offers condoms on request, without appointment.

Pharmacists are able to provide condoms directly from pharmacies and they are also able to provide ECP ("morning after pill"), however there are often cost barriers. Condoms are also available for individuals to purchase from supermarkets, service stations and vending machines.

Support for making inexpensive condoms obtainable from store settings, rather than just through healthcare practices can be found from the fact that most adolescents reported obtaining or planning to obtain condoms from stores rather than healthcare settings in a US study.²⁶ Furthermore, research in the US has found that cost is a real barrier to condom use.²⁷ In an investigation into the fate of condoms distributed in a free initiative in the Republic of South Africa it was reassuringly found that less than 10% wastage had occurred by the 5 week follow-up mark.²⁸

Key Access Issues for Young People Accessing Health Services

Issues for youth health service delivery are complex, however there are key, reoccurring issues for youth health.²⁹

- **Access:** This is a critical issue in youth health and includes practical considerations such as cost, location of services, convenience and service promotion and less tangible considerations, such as appropriate practice.

- **Acceptability:** This issue includes consideration of service environment, front-line services, gender and cultural staff balance, transparent procedures for conduct, practice and feedback. Confidentiality in a youth health service is also paramount. Research suggests that many young people choose not to access a service due to concerns about confidentiality.
- **Specialist Staff:** With youth health being an ‘emerging area,’ finding specialist youth health staff across disciplines (doctors, nurses, social workers, counsellors, peer support workers, health promoters) is a challenge.
- **Quality of Care:** Youth health service providers need to recognise the complexity and diversity of young people’s health needs. This issue also refers to effective assessment and risk screening frameworks, safety of services and intervention ‘styles’ (for example, using early intervention and health promotion approaches).
- **Continuity of Care:** Young people often access a health service preceded by a process of decision making that questions whether they feel safe accessing a service. Once the decision is made, it is imperative the trust young people have placed on the service provider is honoured. If young people are required to see a number of different practitioners, and share their personal information repeatedly, the success of the service in terms of health outcomes is potentially, greatly reduced.³⁰

Primary Care for Young People

An Auckland survey of 10,000 young people found that half identified significant barriers to accessing primary health care. The study found that existing health services do not meet the needs of young people effectively and very few services provide the comprehensive care required for young people with multiple health needs.

There is strong international and local evidence that supports the development of youth specific primary health services, youth appropriate secondary care services and public health programmes that effectively engage young people as full and equal participants.^{31, 32, 33}

School-based health centres have been specifically identified as initiatives that improve young people’s access to health care, particularly for young people from disadvantaged backgrounds.³³

Another key facet of designing services that work was identified to be the involvement of young people in programme design.

Primary care features that have been shown to be associated with increases in condom and contraceptive use are: improving advertising about where young people can go for help; having youth-friendly, accessible services; having young, non-judgemental staff, providing confidential advice; making trained peer supporters available; providing information to young people about their options including via innovative media.¹

Integral to sexual health services is the opportunity to discuss feelings about sexuality, discuss decisions about sexual activity and have support to manage relationship issues. Peer support workers, counsellors and primary care

professionals can all provide this support, with appropriate referral where issues are complex.

Particular support is required for young people living with disability, moving through adolescence to adulthood. Health professionals need to be aware of the sexual health and potential adjustment issues and ensure appropriate support.³⁴

The provision of contact tracing and delivery of antibiotics directly to sexual contacts of those who have been diagnosed with an STI, who are unlikely to seek treatment for themselves, is common internationally.

Finally, there is good evidence that short term programmes to improve sexual health (reduce infection and unwanted pregnancy) have little impact and that a longer term approach to accessible information and services is required.¹

Consultation

This paper reports on four informal consultation meetings with young people, and a recent full meeting of the CCDHB Youth Health Advisory Group (5 May 2005). Consultation meetings were held with Peer Support Workers from Evolve Youth Service and Kapiti Youth Support; a sub-group of the CCDHB Youth Health Advisory Group; and a young people connected to School's Out.³⁵ This adds to the considerable youth consultation already undertaken locally, already available and informing service planning.^{36,37,38,39}

Young Men

In all groups consulted, specific issues for young men with regards to sexual health were important. Young people reported significant access issues for young men. This is consistent with commentary on access issues for young men in youth health literature and service utilisation data from many primary youth health services, in all areas of primary care, not just sexual health. It was suggested that it is possible some youth health services (e.g. Evolve, Kapiti Youth Support, Porirua School Clinics) may get an inaccurate reputation with young people as being sexual health services, which may increase access barriers for young men. However, school clinics and the specialist sexual health service in the Wellington Region do report more favourable access rates for young men. This is consistent with national trends.

Young people suggested some reasons why access was an issue for young men:

- Young men don't see sexual health as their responsibility, therefore there is a need to target them more and use specific strategies
- "Guys think there are invincible"
- Young men don't necessarily take action after unprotected sex – compared to young women who are more likely to request the ECP, and then there is the opportunity to request or suggest a sexual health check at the same time
- Media messages that young men need to have lots of sex

Specific Issues for Māori and Pacific Services for Young People

Young people in Wellington and Porirua suggested cultural awareness and understanding was important in sexual health care, and thought that the diversity of young people in the CCDHB region, required a diversity of service models. It was suggested that currently primary sexual health services largely follow a traditional and homogenous model of care.

Young people suggested that the assumption that Māori and Pacific young people want to be grouped together by ethnicity in the delivery of services and programmes is not always correct, and can be an assumption that leads to access barriers. Many of those consulted favoured youth specific models of care that were culturally aware, culturally diverse and used Māori and Pacific 'styles of practice' in service delivery, over parallel Māori and Pacific youth

services. Young people stressed the importance of more Māori and Pacific staff available within mainstream services.

There were specific issues raised around the tensions with 'by Pacific, for Pacific' service models. It was suggested that in some situations this model actually created major problems across all groups of young people, including perceptions around some people getting different/better services than others, as well as the standard religion/confidentiality/family concerns of Pacific-delivered services for young Pacific people.

The 'intra-Pacific' issues (between groups within the 'Pacific Community' (sic)) were discussed by the CCDHB Youth Health Advisory Group. These issues included the prejudices and assumptions inherent with grouping all young Pacific together and a general sense of health professionals generally having low expectations of young Pacific people, particularly with regard to their sexual health care. Both of these issues were seen as discriminatory.

Gay, Lesbian and Bisexual Young People

Issues for gay, lesbian and bisexual (gay) young people with regard to sexual health services were discussed in all groups, without prompting. Young people suggested that services for gay young people needed to be incorporated within mainstream services, but there was a critical issue with knowing whether the mainstream services were safe for gay young people to access. Specific and targeted service and health information resources for gay youth was seen as important.

Access, Stigma, Non-Judgemental Services and Confidentiality

General issues of access, stigma, judgemental services and discrimination with regard to young people's sexual health were well discussed and was seen as a major issue, but complex. The recurring issues discussed included:

- Confidentiality was stressed more in Kapiti than in other areas
- It was suggested that young people are more likely to make contact with a service initially, if they don't have to see anyone (e.g. web, email, phone contact initially)
- High rates of sexual health need, but low rates of service access for some groups of young people, particularly 'street youth' and young people disconnected from work, school or study
- Particular stigma issues for young mothers - extra support is required, including appropriate post and pre natal care.

Knowledge and Variety of Services

Perhaps the clearest theme to come through was young people's concern with the lack of promotion/marketing of what services are available and how to access them. This is consistent with concerns raised during the Hutt Valley District Health Board review of primary sexual health services. There is no specific, co-ordinated approach for marketing primary sexual health services for young people in the region – services are expected to promote access to the services they provide.

Young people's perception that current sexual health services follow a homogenous and traditional model of care was mentioned earlier. Young people

stressed that a diversity of services needs to be available using different service approaches/models. “Young people want a choice of services - if adults get a choice, why do young people get dealt with in a lump?”

Comments And Perception Of Current Services (Clinical And Public Health)

There were a variety of comments on current services available – they are listed below:

On FPA

- “FPA is ok”
- “FPA is intimidating – from the lift you have to take to get up there, to the reception desk and their whole way of doing things.”

On *Hubba Hubba* Campaign

- “So funny and weird, it works.”
- “Every time you hear the music, you go and see if it is the gay one.”
- “Why is it only the late night ad that the two guys are shown kissing?”
- “Really lame, but catchy”

On sexual health promotion, education and information

- “Sex education in schools can be very straight-focussed, and can ignore queer issues.”
- Sex education needs to start young (3rd form or earlier), but there still needs to be education for 6th and 7th formers too – more advanced
- “Education needs to focus on risks and worst case scenario stuff”
- *Sex Wise* has recently been touring in the Wellington region – “...it was great, but should be for younger people too – not just 6th and 7th formers”
- Availability and knowledge of dental dams is limited
- Gay appropriate sexual health information is limited
- Not enough promotion in migrant communities – need to involve schools in promotion activities

On Youth Specific Primary Health Services

- “Evolve is low maintenance - you choose how involved you want to get and when you do it. Rec programmes increase access to the clinic”
- “Porirua School Clinics generally work really well. Some are scared of accessing the services though”
- “Often get a different doctor every time you go”
- Evolve and KYS clinics are often full up

On Other Primary Health Services

- “I’m not sure that it’s safe to say I’m gay in a health service. It needs to be out there that they’re ok with me.”
- Services being judgemental is a key access issue. Sometime young people think older staff are judging.
- Grumpy Nurses are a big barrier
- Price in GP clinics is an issue – it’s not always free, and it’s difficult to work out if the clinic is part of the WIPA scheme, without having to overtly ask the receptionist

Other Issues

- Counselling and support services around relationships and reasons behind unsafe sexual practice is important, and not very available at the primary health level
- “There are not that many youth friendly-services“
- Some wondered whether the public health nurses could provide more sexual health services (contraception, sexual health screening and education) in schools where there are no school clinics.

Analysis: Service Models and Ideas²⁷

There were a myriad of creative ideas for addressing the issues young people raised in terms of services. They are detailed in the table below.

There was universal endorsement of the primary youth health service models in place at Evolve Youth Service (Evolve) and Kapiti Youth Support (KYS).

Young people emphasised that they did not think primary sexual health services should be provided in ‘sexual health only’ services, but should be integrated with other primary youth health services.

Provision for after hours primary sexual health care, particularly access to emergency contraception needs to be considered in new service modelling.

The list is not exhaustive, and the key issues for specific groups of young people identified in the previous section should be kept in mind. Key groups that may require either specific strategies or careful thinking and planning on how mainstream services can be appropriate were:

- Refugee and Migrant Young People
- Rangatahi
- Young Pacific People
- Young Men
- Gay Young people
- Young People not connected to school, work, study, family

It is important to *emphasise* that young people suggested sexual health services should be provided within a broader primary youth health service framework, and that a diversity of service models and approaches was critical to attract a diversity of young people.

Table 2: Primary Sexual Health Service Models And Ideas

Support for Primary Care	
Primary Care Consultation and Liaison Service	<ul style="list-style-type: none"> ♣ Training (currently provided by Wellington Sexual Health Service under the existing Primary Care agreement) for primary care providers providing sexual health services ♣ Consultation with primary care providers focussed on specialist clinical advice, dissemination of best practice and quality ♣ Co-ordination and support of a Primary Sexual Health Providers Network (PSHPN)
Training – youth appropriate practice	Training for primary care workers providing specific services for young people on youth appropriate practice (could be provided by a youth health service provider)
Service Promotion	
Collaboration with the Hutt Valley District Health Board, sexual health promotion providers and the Wellington Sexual Health Service should be explored for these initiatives.	
<i>Text</i>	Provision of a text number (e.g. *739 (*SEX)) that young people can text sexual health service and issue questions and get responses.
<i>Queer and Youth Friendly ‘Campaign’</i>	Some sort of low key campaign that would identify providers of sexual health services that were appropriate and safe for gay young people as ‘queer friendly’ (e.g. sticker on the door of service and promotion in specific print/web material)
<i>One Phone Number</i>	One phone number (preferably a free phone number that could be called from mobile phones) that young people could use to access information all sexual health services available, ask basic sexual health questions, and make appointments with any of the services available.
<i>Print and Web</i>	<ul style="list-style-type: none"> ♣ One brochure/poster that covers all services ♣ Services should be promoted as youth health services, not just sexual health services ♣ Posters/information in schools, supermarkets, video parlours, internet cafes ♣ Advertisements in school diaries ♣ Posters/information in bathrooms (in Zeal, public toilets, libraries, schools) ♣ Specific sexual health information for gay young people
<i>Other forms of advertising</i>	Radio advertising and billboards were also suggested as possible means of advertising services (or phone, text or web contact details to get service information).
Support/Allied Health Services	
<i>Allied Health Services</i>	Support services which complement medical and nursing services were seen as important components of a

	<p>comprehensive youth sexual health services. Support services could include peer support, community health work, youth work or counselling.</p> <p>Support services could be used for a variety of sexual and reproductive health issues ranging from contraception advice, pregnancy options counselling, pre HIV testing support, pre and post termination of pregnancy support, brokerage to specialist services, relationship counselling and support, sexual abuse counselling and support, and referral.</p> <p>Counselling/Social/Health services would all need to be 'under one roof' and free.</p>
Medical and Nursing Services	
<i>Sexual health clinics at Evolve</i>	Holding one (or more) sexual health clinics at Evolve Youth Service (as is done at the Hutt Valley Youth Health Service/VIBE). ¹
<i>Outreach clinics</i>	<ul style="list-style-type: none"> ♣ KYS providing outreach nursing and/or medical services/clinics (low key, suitcase style clinics) to the two high schools in Kapiti. ♣ Outreach clinics from Evolve into schools or other youth spaces.
<i>PHO located services</i>	<ul style="list-style-type: none"> ♣ Free access to primary care medical and nursing sexual health services for young people (12-24 years) ♣ PHOs asked to submit proposals to provide free access to sexual health services for young people. Proposals to be informal and intended as a means of PHOs reflecting on strategies to increase access to services for young people, and being intentional about service design and planning. ♣ Provision of services is <i>not</i> dependant on a young person's enrolment with that particular PHO.
<i>Porirua Services</i>	Sexual health services as part of any new youth health (outside existing school based) services established in Porirua.
<i>Training for front line staff</i>	Provision of training for front-line staff (receptionists, et al). Front line staff need youth appropriate practice skills and training.
<i>General issues to address in nursing and medical services</i>	<ul style="list-style-type: none"> ♣ Youth appropriate and non-judgemental staff: - "...you need a mix of staff – if it's lots of older people, young people can feel like a minority." ♣ "Young people (working there) and talking about sexual health is important" ♣ It's pretty important to have gay staff too" ♣ It's good to have services you can just drop in to and not have to make an appointment ♣ All services should be free for 12-24 years, wherever they are, irrespective of CSC status

¹ Since this consultation in mid-2005, a specialist sexual health service clinic has started with a nurse-led clinic once/month.

	<ul style="list-style-type: none"> ♣ Consider clinical services being provided outside of traditional clinic/office environments ♣ Consider providing transport to services for young people ♣ Consider provision for making prescription medicines more accessible for young people.
Health Promotion and Health Education	
<i>Training for youth workers and teachers</i>	Acknowledging the importance of youth workers and teachers' roles with young people in terms of brokering service access and providing basic information on sexual health and relationships.
<i>Information for parents</i>	Provision of service and sexual health information for parents and families.
<i>School Clinic staff more involved in education</i>	Porirua School Clinic nursing and medical staff more involved in other health initiatives and sexual health education within the school.
<i>Environmental audits</i>	Environments services are provided in are key to encouraging and increasing access. Clinic environmental audits would see youth health professionals and young people who work with young people visit services, 'auditing' for youth appropriateness, and providing advice on how the environment could improve access.
<i>Young people 'encouraging dialogue' on sexual health</i>	Not formal health education, but other initiatives to encourage dialogue on sexual health issues, e.g. peers providing forums for young people in youth spaces (e.g. youth centres)

Sexual Health Promotion

Sexual health promotion to ensure young people are safe, have information, control and good sexual health requires action at all levels: policy development, creating supportive environments, re-orienting services, strengthening community action and building personal skills. All this needs to be achieved in a manner that acknowledges the values of different ethnic, religious and generational groups, in different settings, languages and youth-friendly- style. Using and developing the relevant evidence for New Zealand adds another layer of challenge.

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

“Sex education” is one mechanisms for building personal skills. Characteristics of effective sex education programmes:

Characteristics Of Effective Sex Education Programmes:

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

Schools

The Health and Physical Education Curriculum Essence Statement 2005 states:

In health education students develop their understanding of factors that influence the health of individuals, groups and society: lifestyle, economic, social, cultural, political and environmental. Students develop competencies for mental wellness, reproductive health and positive sexuality, safety management and understanding nutritional needs. Students build resilience through strengthening personal identity and self worth, managing change and loss, and engaging in processes for responsible decision making. They develop empathy along with other interpersonal skills that enhance relationships. Students use these skills

and understandings to take critical and collective action for personal and societal well-being.⁴⁰

Schools aims to provide young people with balanced, evidence-based information about sexual health and sexual activity and examine attitudes and values relating to sexuality. However, sexuality education is a curriculum area to be addressed by Boards of Trustees who are legally required to consult with their communities and then direct or refrain from directing the school regarding the elements of sex education to be taught.⁴¹ Given this process, there is significant variability in whether or what schools provide in terms of sex and sexuality education.

A review of the sexual and reproductive health education provision, in a sample of 100 schools from around New Zealand, was conducted by the Education Review Office in 1995.⁴² The review found relatively limited information provided to year 7 and 8 students and a piecemeal approach being used by many schools at the secondary school level, with the omission of some core subject areas in many cases. Few schools provided as much as 14 hours per year of sexual and reproductive health education, as is suggested by research to be necessary for effective education in this area. Many schools appear to have chosen the resources most easily obtained rather than the best available. Programme delivery was usually by school staff plus outside 'experts', rather than just by one or the other. Only a minority of schools provided clinical support services, such as a school nurse, health clinic or visiting health professionals, to back up their education programmes.

Public Health Providers

Provider	Coverage	Services
Family Planning Association	Nationwide- Porirua/ Wellington/Hutt	Sexual health promotion, education, resources. Provides school based health promotion usually in the form of 1-2 sessions per year, and presentations to youth groups, adult groups, events, and disabled persons.
Te Puawai Tapu	Porirua/Wellington	Peer education programme for year 9&10, and new work with youth groups, Kura and other settings
NZ Prostitutes Collective	Nationwide/ Wellington	Health promotion targeting the sex industry includes information about STI's, safer practices, protection, free condoms for street workers, liaison with industry work places.
NZ Aids Foundation	Nationwide	Sexual health promotion within the MSM communities, presentations to groups e.g. schools, youth groups etc
Theta	Nationwide	Sexual health, nutrition, alcohol and drug school based drama, they present to most schools in the region x1 per year.
Regional Public Health	C&CDHB	General policy and advice Maori-health promotion, liaison Pacific health promotion, liaison

Kaupapa Maori Services Providing Sexual Health Promotion

Provider	Activity	Location	Funder
----------	----------	----------	--------

Te Puawai Tapu	Peer education programme for year 9&10, and new work with youth groups, Kura and other settings (in development)	Porirua, Wellington	MOH
Ngā Whakatauki Trust.	Previous contract for sexual health promotion, particularly for Maori sex workers. More recently working under Whānau Ora paradigm.	Wellington	C&CDHB

In 2003, the Ministry of Health hosted a Forum for Maori working in Kaupapa Maori organisations delivering sexual and reproductive health services.

A key issue identified was that clinical services are separated from health education and promotion-type services. Kaupapa Maori organisations expressed the need for integrated sexual and reproductive health services, and to make these more whanau-orientated where this is appropriate.

Pacific resources

The Pacific Communications team has completed an audit of current Pacific resources in the sexual health arena. After careful consultation with Pacific sexual health providers and workers, the team has decided to develop a resource for parents that we hope will be translated into four Pacific languages. This will complement the youth radio campaign that will run on Niu FM's youth show.⁴³

National Sexual Health Campaign

In support of the Government's Sexual and Reproductive Health Strategy (2001), the Ministry of Health funded a communication campaign (summer of 2004/2005) to promote and increase safer sexual health practices.

The health objective of the campaign was to reduce the incidence of STIs among this audience. The key goal for the campaign was for at least 80 percent of the priority audiences (15 to 19 year old New Zealanders - with emphasis on Māori rangatahi and Pacific youth) to be aware of the campaign. The campaign materials and website also discuss the wider issues of youth sexual health - such as the consequences of having sex. Young people are encouraged to think carefully about the sexual decisions they make. Parents and caregivers are encouraged to talk to their teenagers about sex, and to discuss the wider issues like understanding that sexual relationships involve caring, concern and responsibility.

How Were The Messages Promoted?

- The campaign included TV, cinema, radio, magazines and outdoor media.
- Events were used to further promote the message, and to distribute more detailed information and sample condoms.
- Printed resources including posters and booklets provided additional information.
- In addition a communications plan kept the issue in the media throughout the campaign

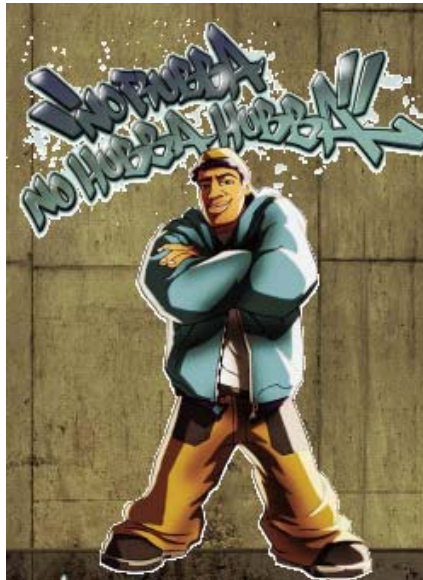
Commercials

- Using the chosen concept, two variations of the commercial were developed: one featuring a male-female couple, and one a male-male couple.
- Two voice-overs were recorded one focussing on chlamydia and gonorrhoea, the other on HIV.
- The voice-overs rotated between the two versions
- Te Reo versions played on Maori Television

Website

- A website – www.hubba.co.nz – was another information source for young people.
- The Hubba website continues to be extremely popular; to date 2.8 million hits have been received. If you have a spare moment, check it out - www.hubba.co.nz.

Campaign Evaluation



Knowledge of STIs

- Don't know much about individual infections.
- Some knew that STIs can have a permanent or temporary impact on health (or can be potentially fatal in the case of AIDS).
- A small number knew that some STIs can be without symptoms, eg, chlamydia.
- Some knew that chlamydia can cause infertility.
- Most knew that STIs can be passed on but don't typically consider the spreading effect.
- Overall STIs were not a major concern for many – pregnancy is more of a worry (particularly for females).
- Most believed there is a low risk of getting an STI because a condom would typically be used in perceived risky situations, e.g. having sex with a stranger.
- STIs weren't a regular topic of conversation for either males or females.
- Likely to believe they knew enough about STIs.

- Unlikely to seek further information about STIs until after the event.

Main Findings

- 49 percent of respondents indicated the campaign had ‘definitely’ or ‘probably’ increased their likelihood of using condoms in the future. The percentage was the same (49%) for Maori but higher for Pacific people (63%)
- The proportion of respondents who said they would still have sex if no condom was available decreased significantly between the pre and post campaign (36%, down from 46%)
- There has not been a change in proportion of youth who agree having a condom is still necessary when having sex with someone they are going out with or know well

Awareness Of Advertising Increased

- Awareness of STI advertising rose from 25 percent to 73 percent
- Awareness of condom advertising rose from 52 percent to 77 percent
- Awareness of condom use rose from 28 percent to 80 percent

Key Messages

Key messages taken from the advertisement were

- To always use condoms (54%)
- No condoms no sex (28%)
- Have safe sex (14%)
- Condoms offer the best protection (10%)

Conclusion

The Hubba Hubba campaign has worked well to

- Stimulate awareness,
- Get the audience talking and acting
- Bring the sector together to support consistent messages going forward
- Make a first step to increase condom use and reduce STIs

In summary, awareness of advertising about STIs, condoms and condom use increased dramatically pre and post the campaign. The ‘No Rubba, No Hubba Hubba’ television advertisement had a high unprompted recall.

Sexual Health Consultations – Primary Care

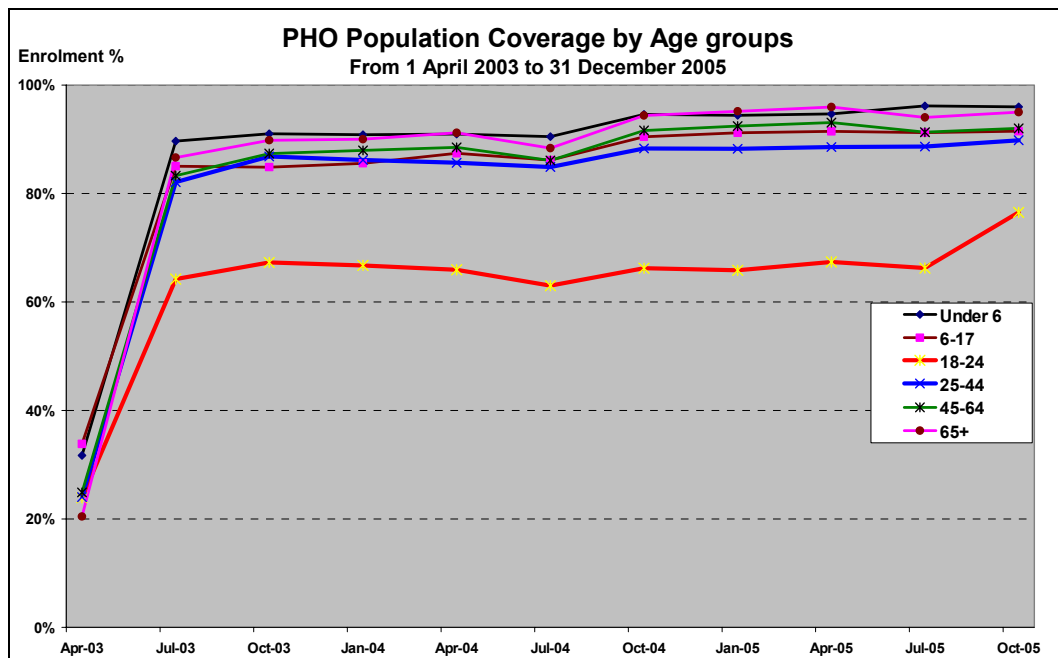
To access primary care services, young people can attend general practices, student health services, youth health services (Wellington, Kapiti), school clinics (Porirua), Family Planning Clinics, Union health services, Maori providers, Pacific health services, Te Aro Clinic and Wellington People’s Centre. Most of these providers are members of the six Primary Health Organisations (PHOs) in the District. Family Planning, Student Health at Whitireia and Kapiti Youth Support.

Practices/primary health services within PHOs receive additional subsidy to reduce the cost of normal consultations for people under 25 years enrolled with them. Sexual health consultations are additionally funded so that they can be offered free to people under 25. Young people can be seen as ‘casual’ patients in primary care and, for sexual health consultations, the GP or nurse visit is normally still funded to be free for people under 25 years. Sometimes young people prefer to use a provider other than their ‘normal’ GP or service for sexual health issues.

PHO Enrolment

Young people may not have a regular GP or be enrolled with a PHO – Figure 1 below summarises PHO coverage by age group in C&CDHB. While this graph measures PHO enrolment (where a person is registered), the utilisation data following this relates to the provider where the consultation occurred.

Figure 1: Quarterly Enrolment Trends – By Age Groups across 6 PHOs



The graph of PHO enrolment shows that enrolment for 18-24 year old age group with PHOs has been lower than in other age groups. However, the percentage of the population in this age group enrolled has increased in late 2005, assisted in

part by increased subsidy for GP consultations in PHOs and the MeNZB™ (meningococcal B immunisation) campaign. However, as illustrated in Table 3, the annual utilisation (average visits per person per year) for GP services in PHOs is relatively low in both the 6-17 year age group and the 18-24 year olds.

Table 3: Quarterly and annual primary care service utilisation by age groups

Age groups	Quarter start date:				Annual Utilisation
	01/04/2004	01/07/2004	01/10/2004	01/01/2005	
Under 6	0.97	1.09	0.97	0.71	3.7
06-17	0.31	0.34	0.32	0.27	1.2
18-24	0.28	0.29	0.30	0.28	1.1
25-64	0.44	0.44	0.48	0.43	1.8
65 and over	1.40	1.14	1.32	1.20	5.1

Information on Utilisation of Current Services

C&CDHB funds primary care providers (General practices, youth health services, school clinics) to provide free consultations to young people and others through a range of historical contracts: some fund people under 19, 19-24 year olds with community service cards and people over 24 with clinical signs and symptoms and 'hardship'; others fund people under 25 years or over 25 with community service card while other providers have contracts with the Ministry of Health (Family Planning). Although general practitioners and primary health services provide a large number of sexual and reproductive health related appointments, comprehensive data on this is unfortunately not available for all providers. Where the 'claim' is not required to obtain funding and there is no fee to the patient, there is relatively little incentive to record the visit as a sexual health consultation in the invoicing system of primary care services. Hence, the data for 'fee-for-service' (WIPA) practices is more accurate and complete.

Wellington Independent Practitioners Association (WIPA) Practices

C&CDHB contracts with WIPA to deliver primary sexual health services through its member GP practices.

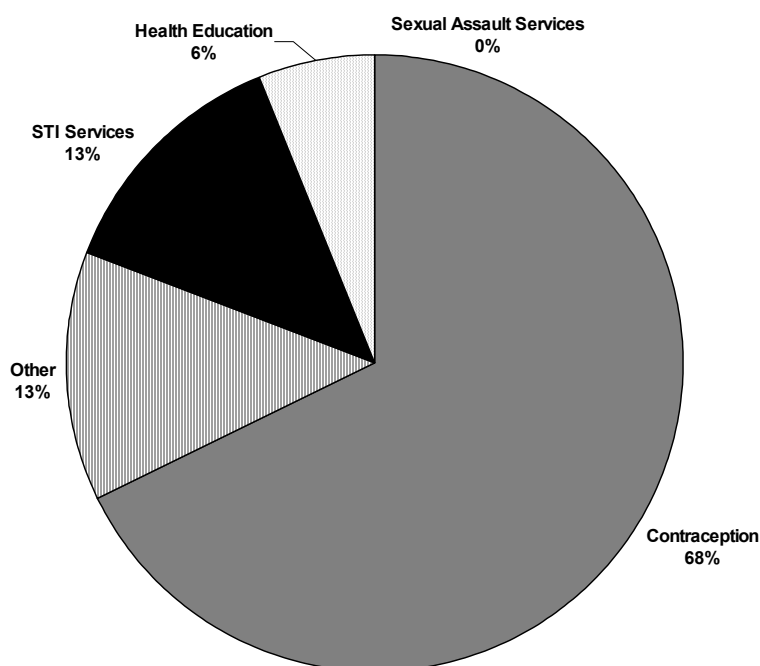
General practices affiliated with WIPA provide primary sexual health services directly to patients for no charge, and then claim the consultation from WIPA. Consultations may be provided by GPs or Practice Nurses, depending on the nature of the consultation.

All GPs and nurses in the programme must attend training. Consultations cannot be claimed unless the appropriate training has been attended.

WIPA also are contracted to provide clinics in four secondary schools in Porirua.

Although information on reason for visit is incomplete (60% of consultations have no reason recorded), visit type information is presented below for those consultations where data is available (2138 out of 5394 consultations for under 25 year olds). Note that for WIPA data, date is based on the date the claim was received and not the actual date of consultation.

Figure 2: Consultation types, WIPA practices, under 25 years, claims received January to June 2005



Source: Wellington Independent Practitioners Association

- The main reasons for sexual health consultations were contraception (68%) followed by sexually transmitted infection services (13%).

Table 4: WIPA practices, number of consultations by age and gender, claims received January to June 2005

Gender	<15 years	15-19 years	20-24 years	Total <25 years
Female	85	2625	2436	5146
Male	0	109	139	248
All	85	2734	2575	5394

Source: Wellington Independent Practitioners Association

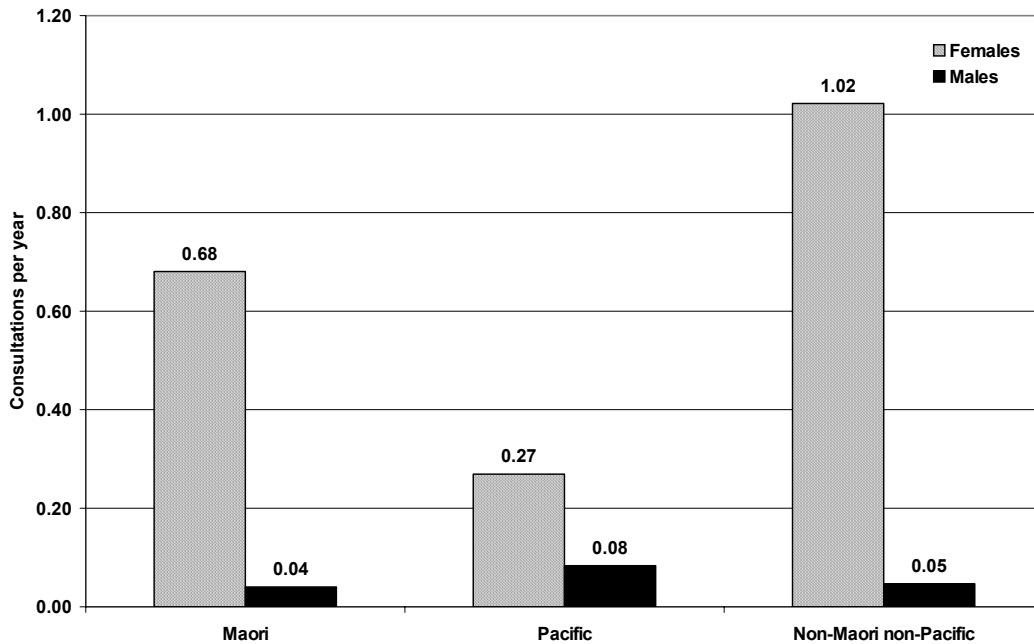
- For 95% of sexual health consultations for people aged under 25 years, the patient was female.

Table 5: WIPA practices, number of consultations by ethnicity and gender, under 25 years, claims received January to June 2005

Gender	Maori	Pacific	Non-Maori non-Pacific	Unspecified	Total
Female	435	99	4434	178	5146
Male	23	31	181	13	248
All	458	130	4615	191	5394

Source: Wellington Independent Practitioners Association

Figure 3: WIPA practices, utilisation rates by ethnicity and gender, age 15 to 24 years, claims received January to June 2005, consultations per year



Source: Wellington Independent Practitioners Association

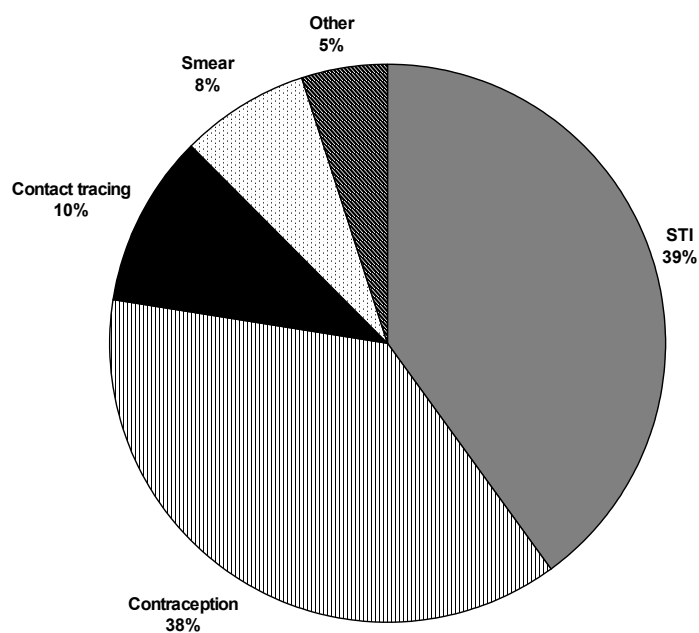
- For females, non-Maori non-Pacific youth had the highest utilisation rate (for sexual health consultations) at WIPA practices (1.02 visits per year).
- Pacific had the lowest female utilisation rate.

Porirua Union and Community Health Service

Porirua Union and Community Health Service (PUCHS) provides free sexual health consultations, including free cervical smears. The service is funded through a fixed funding arrangement (capitation) rather than on the basis of a fee claimed for each visit. Because this service is not specifically funded 'per visit', there is likely to be under-reporting of sexual health consultations.

Services are provided by GPs and nurses who attend ongoing sexual health training provided by WIPA and other training providers.

Figure 4: Consultation types, PUCHS, under 25 years, January to June 2005



Source: Porirua Union and Community Health Service

- The most common reasons for sexual health consultations were sexually transmitted infections (39%) and contraception (38%).

Table 6: PUCHS, number of consultations by age and gender, January to June 2005

Gender	<15 years	15-19 years	20-24 years	Total <25 years
Female	1	11	24	36
Male	0	4	0	4
All	1	15	24	40

Source: Porirua Union and Community Health Service

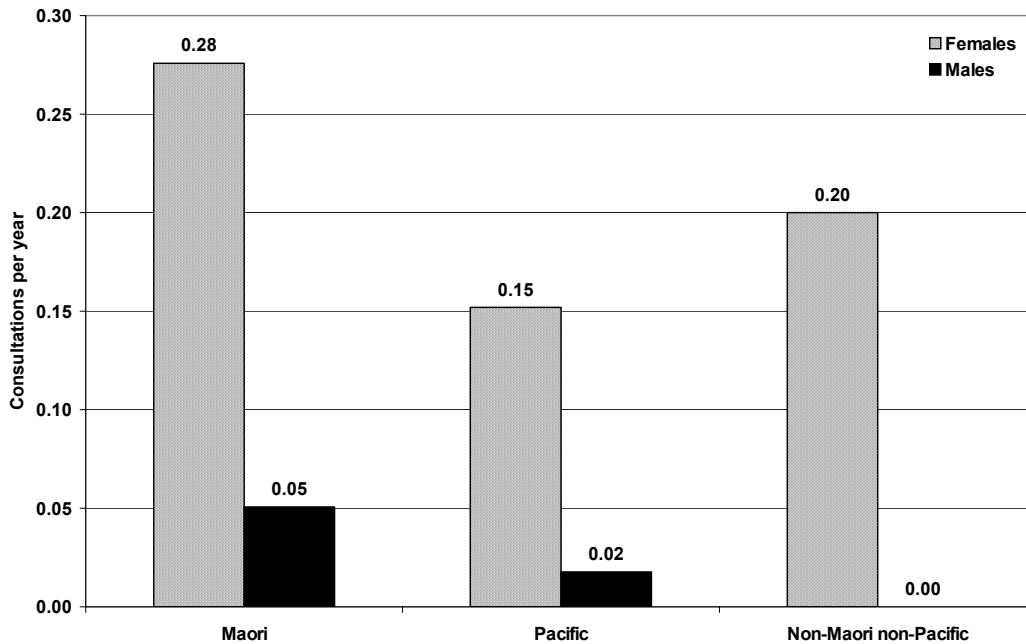
- For 92% of sexual health consultations for people aged under 25 years, the patient was female.

Table 7: PUCHS, number of consultations by ethnicity and gender, under 25 years, January to June 2005

Gender	Maori	Pacific	Non-Maori non-Pacific	Total
Female	13	18	5	36
Male	2	2	0	4
All	15	20	5	40

Source: Porirua Union and Community Health Service

Figure 5: PUCHS utilisation rates by ethnicity and gender, age 15 to 24 years, January to June 2005, consultations per person per year



Source: Porirua Union and Community Health Service

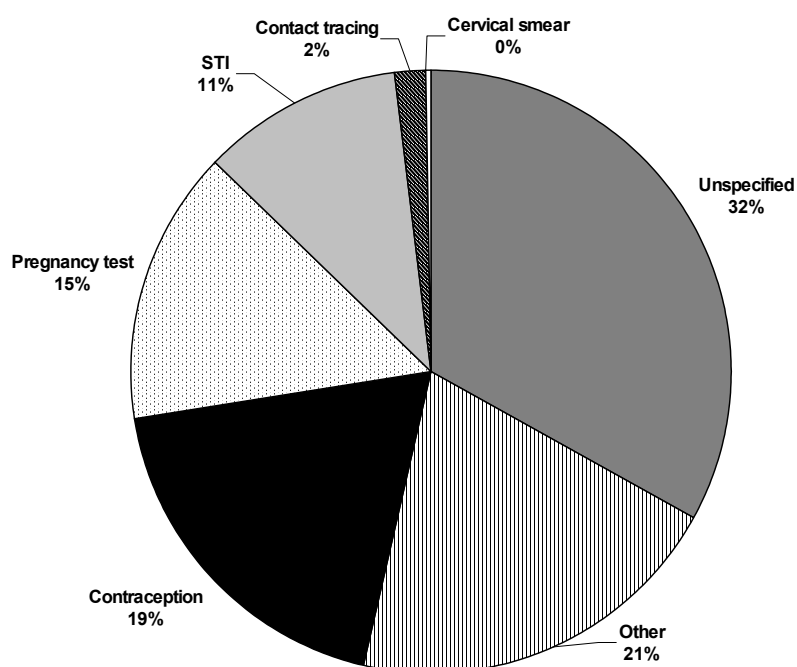
- For both males and females, Maori had the highest utilisation rate for young people aged 15 to 24 years.
- Pacific had the lowest female utilisation rate.

Ora Toa

Ora Toa has four general practice sites – Cannon’s Creek, Mungavin Avenue and Elsdon/Takapuwahia in Porirua and a recently opened general practice in Newtown. Ora Toa provides free sexual health consultations, funded through a capitation contract. Because the service is not funded ‘per visit’, there is likely to be under-reporting of sexual health visits.

Services are provided by general practitioners and nurses who undergo primary care training provided through the contract with WIPA.

Figure 6: Consultation types, Ora Toa, under 25 years, January to June 2005



Source: Ora Toa

- The most common reasons for sexual health consultations were contraception (19%) and pregnancy testing (15%).

Table 8: Ora Toa, number of consultations by age and gender, January to June 2005

Gender	<15 years	15-19 years	20-24 years	Total <25 years
Female	7	78	140	225
Male	3	5	9	17
All	10	83	149	242

Source: Ora Toa

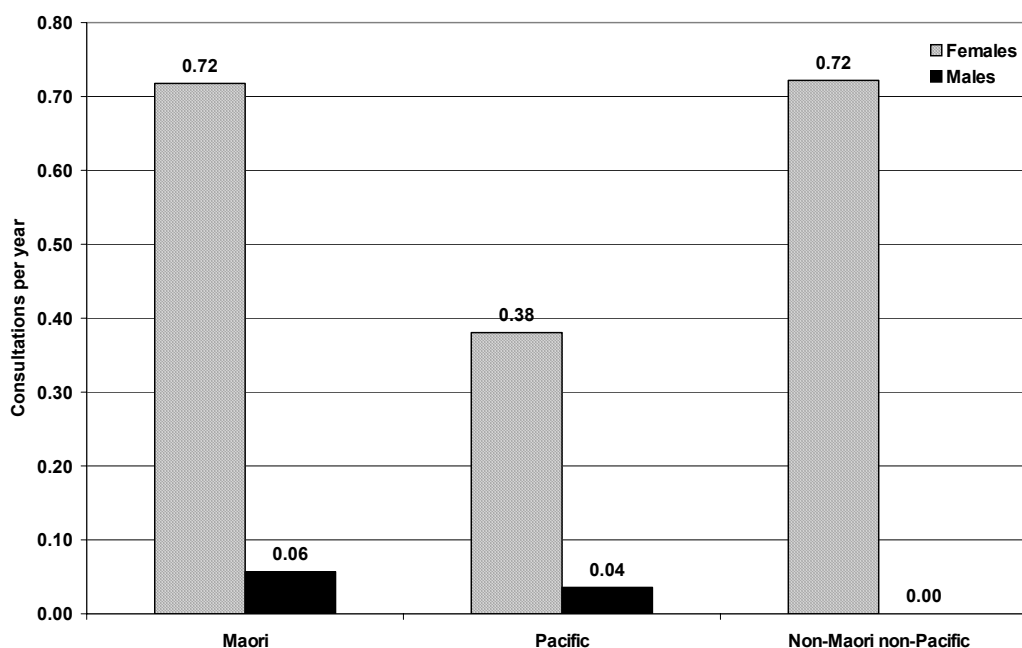
- For 93% of sexual health consultations for people aged under 25 years, the patient was female.

Table 9: Ora Toa, number of consultations by ethnicity and gender, under 25 years, January to June 2005

Gender	Maori	Pacific	Non-Maori non-Pacific	Unspecified	Total
Female	106	81	35	3	225
Male	8	9			17
All	114	90	35	3	242

Source: Ora Toa

Figure 7: Ora Toa utilisation rates by ethnicity and gender, age 15 to 24 years, January to June 2005, consultations per year



Source: Ora Toa

- Both Maori females and non-Maori non-Pacific females had similar utilisation rates.
- Pacific had the lowest female utilisation rate.

Newtown Union Health Service

Newtown Union Health Service offers free sexual health visits to all age groups and free cervical smears. The sexual health funding has been on a capitation (bulk funding) basis so there is likely to be under-reporting of sexual health consultations.

Consultations are not presented by service type for Newtown Union Health Service as reason for consultation was not included in the data set.

Table 10: NUHS, number of consultations by age and gender, January to June 2005

Gender	<15 years	15-19 years	20-24 years	Total <25 years
Female	3	37	102	142
Male	2	4	6	12
All	5	41	108	154

Source: Newtown Union Health Service

- For 92% of sexual health consultations for people aged under 25 years, the patient was female.

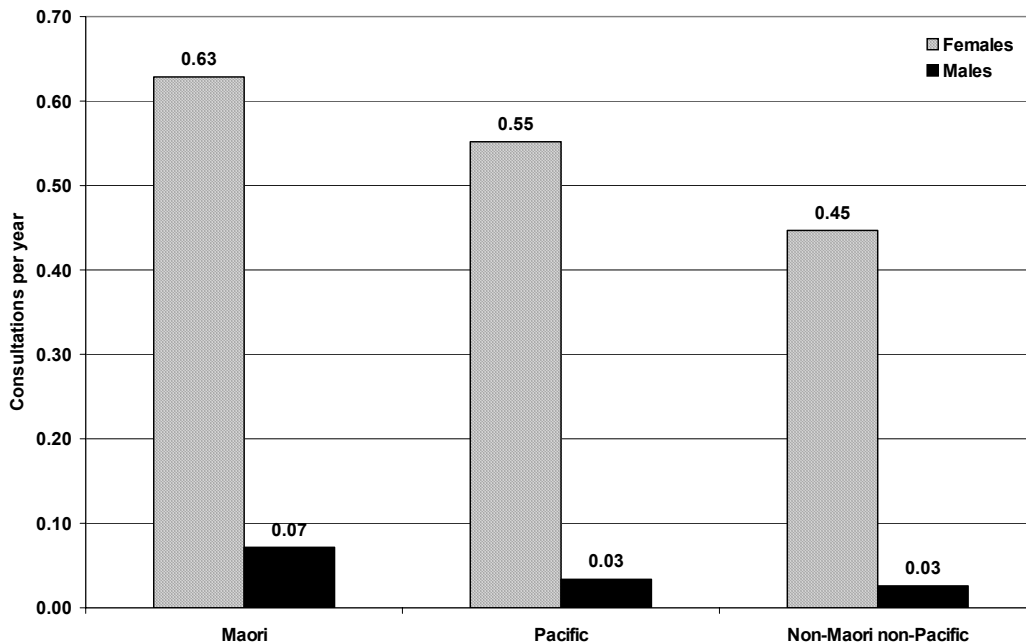
Table 11: NUHS, number of consultations by ethnicity and gender, under 25 years, January to June 2005

Gender	Maori	Pacific	Other	Total
--------	-------	---------	-------	-------

Female	33	26	83	142
Male	3	3	6	12
All	36	29	89	154

Source: Newtown Union Health Service

Figure 8: Newtown Union Health Service utilisation rates by ethnicity and gender, age 15 to 24 years, January to June 2005, consultations per year



Source: Newtown Union Health Service

- For both males and females, Maori had the highest utilisation rate for sexual health consultations.
- For both males and females, Non-Maori non-Pacific had the lowest utilisation rate (for males non-Maori non-Pacific had the same rate as Pacific).

Karori Medical Centre

Karori Medical Centre (KMC) is part of Karori PHO. Sexual health is funded on a capitation basis (bulk funding) and KMC were unable to provide specific information required in the timeframe.

Summary of Primary Care Providers

It should be noted that utilisation rates are probably not directly comparable between providers as they may have different service structures, and recording practices for sexual health consultations may differ between providers. Utilisation rates have been presented to look at relative differences between ethnic groups for each provider.

Table 12: Summary of consultations by provider, ethnicity and gender, 15 to 24 years, January to June 2005

Provider		Maori		Pacific		Other	
		Female	Male	Female	Male	Female	Male
WIPA ¹	Number	412	23	98	31	4375	181
	Rate ²	0.68	0.04	0.27	0.08	1.02	0.05
PUCHS	Number	12	2	18	2	5	-
	Rate ²	0.28	0.05	0.15	0.02	0.20	0.00
Ora Toa	Number	103	7	78	7	35	-
	Rate ²	0.72	0.06	0.38	0.04	0.72	0.00
NUHS	Number	33	3	24	2	82	5
	Rate ²	0.63	0.07	0.55	0.03	0.45	0.03

Source: WIPA, PUCHS, Ora Toa, NUHS

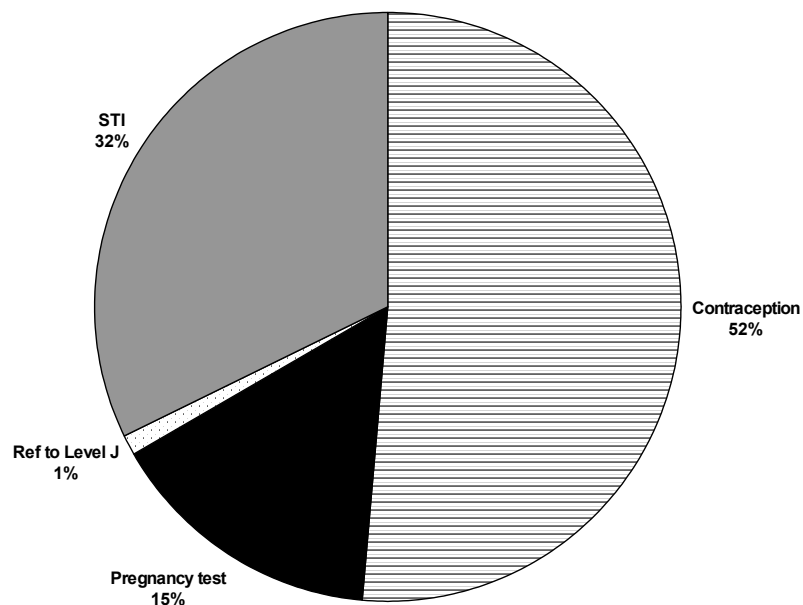
Note:

1. WIPA consultation dates are based on the date the claim was received, and not the actual date of consultation.
2. Utilisation rate is average number of consultations per person per year (denominator is the population registered at that practice aged 15 to 24 years).
3. Note also that number of consultations may vary from those presented in previous tables (for <25 years) as they only include consultations for patients aged 15-24.

Kapiti Youth Support

Kapiti Youth Support provides free GP and nurse consultations for sexual health from their service in Kapiti. Peer support workers at KYS are trained to support young people in accessing services and information, and lead health promotion activities.

Figure 9: Consultation types, Kapiti Youth Support, under 25 years, January to June 2005



Source: Kapiti Youth Support

- The main reasons for sexual health consultations were contraception (52%) and sexually transmitted infections (32%).

Table 13: Kapiti Youth Support, number of consultations by age and gender, January to June 2005

Gender	<15 years	15-19 years	20-24 years	Total <25 years
Female	134	769	205	1108
Male	4	45	11	60
All	138	814	216	1168

Source: Kapiti Youth Support

- For 95% of sexual health consultations for people aged under 25 years, the patient was female.

Table 14: Kapiti Youth Support, number of consultations by ethnicity and gender, under 25 years, January to June 2005

Gender	Maori	Pacific	Other	Unspecified	Total
Female	211	13	840	44	1108
Male	14	2	43	1	60
All	225	15	883	45	1168

Source: Kapiti Youth Support

Utilisation rates have not been presented for Kapiti Youth Support as denominator information was not available in time for this report.

Evolve

Evolve is a youth-led youth health service in central Wellington. All consultations, including sexual health consultations are free, provided by nurse or GP with peer support workers providing liaison and information.

Consultations are not presented by service type for Evolve as reason for consultation was not included in the data set.

Table 15: Evolve, number of consultations by age and gender, January to June 2005

Gender	<15 years	15-19 years	20-24 years	Total <25 years
Female	36	191	95	322
Male	1	18	15	34
All	37	209	110	356

Source: Evolve

- For 90% of sexual health consultations for people aged under 25 years, the patient was female.

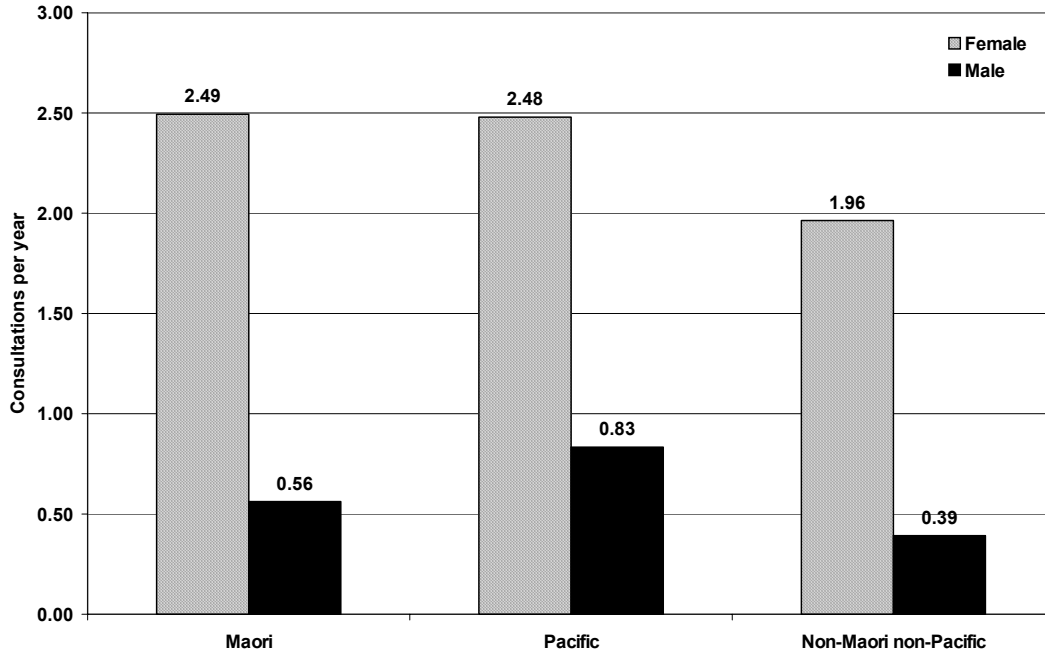
Table 16: Evolve, number of consultations by ethnicity and gender, under 25 years, January to June 2005

Gender	Maori	Pacific	Other	Total
Female	103	31	188	322

Male	9	5	20	34
All	112	36	208	356

Source: Evolve

Figure 10: Evolve utilisation rates by ethnicity and gender, age 15 to 24 years, January to June 2005, consultations per year

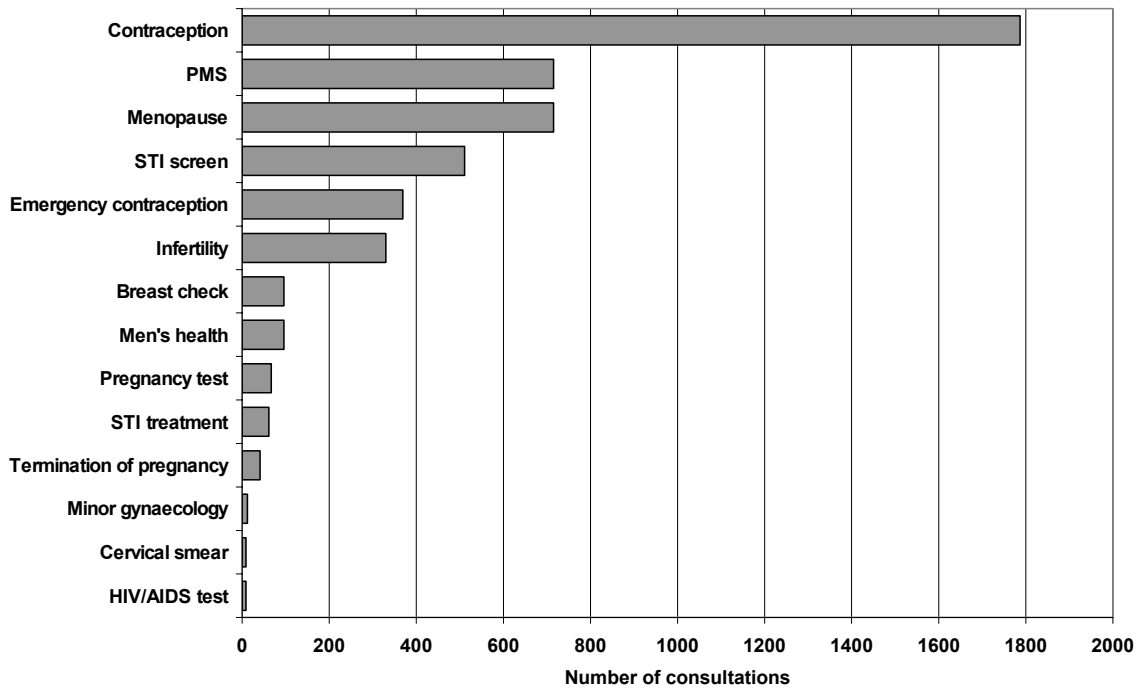


Source: Evolve

- Evolve had high sexual health utilisation rates compared to other non-youth specific primary care providers (different service structure).
- Maori and Pacific females had similar utilisation rates, while the rate for non-Maori non-Pacific was lower.
- Pacific males had the highest rate, followed by Maori and then non-Maori non-Pacific males.

Family Planning Association

Figure 11: Family Planning Association consultation activities, January to June 2005



Source: Family Planning Association

Note: More than one activity/reason may be recorded for a single consultation.

- The most common reason for consultation at Family Planning was contraception (40% of visits included contraception as all or part of the consultation).

Table 17: Family Planning, number of consultations by age and gender, January to June 2005

Gender	<16 years	16-19 years	20-21 years	22+ CSC ¹	Total
Female	213	1647	1385	1057	4302
Male	0	56	46	49	151
All	213	1703	1431	1106	4453

Source: Family Planning Association

Note:

1. Community Services Card

- For 97% of sexual health consultations at Family Planning (people aged under 22 or 22+ with a Community Services Card) the patient was female.

Table 18: Family Planning, number of consultations by ethnicity and gender, under 22 years or 22+ with a CSC¹, January to June 2005

Gender	Maori	Pacific	Other	Total
Female	408	219	3675	4302
Male	20	10	121	151

All	428	229	3796	4453
-----	-----	-----	------	------

Source: Family Planning Association

Note:

1. Community Services Card

School Health Clinics

From 1 January to 30 June 2005 there were 2747 consultations at the four school clinics (Aotea, Mana, Porirua and Viard colleges). During this period there were 2578 “read codes” recorded. Read codes form a comprehensive clinical coding system which covers medical terms and procedural and administrative terms. The codes are not limited to diagnostic and procedural codes, but also include codes for symptoms, test results, screening, family history and many other areas. Of the 2578 read codes recorded, 17% (442) were sexual health related.

The tables that follow are based on the number of read codes assigned rather than consultations (as read codes are assigned to patients, not consultations, in the patient management system). Read codes are closely enough aligned to consultations to give a fairly good proxy for consultation activity.

Table 19: School health clinics, sexual health read codes by school and gender, January to June 2005

School	Sexual health read codes	% of total read codes that were sexual health
Aotea	144	26%
Mana	262	16%
Porirua	29	13%
Viard	7	4%
Total	442	17%

Source: Wellington Independent Practitioners Association

Table 20: School health clinics, sexual health read codes by age and gender, January to June 2005

Age	Female	Male	Unspecified	Total
13	23			23
14	74		2	76
15	143	4		147
16	82	4	9	95
17	75	5		80
18	13	1		14
19	3			3
20	1			1
31	3			3

Source: Wellington Independent Practitioners Association

- For 94% of sexual health read codes at school health clinics the patient was female.

Table 21: School health clinics, sexual health read codes by ethnicity and gender, January to June 2005

Gender	Maori	Pacific	Other	Unspecified	Total
Female	219	68	123	7	417
Male	7	2	4	1	14
Unspecified			11		11
Total	226	70	138	8	442

Source: Wellington Independent Practitioners Association

Sexually Transmitted Infections (STIs)

- Sexually transmitted infections (STIs) are infections that can be acquired through sexual contact. The common STIs in New Zealand are chlamydia, genital warts, gonorrhoea, genital herpes and, in males, non-specific urethritis (NSU).⁴⁴

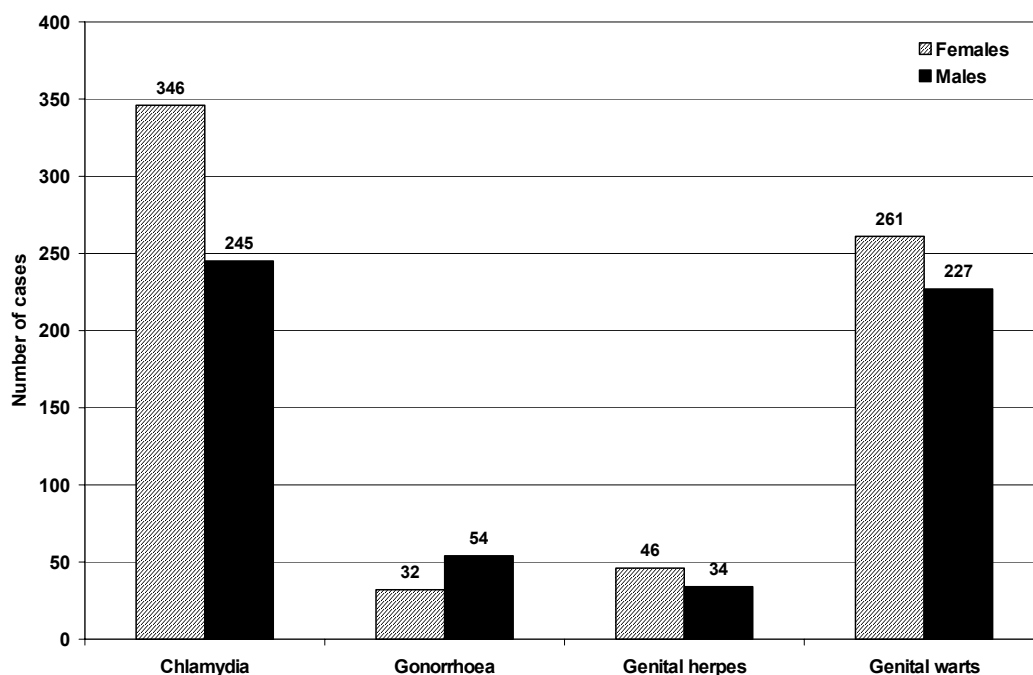
Sexually Transmitted Infections in C&CDHB

There is incomplete data because sexually transmitted infections (STIs), except AIDS, are not notifiable in New Zealand, and surveillance is based on data from specialist sexual health clinics (SHCs), Family Planning clinics (FPCs) and student and youth health clinics (SYHCs).

The number of STI cases reported through the clinic-based system *underestimates* the true burden of disease in New Zealand, because a substantial proportion of STIs are diagnosed by other health care providers, particularly GPs and other primary health care practitioners. A comparison of clinic-based and laboratory data undertaken by ESR, for areas where both are collected, indicated that the incidence of chlamydia is three times higher than that reported from clinics, and twice as high for gonorrhoea.⁴⁵

Note that the clinic-based data cannot be used to calculate population rates. Rates presented in this section are the total number of reported cases divided by the total number of clinic visits for any reason. Infection rates in different clinical settings are not directly comparable due to wide variation in the range of services provided. Surveillance is not in place at all sexual health, Family Planning, or student and youth health clinics.

Figure 12: STI clinic surveillance for Capital &Coast (SHC, FPC, SYHC) under 25 years, 2004



Source: Institute of Environmental Science and Research Limited. www.surv.esr.cri.nz

Chlamydia

Table 22: Number and rates of Chlamydia cases by sex and health care setting, under 25 years, 2004

Clinic type	Number of confirmed cases			Total number of cases			Rate (% of clinic visits)		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
SHCs	82	120	202	99	181	280	0.3	0.5	0.4
FPCs	148	31	179	214	57	271	0.3	1.2	0.3
SYHCs	32	7	39	33	7	40	0.1	0	0.1

Source: Institute of Environmental Science and Research Limited. www.surv.esr.cri.nz

Note:

1. **Confirmed:** Laboratory detection in a clinical specimen. Cases should be classified as:
 - a. Uncomplicated infection of the lower anogenital tract (includes urogenital and anorectal infection)
 - b. Pelvic Inflammatory Disease or epididymitis
 - c. Infection of another site (eg eye or pharynx)
2. **Probable:** Cases must be all of the following:
 - a. Symptomatic, and
 - b. A contact of a confirmed case, and
 - c. Non-laboratory confirmed (test negative or test not done)

Gonorrhoea

Table 23: Number and rates of Gonorrhoea cases by sex and health care setting, under 25 years, 2004

Clinic type	Number of confirmed cases			Total number of cases			Rate (% of clinic visits)		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
SHCs	11	33	44	16	49	65	0	0.1	0.1
FPCs	13	3	16	16	5	21	0	0.1	0
SYHCs	-	-	-	-	-	-	-	-	-

Source: Institute of Environmental Science and Research Limited. www.surv.esr.cri.nz

Note:

1. “ - “ denotes number of cases less than five.
2. *Confirmed*: Laboratory isolation from a clinical specimen. Cases should be classified as:
 - a. Uncomplicated infection of one or both of the following – urogenital tract – anorectal area
 - b. Pelvic Inflammatory Disease or epididymitis
 - c. Extra-genital infection of one or both of the following – pharynx – other site not listed
3. *Probable*: Cases must be all of the following:
 - a. Symptomatic, and
 - b. A contact of a confirmed case, and
 - c. Non-laboratory confirmed (test negative or test not done)

Genital Herpes

Table 24 Number and rate of Genital Herpes (first presentation) cases by sex and health care setting, under 25 years, 2004

Clinic type	Total number of cases			Rate (% of clinic visits)		
	Female	Male	Total	Female	Male	Total
SHCs	30	34	64	0.1	0.1	0.1
FPCs	16	-	18	0	-	0
SYHCs	-	-	-	-	-	-

Source: Institute of Environmental Science and Research Limited. www.surv.esr.cri.nz

Note: “ - “ denotes number of cases less than five.

Genital Warts

Table 25: Number and rate of Genital Warts (first presentation) cases by sex and health care setting, under 25 years, 2004

Clinic type	Total number of cases			Rate (% of clinic visits)		
	Female	Male	Total	Female	Male	Total
SHCs	217	214	431	0.6	0.6	0.6
FPCs	38	13	51	0	0.3	0.1
SYHCs	6	-	9	0	-	0

Source: Institute of Environmental Science and Research Limited. www.surv.esr.cri.nz

Note: “ - “ denotes number of cases less than five.

Hepatitis B

Hepatitis B is a viral diseases that can be spread through sexual contact, in addition to other potential forms of transmission, such as through blood contact. Hepatitis B causes inflammation of the liver and can develop into a chronic form that is associated with a risk of hepatocellular carcinoma, a form of liver cancer. Immunisation to prevent the acquisition of Hepatitis B infection is available and should be offered to young people who have not already been vaccinated or who are non-immune.

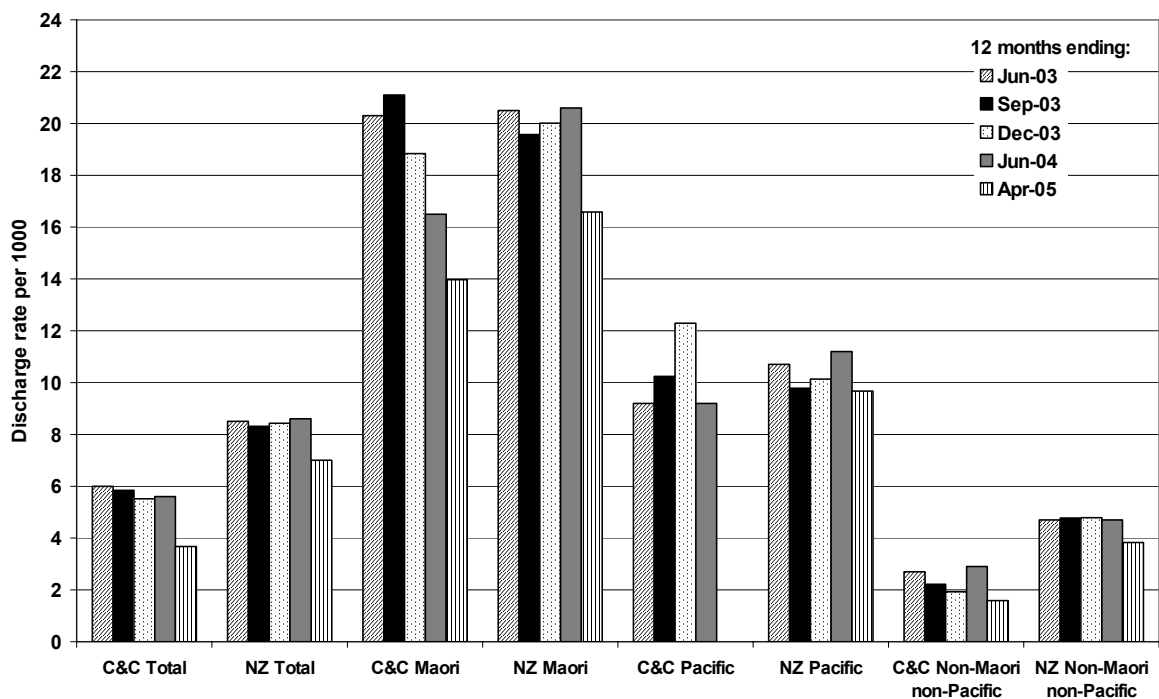
Teenage Pregnancy

Teenage pregnancy is defined as pregnancy in 13-17 year old age group. New Zealand has a comparatively high rate of teenage births (27.3 per 100,000), in comparison with other developed nations.⁴⁶ Our teenage birth rate was found to be the third highest of 28 nations in a UNICEF study, behind only the United States (at 52.1 per 100,000) and United Kingdom (at 30.8 per 100,000). The rate of teenage births among Maori young women in this country is particularly high (74 per 100,000).

Of potential concern because young mothers may miss out on educational and training opportunities. There is also a relatively high rate of unexpected/unwanted pregnancies amongst this group. However, some young women and men choose parenthood at a relatively early age and many, whether or not their pregnancy was a deliberate choice, are happy to become parents.

C&CDHB

Figure 13: Teenage deliveries by ethnicity, mothers aged 13 to 17 years, rate per 1000



Source: Ministry of Health – NMDS indicators

Note:

- a. 12 month periods are not at equal intervals.
- b. Only includes births in public hospitals.

Table 26: Teenage deliveries by ethnicity, mothers aged 13 to 17 years, 12 months ending April 2005, rate per 1000

	Maori	Pacific	Non-Maori non-Pacific	Total
Capital and Coast	14.0 (8.7, 22.2)	-	1.6 (0.8, 2.9)	3.7 (2.6, 5.2)
New Zealand	16.6 (15.2, 18.1)	9.7 (8.0, 11.7)	3.8 (3.5, 4.2)	7.0 (6.6, 7.4)

Source: Ministry of Health – NMDS indicators

Note:

1. Only includes births in public hospitals.
2. 95% confidence intervals are shown in brackets underneath the rate.

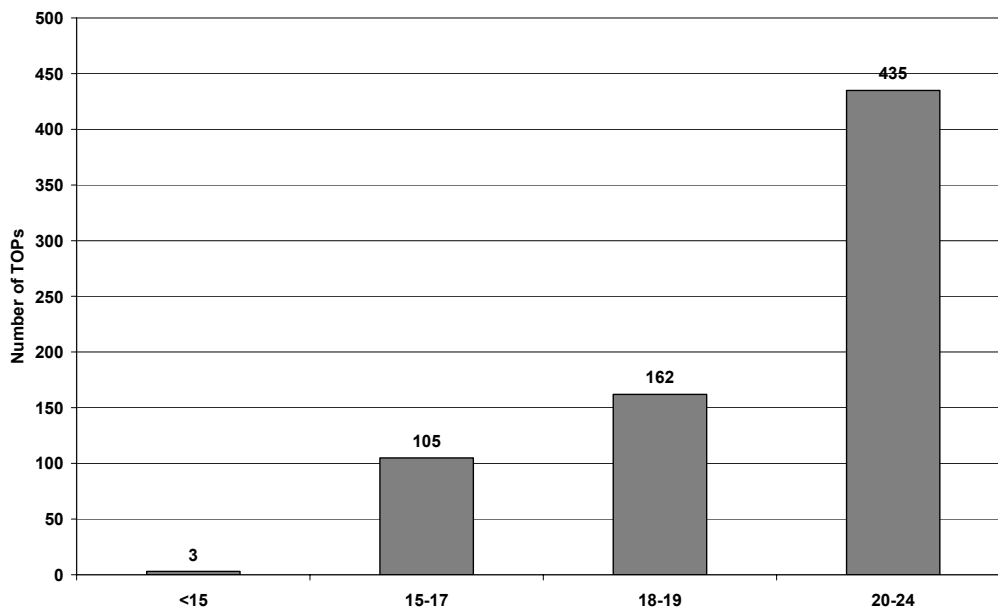
The overall Capital and Coast rate for teenage deliveries is significantly lower than the New Zealand average. Rates for all groups in the district are lower than national averages, however the difference is only significant for Non-Maori non-Pacific. Maori teenagers in the district have a significantly higher delivery rate than the district average. The rate for Maori in Capital and Coast has decreased over the last two years.

Termination of Pregnancy

Termination of pregnancy (TOP) are legally regulated in New Zealand under the Contraception, Sterilisation and Abortion Act 1977. Nationally, the greatest number of abortions are performed for 20-24 year olds and this age band is also showing the greatest rate of increase.

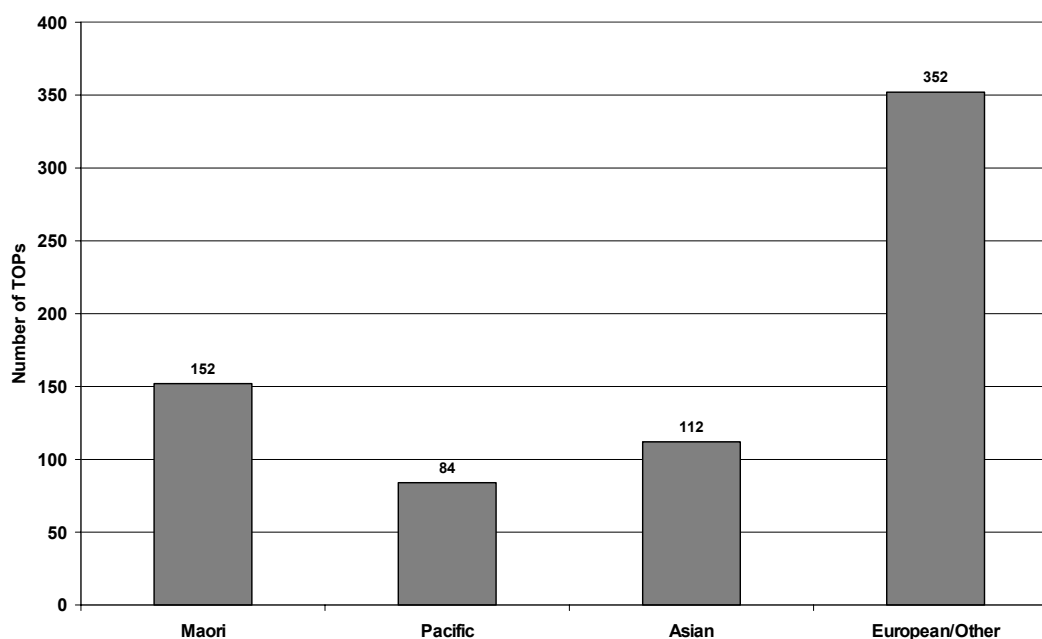
In 2004, there were 705 terminations of pregnancy performed for females aged under 25 years living in the Capital and Coast district. The greatest number of TOPs was in the 20 to 24 year old age group .

Figure 14: Number of TOPs by age group, 2004



Source: Level J Unit, Capital and Coast District Health Board

Figure 15: Number of TOPs by ethnicity, under 25 years, 2004



Source: Level J Unit, Capital and Coast District Health Board

Note: Cases where ethnicity was unspecified (five cases) are excluded from the above graph.

The greatest number of TOPs was for European/Other ethnic group. However, Maori, Pacific and Asian females are over-represented in TOP statistics. For females aged 15 to 24 years having a TOP in 2004 Maori made up 22% (only 12% of female youth population), Pacific made up 12% (only 9% of female youth population), and Asian made up 16% (only 10% of female youth population). (Note population figures are Census 2001 total response).

Table 27 TOP rates by ethnicity, 2004, age-specific rate per 1,000

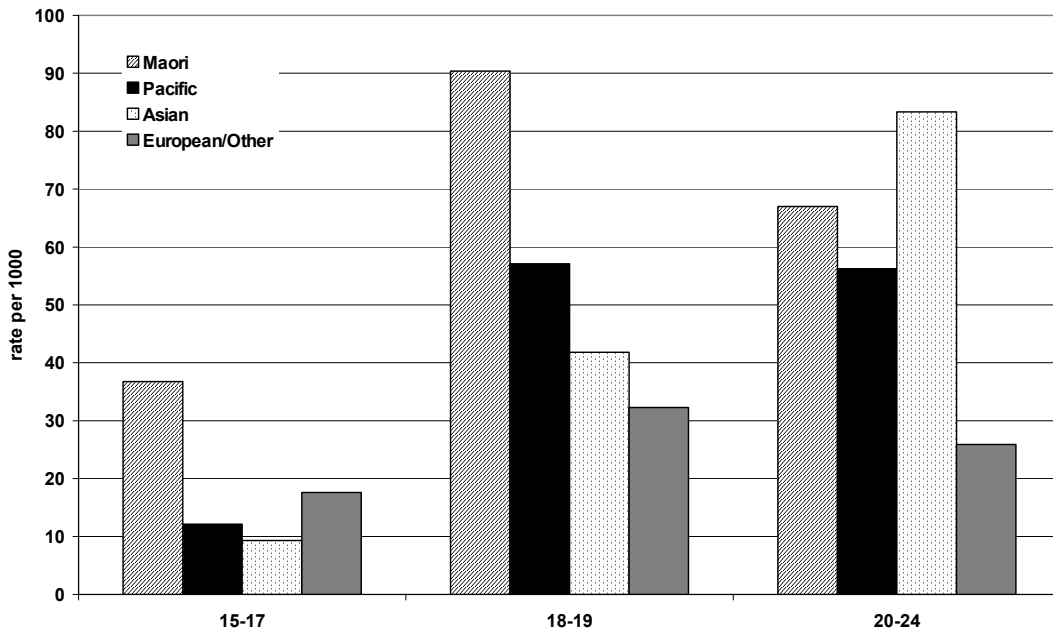
	Maori	Pacific	Asian	European/Other	Total
15-17 years	36.7	12.1	9.3	17.6	18.7
18-19 years	90.4	57.1	41.8	32.3	43.4
20-24 years	67.0	56.2	83.3	25.9	39.0

Source: Level J Unit, Capital and Coast District Health Board

Note:

1. Population denominator is Census 2001 total response.
2. Population denominators for the 15-17 and 18-19 year age groups have been pro-rated from 15-19 years population count.
3. Rates for less than 15 years are not presented as the raw number was less than five.
4. Cases where ethnicity was unspecified (five cases) are not presented.

Figure 16: TOP rates by ethnicity, 2004, age-specific rate per 1,000



Source: Level J Unit, Capital and Coast District Health Board

Although the greatest number of terminations is in the 20 to 24 year old age group, on a 'per population' basis, 18 to 19 year olds have a higher rate of TOPs. Maori females had the highest TOP rate in the 15 to 17 and 18 to 19 year age groups. For the 20 to 24 year olds, Asian females had the highest TOP rate. Pacific females aged 18 to 24 also had a high termination rate.

Note that these may not be true population rates, as Capital and Coast residents who go out of the district for a termination of pregnancy are not included.

References

1. Ministry of Health. Sexual and Reproductive Health: A resource book for New Zealand health care organisations. 2003.
2. Ministry of Youth Affairs. Youth Development Strategy Aotearoa. Min Youth Affairs: Wellington 2002.
3. C&CDHB Health Needs Assessment 2005. www.ccdhb.org.nz
4. Ministry of Health. Sexual and Reproductive Health Strategy – Phase One. Ministry of Health. Wellington, 2001.
5. Ministry of Health. The New Zealand Health Strategy. Min of Health: Wellington. 2000
6. Ministry of Health. Youth Health. A Guide to Action. Ministry of Health: Wellington 2002.
7. Ministry of Health. An Integrated Approach to infectious Disease. Priorities for Action 2002-2006. Ministry of Health: Wellington 2001.
8. King A. He Korowai Oranga. The Maori Health Strategy. Min of Health: Wellington. 2002
9. King A. The Pacific Health and Disability Action Plan. 2002.
10. Ministry of Health and Ministry of Pacific Island Affairs. Tupu Ola Moui: Pacific Health Chart Book. Ministry of Health: Wellington 2004.
11. Minister for Disability Issues . The New Zealand Disability Strategy. Making a World of Difference . Whakanui Oranga Ministry of Health: Wellington 2001.
12. Pool I, Dickson J, Dhamalingam A, Hillcoat-Nalletamby S, Johnston K, Roberts H. New Zealand's Contraceptive Revolution. University of Waikato, 1999.
13. Dickson N, Paul C, Herbison P. Adolescents, sexual behaviour and implications for an epidemic of HIV/AIDS among the young. *Genitourinary Medicine*, 69 (2) 133-40, April 1993.
14. Corwin P, Abel G, Wells J et al. Chlamydia trachomatis prevalence and sexual behaviour in Christchurch high school students. *New Zealand Medical Journal* 115(1158):107-14, 2002.
15. Ministry of Health. Based on annual survey of sexually transmitted infections 2001.
16. Institute Environmental Science and Research Sexually Transmitted Infections (STIs) in New Zealand, Annual Surveillance Report 2003, www.surv.esr.cri.nz.
17. Lawton B, Rose S, Bromhead C et al. Rates of Chlamydia trachomatis testing and chlamydial infection in pregnant women. *NZ Med J* 117 2004.
18. Shew R, Say J, Ellis-Pegler R, Thomas M. Human immunodeficiency virus infection in women in Auckland: an evolving epidemic. *New Zealand Medical Journal*. 108(1003): 263-5, Jul 1995.
19. Moens V, Baruch G, Fearon P. Opportunistic screening for Chlamydia at a community based contraceptive service for young people. *British Medical Journal*. 326: 1252-5, June 2003.
20. Chen M, Donovan B. Screening for genital Chlamydia trachomatis infection: are men the forgotten reservoir? *Medical Journal of Australia*. 179:124-5, August 2003.
21. Adolescent Health Research Group. 2003. *New Zealand Youth: a profile of their health and wellbeing*. University of Auckland: Auckland.
22. Goodyear-Smith F, Arroll B. Contraception before and after termination of pregnancy: can be do better? *New Zealand Medical Journal*. 116 (1186), November 2003.
23. Abel G., Brunton C. (2005). Young people's use of condoms and their perceived vulnerability to sexually transmitted infections. *Australian and New Zealand Journal of Public Health* 29:254-260.
24. Berenson AB, Wu ZH, Breitkopf CR, et al. 2006. The relationship between source of sexual information and sexual behavior among female adolescents. *Contraception* 73(3):74-78.
25. Marsiglio W, Ries A, Sonenstein F et al. *It's a Guy Thing: Boys, Young Men and Teen Pregnancy*. Washington DC: National Campaign to Prevent Teen Pregnancy. 2006
26. Klein J, Rossbach C, Nijher H et al. Where do adolescents get their condoms? *Journal of Adolescent Health*. 29 (3): 186-93, 2001.

-
27. Cohen D, Scribner R, Bedimo R, Farley TA. Cost as a barrier to condom use: the evidence for condom subsidies in the United States. *American Journal of Public Health*. 89 (4): 567-8, 1999.
 28. Myer L, Mathews C, Little F, Karim S. The fate of free male condoms distributed to the public in South Africa. *AIDS*. 15 (6): 789-93, 2001.
 29. Central Regional Health Authority (CRHA). 1995. *Whiti te Ra - Young & Healthy: health and disability support services for young people in the Central Region*. Central Regional Health Authority: Wellington.
 30. Ministry of Health. 1995. *Effective Health Services for Young People: Te Toiora o Toku Whanaketanga*. Ministry of Health: Wellington.
 31. Raeburn J, Sidaway A. 1996. *One stop shopping: integrated health, education and social services for young people*. Department of Psychiatry and Behavioural Science, School of Medicine, University of Auckland: Auckland.
 32. Mathias K. Youth-specific primary health care – access, utilisation and health outcomes. *New Zealand Health Technology Assessment Report*. Christchurch, 2002.
 33. McLaren, K. 2002. *Youth Development Literature Review – Building Strength, a review of research on how to achieve good outcomes for young people*. Ministry of Youth Affairs: Wellington.
 34. NZ Paraplegic & Physically Disabled Federation. *When Love is a Challenge*. Wellington. 1979.
 35. Consultation facilitated by S Harger-Forde for C&CDHB. 2005
 36. Ball J. *The Lower Hutt Youth Research Report*. Project Adventure NZ. 2001.
 37. McGachie C. Report to the Wellington City Council of the information gained from the Wellington Youth Project. Wellington Youth Project, Project Adventure. 2001.
 38. Ahmed A, Dagger M, Exeter D et al. *How Healthy Is Our Future? Addressing the Needs of Young People in Wellington*. A Public Health Report for the Wellington Youth Health Service Project. Wellington School of Medicine. 2001.
 39. King P. *The Porirua Secondary Schools' Health Service*. An independent component of the Evaluation Report. Family Centre Social Policy Research Unit. C&CDHB 2003.
 40. Ministry of Education. *NZ Curriculum Maturanga Project –What's Happening in Health and Physical Wellbeing? 2005*
www.tki.org.nz/r/curriculum/whats_happening/health_physical_e.php
 41. Ministry of Education. *Health and Physical Education in the New Zealand Curriculum*. Wellington. 1999.
 42. Education Review Office. *Reproductive and Sexual Health Education: A report provided by the Education Review Office for the Ministry of Health*. Wellington, 1996.
 43. Ministry of Health. *Sexual Health Update*. October 2005.
www.moh.govt.nz/publications/newsletters
 44. Ministry of Health. *Sexual and Reproductive Health: A resource book for New Zealand health care organisations*. Ministry of Health. Wellington, 2003.
 45. Institute of Environmental Science and Research Limited.. 2005. *Sexually Transmitted Infections in New Zealand Annual Surveillance Report 2004*. Wellington: ESR.
 46. Ministry of Health. *Sexual and Reproductive Health: A resource book for New Zealand health care organisations*.