

Sexual Health Over Tairawhiti Strategy S.H.O.T.S

“Relationships, Respect, Whare Tangata”

**“A living document to promote positive attitudes and to reduce
harm”**

Prepared on behalf of the Ministry of Health

by

Tairawhiti District Health

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Executive Summary

Sexuality and reproductive capacity are fundamental aspects of being human. Our sexual and reproductive health and wellbeing is as important to our quality of life as other key aspects of health such as physical and mental health and wellbeing. This is true regardless of age, gender, culture, abilities, sexual orientation or other characteristics that make up our identity.

This strategy was developed over 18 months by the Population Health group within Tairāwhiti District Health (TDH) with a large number of key stakeholders on behalf of the Ministry of Health as funders of sexual and reproductive health promotion services in Tairāwhiti. The strategy focuses on partnership working and collaboration to ensure that sexual and reproductive health and wellbeing become an integral aspect of the existing work of participating organisations. It will build on existing work rather than developing an entirely new area of work.

Aims and Objectives

This strategy aims to improve, protect and promote sexual and reproductive health and wellbeing of young people in Tairāwhiti over the next five years by encouraging the development of healthy personal and sexual relationships. It will do this by providing information, education and services that are health promoting and that seek to reduce the rates of teenage pregnancy and sexually transmitted infections (STIs), in an environment where sexual health and diversity can be discussed in a respectful and culturally appropriate manner.

Scoping the Strategy

TDH convened an inter-sectoral group to scope and draft this strategy on behalf of the Ministry of Health. Focus groups were held with a range of groups to gather the views of people, and in particular youth, who will be affected by the strategy. Finally, evidence from databases were examined to profile the health of this district

Guiding Principles

The strategy incorporates the principles of the Treaty of Waitangi - partnership, participation and protection. These principles provide a framework for Māori and non-Māori to exercise control over their health and well-being.

Action Plan

The strategy acknowledges that sexual health is one of the few areas that affects all people and is relevant throughout a person's life. It recognises that a range of information, education and services exists, and highlights what needs to be done to ensure that these are available, accessible, and acceptable to people at different ages and stages in their life. These actions fall into five key areas: Policy development, improving service delivery, promotion and prevention, education and training, and evidence and information.

Conclusion

Significant time and resources over the last 18 months have been invested in the development of this Strategy: how the Ministry leads the implementation of this Strategy along with stakeholders is critical given this investment. The monitoring and review of the strategy will also be a key requirement. We propose that the five-year strategy is subject to regular review in light of new information, patterns and trends and formally evaluated at the end of the strategy period.

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1. Introduction

Positive sex and sexuality are Government priorities and are a key part of life. As we are sexual beings, positive sexual identity and sexuality are fundamental to our sense of self, self esteem and ability to lead a fulfilling life. Positive sex and sexuality contributes to our individual sense of health and wellbeing. Sexual expression forms an important component of our closest relationships, and adds to our personal fulfilment as human beings, partners and parents. While sex and sexuality play a vital part in our lives, they are often difficult issues to talk about, and are the subject of many diverse and strongly held views.

In this strategy, Tairawhiti stakeholders prescribe towards an environment where sex and relationships can be discussed respectfully, and propose strategies that can develop and support such an environment.

Sexual Health and well-being is a significant population health issue, particularly for Rangatahi /young people. Evidence suggests that the most effective approach to improving Youth sexual health is multi-pronged and combines Population Health, Youth-focussed Primary Health care and comprehensive Sexuality Education¹. There are a number of health and non health providers that are responsible for ensuring that young people in Tairawhiti have access to quality sexual health education, promotion and services, but there are gaps, and as a whole lacks cohesion to move forward.

The "Sexual Health Over Tairawhiti Strategy" (S.H.O.T.S) identifies young people as key 'communities of interest' for its strategic direction. This inclusion is based on evidence that young people are in the highest sexual health risk category. The intention of this strategy is to address two areas of approach:

- Population Health as opposed to a Clinical Service
- Professional training and development.

From a population health perspective, health has been defined not simply as a state free from disease but as "the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish et al., 1996).

S.H.O.T.S subscribes to the definition of sexual health promoted by the World Health Organisation:

¹ Overview of Health Promotion Programmes Report 1999

*'Health is a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'*²

A key barrier in tackling this challenging but essential area of work is the impact of stigma and discrimination. Stigma surrounds many aspects of sex, sexuality and sexual behaviour.

Sexual health is one of the most personally, socially and politically challenging aspects of health inequality. Through the implementation of this strategy we aspire to reduce the inequities in sexual health. It is proposed that this is undertaken by tackling the barriers to achieving and maintaining optimum sexual health for individuals (particularly youth) and the wider Tairāwhiti community.

Barriers exist at an individual, whānau/family, hapu/community and Iwi / population level. Action is required in all of these settings, and the underlying principles for action are described later in this document. Sexual health inequality is not about differences between individuals, but about the degree to which an individual does not experience optimal sexual health, and the causes of that shortfall.

1.1 Aims of the Strategy

The overall aim of S.H.O.T.S is to improve, protect and promote positive sexual health and wellbeing of the rangatahi / youth population in Tairāwhiti.

Over the next five years S.H.O.T.S will:

- Work towards reducing the incidence of all sexually transmitted infections and reduce the prevalence of curable sexually transmitted infections;
- Provide appropriate, effective, accessible and equitable information to enable and support rangatahi / youth to make informed choices to develop healthy and fulfilling sexual relationships;
- Create and develop an environment where sexuality, diversity, choice and relationships can be discussed respectfully.

² WHO 2002; http://www.who.int/reproductive-health/gender/sexual_health.html

- Provide a cohesive and supportive approach to service delivery of sexual health services to the Tairāwhiti community.

1.2 Guiding Principles

The implementation of S.H.O.T.S will be guided by the following principles:

- Sexual health and wellbeing is an integral part of all relevant strategies and services;
- Promote respect for self and others in the context of sexual relationships;
- Promote a positive and affirming approach to sex and sexuality;
- Challenge stigma and discrimination which impacts negatively on sexual health;
- Collaborative approaches are necessary to ensure the effective and efficient use of existing resources, planning and evaluation using the best available data and evidence;
- Create opportunities to involve rangatahi/young people in the design and monitoring of sexual health programmes;
- All policies and programmes should be enabling and empowering, be evidenced based or reflect best practice, be adequately resourced and be subject to regular monitoring to ensure effectiveness and quality;

1.3 Priority Group

S.H.O.T.S aims to promote the sexual health of rangatahi / youth population. These age groups feature highly in behaviours which can lead to negative impacts on their sexual health and general wellbeing therefore it is important that the protection of their health be prioritised and that planning is appropriate, done in partnership, and with the participation of youth³. However the following groups have been identified and are acknowledged or require particular action:

- People who have come out of marriages or long term relationships and entering into the 'singles market' (at risk group identified by NZAF)
- People who are over the age of 55 (at risk group identified by New Zealand Sexual Health Society)
- Commercial sex workers because of the associated risks with this work. However both Escort establishments have closed down in Tairāwhiti and private escorts keep in close contact with the New Zealand Prostitutes Collective

³ Research from Youth Health, A guide to Action – September 2002.

- Those with a disability and have particular requirements in accessing information, advice and services
- Support the HPV vaccination programme. The vaccination programme is an investment in protecting future generations by immunising girls born after 1990 against the HPV types that cause most cervical cancers

1.4 The Treaty of Waitangi

The Treaty of Waitangi is a contract between two nations – Maori and the Crown. In this instance the Crown is represented by the Government and various mainstream institutions and organisations. Mainstream organisations are obliged to recognise and act in accordance with the Treaty.

The underlying aspirations of health promotion can be seen in the Treaty of Waitangi. The Treaty was partly developed as a result of concerns over Maori health. It can be seen as assuring the well-being of Maori and non-Maori by recognising the importance of such factors as social and economic aspirations which are actively protected and promoted under the Treaty. The Treaty is, therefore, a key document which provides a framework for Maori and non-Maori to exercise control over their health and well-being.

- **Partnership:** refers to ongoing relationships between the Crown and whanau, hapu and Maori communities to develop strategies for improving health status of Maori.
- **Participation:** emphasises Maori involvement in all aspects of society within Aotearoa. This includes involvement of Maori in the planning, development, delivery and monitoring of health programmes that are relevant to Maori.
- **Protection:** recognises that the Crown needs to be pro-active in the development of preventative strategies thereby ensuring Maori wellbeing is protected and improved as well as safeguarding Maori cultural concepts, values and practices.

Together these three principles have a role in understanding health and sickness; the development of health policy and the delivery of health services and programmes.



1.5 Linkages with other strategies

S.H.O.T.S cannot have maximum impact when considered in isolation. It is linked to other key legislative, policy and guidance strategies or initiatives noted below and should be read in the context of these documents. The Government is concerned about New Zealand's:

1. Increasing number of sexually transmitted infections (STIs), particularly chlamydia, gonorrhoea and HIV.
2. The high rate of unintended /unwanted pregnancies.

These two key areas correspond with TDH's strategic plan. TDH's strategic plan also encompasses the conceptual philosophy of AWHI as a way to move forward to achieve the goal of TDH. The AWHI model structures action on health and independence from personal responses: Au/me, through Whanau/ family, to Hapu/community and Iwi/Tairawhiti⁴. This model guides the vision for Tairawhiti of the future; therefore it guides the vision of Sexual Health to advance constructively.

Strengthened collaboration and improving population health across the sector is fundamental to the success of this sexual health strategy. S.H.O.T.S aligns with health outcomes identified in the documents described below, for more detail see Appendix One:

- Strategic Health Plan for Te Tairawhiti District – Hauora Titiro Whakamua (Health Looking Forward) 2005 - 2010
- New Zealand Health Strategy December 2000
- He Korowai Oranga – Māori Health Strategy and the implementation plan Whakatataka: Maori Health Action Plan 2002 - 2005
- Youth Development Strategy Aotearoa January 2002
- Primary Health Care Strategy – February 2001
- Sexual and Reproductive Health Strategy – Phase One October 2001
- Tairawhiti Youth Health Services Plan – 2008

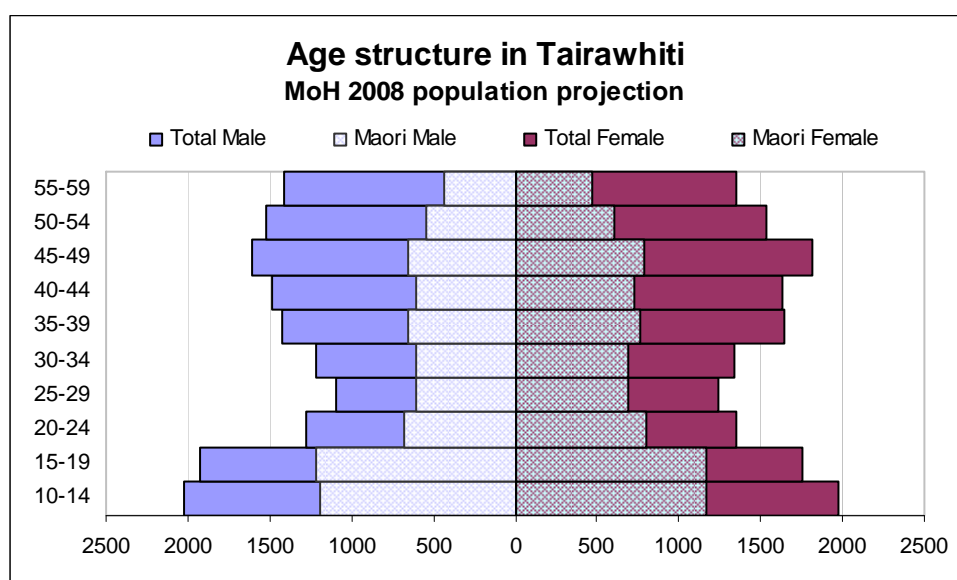
⁴ Strategic Health Plan for Te Tairawhiti District – Hauora Titiro Whakamua (Health Looking Forward) 2005 - 2010

2. Tairawhiti - Demographic Overview

The 2006 Census recorded a population of 44,460 for the Gisborne District. This population is relatively young with almost half (49.94%) being classified as Youth (15 – 24 years) and 61.2% of whom identify as Maori. The proportion of Maori in Tairawhiti is nearly four times the national level. The age profiles for the region show that Maori have a younger population structure than non-Maori. This can be attributed to a higher birth rate and lower life expectancy.

The age structure also shows a large proportion of young people (16.1% of males and 15.5% of females aged 0-14yrs). The national comparison aged less than 15 years is 21.5%. One-parent families comprise of 27.5% of all Tairawhiti families, compared with 18.1% of families nationally. This is the highest percentage for any district. (Statistics NZ, 2006 Census)

Figure 1 - Age structure in the Tairawhiti region



Source; MoH population projections

Tairawhiti is a relatively isolated coastal region with a number of rural communities dispersed throughout the area. This district has a rich cultural background and history. There is a strong sense of Iwi identity and pride that drives cultural, social and economic development in the area.

Tairawhiti still experiences higher levels of deprivation than New Zealand as a whole, with almost half (47.5%) of the population living within deciles 9 and 10⁵. This trend is exacerbated when split by ethnicity. Seventy-eight percent of Maori in Tairawhiti live within deciles 9 and 10, while this figure reaches 86% for Pacific peoples. Tairawhiti is one of the

⁵ Source: NZ Dep2006 Index of Deprivation, (Wgtn School of Medicine (2000)).

most isolated regions in the country which has implications for access to health and other services for rural residents.

Low socio-economic position, ethnic identity, gender and place of residence influence health outcomes and create inequalities among New Zealanders (MOH, 2002). These factors need to be considered to ensure equitable funding and planning decisions at all levels of health service delivery.

3. Development of this strategy

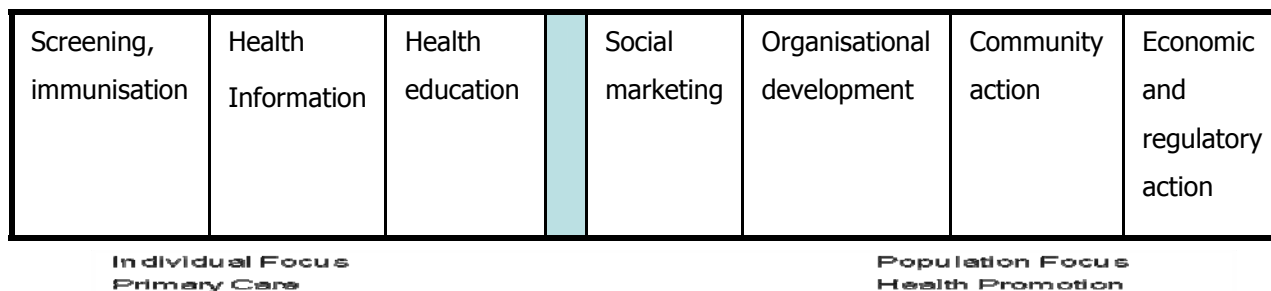
3.1 Background

The increasing incidence of Sexually Transmitted Infections, and the demographics of Tairāwhiti are the platform for the development of S.H.O.T.S. This strategy was developed at the instigation of the Ministry of Health as funders of sexual and reproductive health promotion in this district and nationally.

A comprehensive series of consultation meetings and hui was undertaken including:

- An invitation to meet and discuss the development of a Tairāwhiti Sexual Health Strategy was sent out to organisations, community groups and individuals who either have an interest in sexual health or work with rangatahi / youth.
- A stocktake of what is currently being delivered in Tairāwhiti undertaken by all Stakeholders using a continuum model based on the figure below

Figure 1: Activities used to improve individual and population health



Ottawa Charter

| | |
|----------------------------|---|
| Developing Personal Skills | Building healthy public policy Creating supportive environments Strengthening community action Reorientating health services |
|----------------------------|---|

Adapted from: Victorian Government Department of Human Services 2000

Arising from this consultation was agreement to:

- To base the strategy around rangatahi / youth;
- Involve and work with Rangatahi Reference Group (RRG);
- Involve the stakeholder group in initial methodology and draft survey;
- Develop a survey peer reviewed by the Rangatahi Reference Group for feedback and amendments;
- Use a variety of settings for the survey – Community Clinic, schools, young mums groups, youth hangouts, Pa Wars, TDH Website and Organisations who have an interest in sexual health matters;
- Conduct focus groups and survey to gather information from participants;

3.2 Survey – Key Points

The survey was designed to identify priority areas in Sexual Health to progress in the development of this strategy. From inception the survey was refined, tested with the Rangatahi Reference Group then undertaken with young people aged between 13 – 25 years, over the whole Tairāwhiti region. It provided an update on the youth climate in regards to

sexual health. The survey included general information; age, gender, ethnicity and Hapu / Iwi affiliations. Questions were discussed at a Sexual Health Stakeholders meeting.

The survey was intended to gather information to support outcomes that:

- Promote long term health relationships
- Identify issues for rangatahi / young people include infections, pregnancy, peer pressure, alcohol, power balance in relationships, contraception and finding out a partner is a relative.
- Arm teachers, educators, health professionals and parents with information to allow rangatahi / young people to make an informed choice.
- Identify areas where there is a lack of understanding of traditional concepts.
- Encourage young people to be aware of their bodies, when things are not right, the risks and consequences.
- Allow rangatahi / young people to be understanding towards people who think they are gay; although many feel anger and aggression (particularly male) over this issue.
- Provide services which are free or cheap, available in time and in location. Services should be non-judgemental and confidential.
- Are appropriate to rangatahi / young people. Many don't want lectures, they want answers. They want help.
- Provides services to information, education and advice on contraception which are readily available.
- Availability of weekend clinics, clinics for men, clinics where they need to be and staffed by Maori.
- Provides support and guidance around unwanted / unintended pregnancies with adoption as an option.
- Recognises support from whanau / family is important.
- Rangatahi / young people recognise that saying no is OK - 'it's OK so say no'.

A comprehensive narrative is provided as Appendix Two.

4. Epidemiology

4.1 Sexual Health in New Zealand – key points

STIs are among the main preventable causes of ill health among rangatahi/young people in NZ. Untreated they can have life-long consequences, increase risk of infertility, sub-fertility, ectopic pregnancy, cancer and other chronic diseases.

Over recent years STIs do not appear to be reducing. Chlamydia, Gonorrhoea, Genital Herpes, Genital Warts, Syphilis and Non-Specific Urethritis (NSU) in males were all showing higher rates in the first half of this year compared to 2007⁶

- Chlamydia trachomatis infection is the most commonly diagnosed STI in New Zealand. Data on diagnoses in other care settings, for example general practice are not known
- From 2003 to 2007 the number of cases of chlamydia and gonorrhoea diagnosed has increased by 19.4% and 55.5% respectively. Over the same time period clinic visits increased by 11.3%
- Genital warts remain the most common viral infection diagnosed and the rate was highest in the 20 – 24 years age group for males and the 15 – 19 years age group for females
- Young people remain at high risk of STIs. In SHCs, 72.0% of chlamydia, 61.1% of gonorrhoea, 43.2% of genital herpes and 62.3% of genital warts cases were aged less than 25years
- In 2007, young people, Maori and Pacific Peoples were at greater risk of concurrent infections

4.2 Sexually Transmitted Infections

4.2.1 Chlamydia

Chlamydia trachomatis infection is the most commonly diagnosed STI in New Zealand. The number of cases of Chlamydia reported by sexual health clinics increased by 27% from 2002 to 2006 along with a 50% increase of gonorrhoea diagnosed cases (www.est.cri.nz). Chlamydia presents a significant challenge as up to 75% of cases in women and 50% of cases in men are asymptomatic.⁷

⁶ Sexually Transmitted Infections in New Zealand. Annual Surveillance Report 2007.

⁷ S Hillis, C Balck, J Newhall et al., 'New opportunities for Chlamydia prevention: applications for science to public health practice', *Sexually Transmitted Diseases*, vol.22, May-June, 1995,p.197

Most people may be unaware of their infection, and therefore may not seek treatment. When diagnosed, Chlamydia can be easily treated and cured. Untreated Chlamydia in women can cause severe reproductive and other health problems including Pelvic Inflammatory Disease (PID). PID can lead to internal abscesses, long-lasting pelvic pain, and infertility. PID can damage the fallopian tubes enough to increase the risk of ectopic pregnancy. Chlamydia may also result in adverse outcomes of pregnancy, including neonatal conjunctivitis and pneumonia.

Chlamydia is also common among young men. Untreated Chlamydia in men typically causes urethral infection, but may also result in complications such as swollen and tender testicles.

4.2.2 Gonorrhoea

Untreated gonorrhoea can cause serious and permanent problems in both women and men. In women, gonorrhoea is a common cause of Pelvic Inflammatory Disease (PID). In men, gonorrhoea can cause epididymitis, a painful condition of the testicles that can sometimes lead to infertility if left untreated. Without prompt treatment, gonorrhoea can also affect the prostate and can lead to scarring inside the urethra, making urination difficult. Gonorrhoea can spread to the blood or joints. This condition can be life threatening⁸.

4.2.3 Genital Warts

Genital warts are a symptom of some strains of Human Papilloma Virus (HPV) infection. HPV is readily transmitted through sexual contact and does not always result in manifestation of warts. While warts themselves can be effectively treated by a variety of means, the virus is not treatable and the incubation period is variable. Treatment of warts can be prolonged and uncomfortable.

Genital warts and HPV infection are significant for a number of reasons:

- Warts themselves can be unsightly and may impact on body image and self-esteem. This, in turn, can influence sexual choices and behaviour and may result in increased risk of exposure of other STIs;
- HPV infection is central to the pathogenesis of cervical intraepithelial neoplasia (CIN), which in turn may lead to cervical cancer. However, the variants of HPV which can cause visible genital warts are different from those associated with increased risk of CIN and cervical cancer⁹;

⁸ Handbook on Sexually Transmitted Diseases 3rd edition – National Health and Medical Research Council(a)

⁹ Handbook on Sexually Transmitted Diseases 3rd edition – National Health and Medical Research Council (b)

- HPV is a common sexually transmitted infection. About 8 in every 10 women who have ever been sexually active will have HPV at some stage in their life;
- Most HPV infections don't have any symptoms, and in 98% of cases HPV clears up by itself.

4.2.4 Genital Herpes

Herpes is a sexually transmitted infection caused by the herpes simplex virus type 1 (HSV-1) and type 2 (HSV-2). Most individuals have no or only minimal signs or symptoms from HSV-1 or HSV-2 infection. When signs do occur, they typically appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender ulcers (sores) that may take two to four weeks to heal the first time they occur. Typically, another outbreak can appear weeks or months after the first, but it almost always is less severe and shorter than the first episode. Although the infection can stay in the body indefinitely, the number of outbreaks tends to go down over a period of years¹⁰.

4.3 Sexual Health in Tairawhiti

Rates of Sexually Transmitted Infections amongst the youth population in Tairawhiti are, according to the Ministry of Health, similar to national figures which are consistently high by OECD standards and should be cause for greater attention.¹¹ While it can be seen that the rates of STIs are comparatively steady and therefore not increasing radically, the gap between what many young people know and what they do shows that a lot of work needs to be undertaken.

A recent review (April 2008) of screening by T-Lab showed that 70 – 80% of STI screening in Tairawhiti is carried out by the Community Clinic.

The following graphs and supporting information are from data provided by the Gisborne Community Clinic only.

- Chlamydia is the most common diagnosed STI. Chlamydia rates far exceed those for Gonorrhoea, and rates of diagnosis are high. However the dramatic rise in diagnosis in the past year is not necessarily indicative of incidence of new infections, but reflects increased awareness, particularly among young people and increased uptake of screening.

¹⁰ Handbook on Sexually Transmitted Diseases 3rd edition – National Health and Medical Research Council

¹¹ Rangatahi Sexual Wellbeing and Reproductive Health – The Public Health Issues – MoH 1997

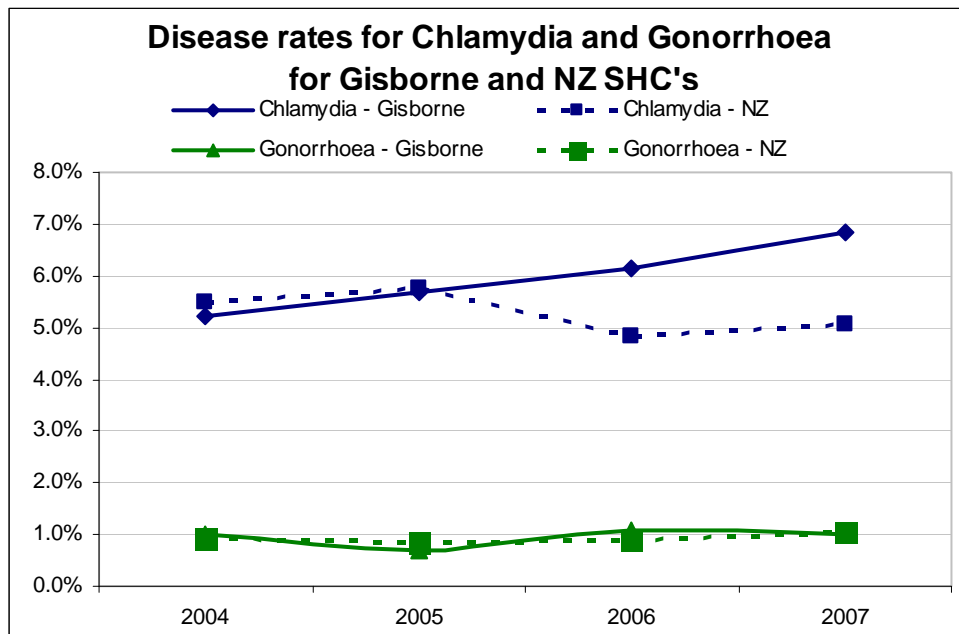


Figure 2 - Disease rates for Chlamydia and Gonorrhoea: Gisborne Community Clinic

- Figure 3 shows seasonal trends and highlights peaks, these peaks indicate holiday periods (Christmas, Easter, School Holidays etc) and/or key events that take place in Tairāwhiti - Rhythm and Vines Festival, Food and Wine Festival (both these events mark a huge increase in visitors to Tairāwhiti), Kapa Haka Super 12, Pa Wars, Ru-Uawa and School Balls. These events provides a window for opportunistic screening. These all contribute to the Chlamydia continuum.

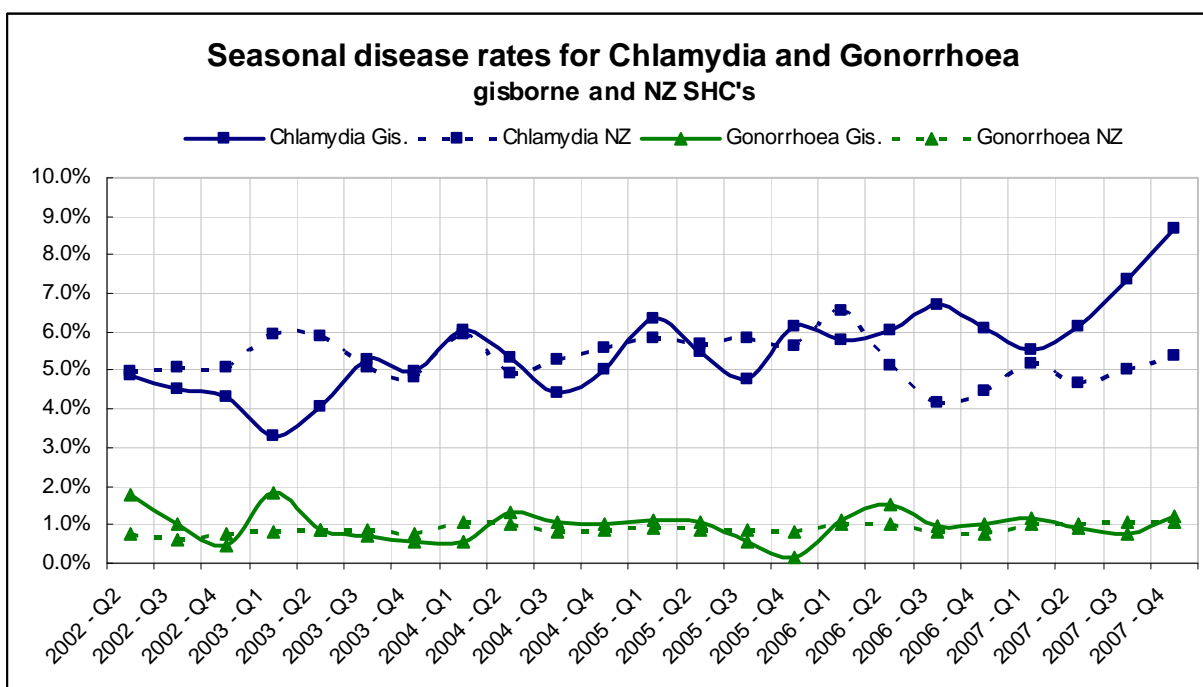


Figure 3: Seasonal disease rates for Chlamydia and Gonorrhoea

- What is clear is that a large number of people are affected. Although these graphs do not show gender and ethnicity, young Maori females are the highest group affected. Data can be seen in Figures 5, 6 and 7 in Appendix Three
- Figure 4 shows the age structure and although the data is old it does reiterate the current national trend - that diagnoses of STIs in Tairāwhiti are consistently higher among 15 – 25 year olds.

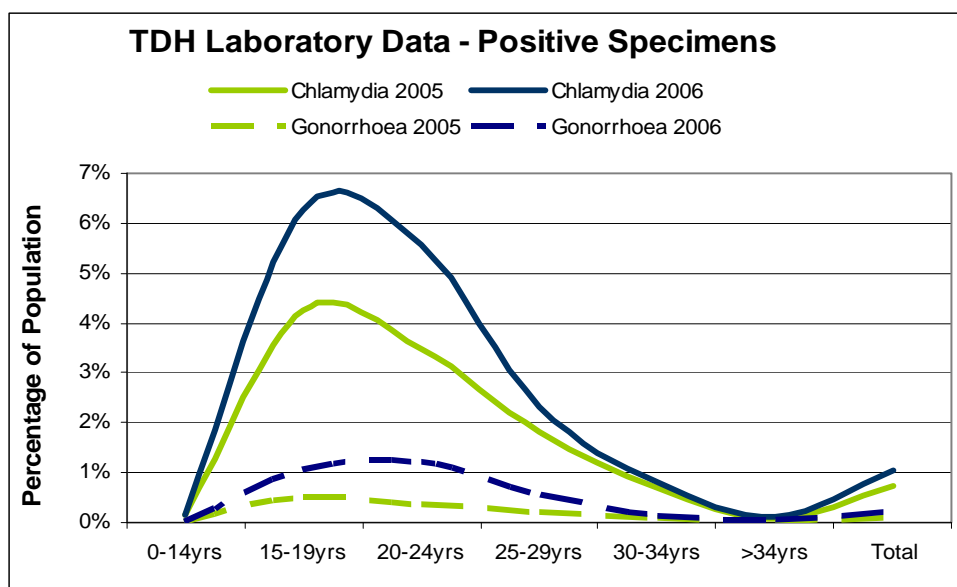


Figure 4: TDH Laboratory Data – Positive Specimens

- Increased clinic visit rates in males were identified in the Annual Surveillance Report¹². Data from Community Clinic consultation stats 2003 – 2007 (see Figures 8, 9 and 10 in Appendix Four)

4.4 STI Disease Rates.

Table 1: Comparison of STI Disease Rates

| Chlamydia | | | | | | |
|-------------------|----------------------|-----------------|-----------------|----------------------|--------------|-------------|
| | Gisborne | Gisborne | Gisborne | NZ | NZ | NZ |
| Year | Clinic Visits | Cases | Rate | Clinic Visits | Cases | Rate |
| 2004 | 2,911 | 152 | 5.2% | 83,667 | 4,579 | 5.5% |
| 2005 | 2,944 | 167 | 5.7% | 87,015 | 5,002 | 5.7% |
| 2006 | 3,010 | 185 | 6.1% | 88,770 | 4,294 | 4.8% |
| 2007 | 2,884 | 197 | 6.8% | 89,208 | 4,501 | 5.0% |
| Gonorrhoea | | | | | | |
| | Gisborne | Gisborne | Gisborne | NZ | NZ | NZ |
| Year | Clinic Visits | Cases | Rate | Clinic Visits | Cases | Rate |

¹² Sexually Transmitted Infections in New Zealand – Annual Surveillance Report 2007, pg 9

| | | | | | | |
|-------------|-------|----|------|--------|-----|------|
| 2004 | 2,911 | 29 | 1.0% | 83,667 | 789 | 0.9% |
| 2005 | 2,944 | 21 | 0.7% | 87,015 | 748 | 0.9% |
| 2006 | 3,010 | 32 | 1.1% | 88,770 | 802 | 0.9% |
| 2007 | 2,884 | 29 | 1.0% | 89,208 | 925 | 1.0% |

Source: Sexually Transmitted Infections in New Zealand - Annual Surveillance Report's

The rates in the table above are based on the number of confirmed cases for the total number of SHC visits and does not separate gender, ethnicity, age or whether the case is a first time or follow up visit.

The comparison of Chlamydia rates show a slight increase over each year period and are consistent with national rates, however 2006 / 07 is slightly higher in the Gisborne figures and reiterates the seasonal trends and opportunistic screening as referred to in Figure 3.

5. Current Sexual Health Services in Tairāwhiti

5.1 Sexual and Reproductive Health Services in Tairāwhiti

The Ministry of Health funds a number of sexual and reproductive health promotion services for Tairāwhiti.

The total funding for these services is \$283,282.00 per annum for 2007/2008. This figure includes health promotion contracts and some primary care services. The expenditure for clinical services has not been included eg. terminations and contraception as a strategy for clinical services are to be covered in a regional strategy being coordinated by the DHB Midlands collective. This figure does not include expenditure of services such as Family Planning Association, FEN and Rural Nursing (who choose to provide sexual health services in their areas) as required.

In addition to national government funding, further investment decisions are made locally by TDH, Primary Health Organisations, Turanganui a Kiwa and Ngati Porou Hauora who may choose to use discretionary funding for additional sexual health services if it is deemed a priority for its enrolled population.

Below is a brief description of sexual health services by Provider.

Turanganui PHO Ltd (TPHO)

Turanganui PHO Ltd (TPHO) has an enrolled population of 33,000. Examples of funding streams include Services to Improve Access (SIA) and Health Promotion. In March 2006 TPHO established a sexual health service prioritising Maori and Pacific peoples under 25 years of age; and low income families.

The Under 25's programme is a free primary care based sexual health and contraception service for under 25 year olds. TPHO contracts GPs and their practice nurses who accept self referrals and provide the following services:

- assessment, diagnosis and treatment of STI related problems
- health promotion and disease prevention advice
- contraceptive advice
- screening services
- contact tracing
- referral to specialist sexual and reproductive health services, if required
- referral to sexual abuse and assault services, if required.

The aims of the programme are to improve access to first level GP services in order to facilitate the following:

- A reduction in unwanted pregnancies amongst the target group
- A reduction in STIs amongst the target group
- A reduction in infertility amongst target group

The programme is funded through THPO's Services to Improve Access fund.

Ngati Porou Hauora

Ngati Porou Hauora (NPH) is based at the Te Puia Springs hospital with health clinics located across the east coast region and Gisborne city and has an enrolled population of approximately 13,000. This Iwi-owned organisation applies a population health approach to much of its whanau and community-based service delivery. Programmes such as Ngati and Healthy, Manaaki Tinana, Whanau Ora and Problem Gambling incorporate health promotion strategies, social marketing, community action and advocacy.

One of the Rural Health Nurses is a NZQA FPA trained sexuality and contraception educator and is also certificated as a health promoter. The service includes cervical screening in Ruatoria, plus STI education on a one to one basis as required. STI treatment is delivered after a full sexual health assessment and in consultation with a local GP.

Turanga Health Ltd

Turanga Health Ltd is an iwi community-based provider and delivers early intervention and health promotion programmes to the communities of Turanganui a Kiwa as part of its broader primary healthcare service. Programmes include but are not limited to nutrition and physical activity, injury prevention, oral health, tobacco control, smoking cessation, sunsmart, alcohol and drug, sexual health.

Te Aitanga a Hauiti Hauora (TAHH)

Based in Tolaga Bay (with a second office in Gisborne), TAHH provides a number of public health programmes particularly for the communities of Uawa and also district-wide. Programmes include but are not limited to sexual health, whanau ora, smoking cessation, Breastscreen Aotearoa, Community Action Youth Against Drugs (CAYAD).

Until recently TAHH delivered the Rangatahi Peer Education (RPE) sexual health programme. Following a national review of this type of programme the MoH made a decision not to continue funding this service. Since then the sexual health service delivered by TAHH includes a broad range of health promotion activities including education and training, policy work, communications (including media and campaigns), information and advisory services as well as networking.

Rangatahi Maori and influential people in their lives (eg. parents, teachers and caregivers) are the key audience for this service and programmes are designed with this in mind.

The service employs 1 FTE to deliver this service. Work is carried out along side and in consultation with other sexual health providers such as Tairāwhiti District Health and Family Planning Association.

The NZ Family Planning Association

Prior to 2005 FPA employed a part time health promoter to provide education (not health promotion) in schools and other community settings.

In 2005, FPA commissioned a scoping report¹³ that provided a profile of local sexual health services and identified issues and service gaps. The report is a useful contribution to the sexual health strategy although some of the information requires updating.

Following the scoping project, NZFPA established a site in Gisborne. The Gisborne clinic employs 1 FTE nurse and 1 FTE Health Promoter to carry out education programmes, raise

¹³ Demographic analysis, analysis of service provision and service gaps in Tairāwhiti, Wanganui and Wairarapa: A report for NZFPA by Debbie Hager and Carol Waterman, June 2005.

community awareness about sexual health and reproductive health issues, work in partnership with others to implement programmes to promote key messages and provide advice and support to professional groups about education and health promotion approaches.

TLab service is contracted for provision of laboratory services to FPA.

The Family Education Network (FEN)

FEN are responsible for delivering a programme known as Postponing Sexual Involvement (PSI) to Year 9 and 10 students in self-selecting schools. At this time 4 Schools in Tairāwhiti are participating in the PSI programme. The service is currently delivered by 1 FTE contracted by FEN.

Tairāwhiti District Health (TDH)

The Gisborne Community Clinic (Sexual Health and Contraception service) is based in central Gisborne and provides both clinical and health promotion services to the community.

The clinic is open 4.5 days per week offering 4 medical clinics on Monday and Tuesday 1-6pm, Wednesday and Friday 9-12.30.

A health promotion contract is held by Te Puna Waiora. The position is made up of 0.2 FTE clinic and 0.8 FTE sexual health promotion and education. The programme has a strong focus on youth. Activities include the delivery of sexual and reproductive health training for teachers, youth workers and community groups; resource development and collaborative arrangements with community organisations.

The Planning, Funding and Population Health arm of TDH, Te Puna Waiora, has the coordination and development role of this strategy.

5.2 Sexuality Education

Comprehensive sexuality education recognises that sexuality is not just about sexual intercourse. It encompasses a broad range of human experiences that are central to who we are as human beings, including human development, emotions and relationships, sexual health, sexual behaviour, and sexual violence. In addition to providing accurate information, comprehensive sexuality education encourages young people to explore their own values and develop communication skills and self respect necessary for a positive and healthy sex life.

All local secondary schools are required to provide sexuality education that is compulsory in Year 10. The guideline for teaching and learning this component is contained within the Health and Physical Activity curriculum. Teachers will often pass responsibility of sex education onto

health workers. If students are not accessing health services (for various reasons), this can lead to gaps in knowledge leading to potentially unsafe situations. As a result health workers may either 'train the trainers' or work directly with rangatahi instead of the teacher.

Training and education can occur in a range of settings - social services, alternative education, and church. Training can be delivered by a range of professionals and non-professionals in these settings. This lack of cohesion around education may mean a lack of consistency of messages, access to resources, and the standard delivery approaches. For this to be addressed it is essential that educators have access to the same tools and resources, that there is a peer support process and opportunities to develop skills through coordinated education programmes. Areas (Gisborne City) that have training for teachers apparently have good effect.

5.3 Current approaches to promoting sexual health in Tairāwhiti

The following approaches to sexual health promotion are used through a variety of health workers:

5.3.1 Sexuality Education

- Postponing sexual involvement – taught to year 9 and 10 at high schools through FEN
- Mentoring students at risk – take them to clinic
- Development of Pubertal Change Resource Toolkit for all Intermediate and Primary Schools including Kura Kaupapa. The Toolkit is to support Teachers to deliver the Pubertal Change programme. The contents include workbooks for Teachers, Yrs 5 and 6 students, yr 7 and 8 students, Sexuality Education Policy Development Package, Resource Manual, Sanitary Product Display, CD–Rom with various Pubertal and Menstrual Hygiene power point presentations.
- Delivery of sexuality education in all secondary schools in Gisborne. A big success is Gisborne Boys' High School. Around two thirds of the delivery is done by the P.E teaching department and one third by outside providers.

5.3.2 Health Promotion

- Train the Trainer programmes undertaken with schools (Primary, Intermediate and Secondary) through TDH and FPA (2007).
- Train the Trainer programmes undertaken with Alternative Education Providers and Te Whare Whai Hua (Young Mums Centre) through TDH.
- Contraception, Conception, Sexually Transmitted Infections and H.I.V Accredited Unit Standards: MoE / MoH Stock-take of sexuality resources used by schools and health professionals

- “Luv 2 Score” Condom campaign in various Sporting Clubs promoting positive health behaviours through a sports setting with young males being the priority of the campaign. Piloted in 2004 with 4 rugby clubs, “Luv 2 Score” has moved to the next level, where the Clubs have now taken ownership of the campaign. The campaign focuses on the delivery of sexual health messages, improving the sexual health and wellbeing of Rangatahi Tane by supporting safer sex options and destigmatise condom use.
- Input into Regional Sexual Health Strategy undertaken for Midland area
- Square Pegs group: young people that are queer or questioning are supported to make healthy choices in a community that is safe and supportive of them. Terms Of Reference, Strategy plan and manual finished.
- Submissions forwarded to Pharmac to increase the listing of free or subsidised condoms, lubricant, Dental Dams and female condom. This was a collective submission through PASHANZ (Promoters Advocating for Sexual Health in Aotearoa New Zealand) – Sexual Health Promoters who have a contract within a DHB
- Access to Condoms project
- Input into new social marketing campaign currently facilitated by Quigley and Watts.

6. Evidence for Effectiveness of Sexual Health Intervention

Health promotion interventions aimed at individuals are not enough on their own. A range of activities which include community driven initiatives that are achieving results or that have the potential to do so along with research, training and capacity building are required to bring about the aims of this strategy. These are reflected throughout the document and the Sexual Health Action Plan will detail how these will be further developed. Through integrated programmes we aim to bring about a reduction in sexual health inequalities, and to serve the needs of our community.

7. Issues and Gaps in Sexual Health Services in Tairāwhiti

7.1 Summary of issues for the region

- 7.1.1 All of the agencies work together to enhance each other’s work. There is very good cooperation in this region through informal networks.
- 7.1.2 Turanganui PHO do not have specialised sexuality educators. They incorporate sexual health into the other work that they do. The PHO have a comprehensive extension to their sexuality services for people under 25.

- 7.1.3 Currently there are three people in the region who undertake sexual health education. The majority of this work is only with Youth. However there is still a need for more sexuality education/educators within school settings.
- 7.1.4 There is the Community Clinic which:
- Is focused on sexual health with less waiting time than at a GP.
 - Have education services on site. If people need education they get it.
 - Identifies about 80% of all STIs in the region in 15/20 hours per week.
 - Have free sexual health and contraception services. There is two days a week for terminations and 1 day for cervical screening. One in four pregnancies are terminated through all age groups – but adolescents are having the babies.
 - Is only funded for people under 25 years for contraception, any age for sexual health. However, contraception for people who are older than 25 years is provided, as there is nowhere else (free) for people to go.
- 7.1.5 There are general practitioner outreach clinics in some schools, run by Turanganui PHO. One – One education occurs at these clinics.
- 7.1.6 The Turanganui PHO has a Rangitane programme. This incorporates sexual health into a range of other issues – drugs, alcohol and other risk behaviours.
- 7.1.7 A “Train the trainer” programme was run on the coast with secondary schools, but then all of the trained staff left. With a high teenage pregnancy rate on the East Coast there is an ongoing need for sustainable development of sexual health educators.
- 7.1.8 The local Wananga provide teachers training, but doesn’t provide training for teachers in sexual health delivery.
- 7.1.9 Work in Tairāwhiti is seasonal. Women only have money occasionally and tend not to spend it on themselves/sexual health services. Therefore, services need to be free or as low cost as possible.
- 7.1.10 In the community, it’s not only young people who engage in high risk sexual behaviour. There are people of all ages who use drugs and alcohol and practice unsafe sexual behaviours.
- 7.1.11 There is a need for support of teachers to deliver sexual health education in school settings. There are teachers who are unaware it is now their role, whilst other teachers who are aware this is now part of their role either have had no training or resources or do not wish to undertake sex education.
- 7.1.12 Better communication between all stakeholders.

7.2 Perceived gaps in services

There is a need for:

7.2.1 Workforce Development

- Training: of teachers and other people who potentially would undertake health education in schools. Because of the size of the region and because the existing staff can't cover all of the schools, there is a need to train teachers and people from the community. An appropriate cultural component for training is important in this region.
- Male educators. This has been expressed by some schools and community groups and is important to provide peer support for young males who may otherwise feel embarrassed to discuss sexuality with a female.
- Sexuality Education component in the teachers training provided by Te Wananga o Aotearoa. This will help to integrate sexual health, including intimacy and relationship issues, into the whole curriculum

7.2.2 Service Delivery

- A comprehensive approach to sexual health education and clinical services for individual risk groups of all ages.
- Work with parents about how to talk to their children about sexuality and sexual health.
- Good relationships between services and rangatahi. This will enable services to provide a holistic approach to health.
- Positive role models. Rangitahi/young people are particularly susceptible to peer pressure which can place them into unsafe situations. The use of role models with positive messages (ie "its ok to say no") can strengthen perceptions and provide coping mechanisms.
- Working with whanau/family.

7.2.3 Building healthy public policy

- Collaborate with work already being undertaken with health promoting schools, and with the students identifying priorities.

- Sexual abuse is not acceptable in any form. Communities need to support and follow up potential situation by alerting their health provider.
- Identify potential funding and service gaps in the area of sexual health and communicating these to their health provider.
- Collaborative evaluation / impact assessment opportunities to build alliances and effective delivery of services.
- Regular networking and information sharing amongst Health Promoters involved in sexuality education.

8. Future Priorities

S.H.O.T.S comprises of a number of priorities grouped under six headings

- Managing the Strategy and Action Plan
- Sexual Health Service Delivery
- Promotion and Prevention
- Training and Education
- Evidence and Information

The promotion of sexual health through the following priorities requires a multi-agency approach and partnership working across all sectors of expertise and resources.

8.1 Sexual Health Priority One: *Managing the Strategy and Action Plan*

- 8.1.1 Management in the implementation of the strategy – S.H.O.T.S
- 8.1.2 Development of a Sexual Health Action Plan
- 8.1.3 Review and evaluation of implementation of Strategy.

8.2 Sexual Health Priority Two: *Sexual Health Service Delivery*

- 8.2.1 Formally establish Tairawhiti Sexual Health Networking group
- 8.2.2 Develop Memorandum of Understanding, Terms of Reference
- 8.2.3 Review of all services, including Health Promotion – FTE coverage
- 8.2.4 Management of Sexual Health coverage in Tairawhiti

8.3 Sexual Health Priority Three: *Promotion and Prevention*

- 8.3.1 Development of existing sexual health promotion and community development work in a range of settings and in the context of community planning

8.3.2 Programmes are adapted as required, to improve the delivery of the health outcomes identified

8.4 Sexual Health Priority Four: *Training and Education*

8.4.1 Develop and maintain a skilled workforce that can assist in reducing the transmission, and minimise the impact of sexually transmitted infections in Tairāwhiti

8.4.2 Increase the capacity of trainers to deliver effective sexual health promotion interventions

8.5 Sexual Health Priority Five: *Evidence and Information*

8.5.1 All service providers are informed and have sound communication links.

8.5.2 Service planning and delivery is informed by quality research.

8.5.3 Data is captured using effective reporting systems.

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Appendices

Appendix One: Associated Strategies

Strategic Health Plan for Te Tairāwhiti District – Hauora Titiro Whakamua (Health Looking Forward) 2005 - 2010

This strategic health plan identifies local priorities and should be referred to when developing health promotion programmes.

The plan outlines the current status of Te Tairāwhiti population for health and independence then proposes the conceptual philosophy of **AWHI**¹⁴ as a way to move forward to achieve the goal. To achieve the goal and create a Te Tairāwhiti that embodies the vision, the plan recognises eleven guiding principles that will be applied to all actions by Tairāwhiti District Health.

The New Zealand Health Strategy December 2000

There are 13 priority objectives in this strategy and toolkits have been developed for each of the priority areas identifying possible health promotion actions. These can be accessed on the Ministry of Health website (<http://www.newhealth.govt.nz/toolkits/about/toolkits.htm>).

He Korowai Oranga – Māori Health Strategy and the implementation plan Whakatataka: Maori Health Action Plan 2002 – 2005

The overall aim of He Korowai Oranga is whanau ora: Maori families supported to achieve their maximum health and wellbeing.

"He Korowai Oranga asks the health and disability sectors to recognise the interdependence of people, that health and wellbeing are influenced and affected by the 'collective' as well as the individual and the importance of working with people in their social contexts not just with their physical systems" (Minister of Health and Associate Minister of Health 2002a).

Maori holistic models and wellness approaches to health and wellbeing are strongly supported.

Whakatataka: Maori Health Action Plan 2002 – 2005 is the implementation plan for He Korowai Oranga (Minister of Health and Associate Minister of Health 2002b). This plan is currently being reviewed.

Youth Development Strategy Aotearoa January 2002

¹⁴ The **AWHI** model structures action on health and independence from personal responses Au/me, through Whanau/family, to Hapu/community and Iwi/Te Tairāwhiti. This model guides the vision for Te Tairāwhiti of the future.

The Youth Development Strategy Aotearoa (YDSA) is how government and society can support young women and men aged 12 to 24 years inclusive to develop the skills and attitudes they need to take part positively in society, now and in the future. The strategy is based on a youth development approach that encompasses six key principles. In combination, the principles contribute to the desired result of positive youth development where young people gain a sense of contributing something of value to society, feeling of connectedness to others and to society, belief that they have choices about their future and feeling of being positive and comfortable with their own identity.

Primary Health Care Strategy – February 2001

This strategy provides a clear direction for the future development of primary health care so that it can play this central role within the new health system. The vision involves a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventative care, the need to involve a range of professionals, and the advantages of funding based on population needs rather than fees for service.

Sexual and Reproductive Health Strategy – Phase One October 2001

This strategy provides an overall direction for improved sexual and reproductive health outcomes in New Zealand. It highlights the need to increase knowledge about safer sex and provide information on sexual health, the risk of STI's and HIV and on prevention, early diagnosis and treatment.

Tairāwhiti Youth Health Services Plan: 2008-2011 (Draft)

This Youth Plan provides a plan of action based on an analysis of four strategic areas designed to achieve the level of change required with the short to medium term: improving access to youth health services, supporting initiatives that strengthen healthy and positive connection between young people and their communities, supporting the voice of young people to be heard and taken into account during planning processes and when decisions are made that will impact on young people, and increase the quality of information about youth health in the district and access to it by stakeholders. The plan includes a set of actions that will be undertaken by TDH over the next three years.

Appendix Two: Survey

Where are we now? - What are rangatahi are telling us

There are good things about sex that we need to promote, this includes '*sharing love*', '*bonding*' and '*making babies and whanau*'. This is all about long term health relationships.

But there are some not so good things about sex that are very real issues to our rangatahi and that need to be dealt to. These include; infections, pregnancy, peer pressure, alcohol, power balance in relationships, contraception and finding out a partner is a relative.

Most information about sex is from our schools and this needs to be developed. School education is good because it is a good time for young people to learn. Parents remain a very important source of information and they in turn need information that they can use to help them speak to their rangatahi.

Of course health professionals, GPs, the Community Clinic and Family Planning are there but we need to have a list of these sources of care and information.

Basically we need to empower teachers, educators, health professionals and parents to have the information they need to help them talk about this to rangatahi. This subject doesn't need to be boring.

There is a lack of understanding of some of our traditional concepts. Perhaps this is due to a generally devaluation of womanhood and the value of sex and relationships in modern society. Whatever the cause there is a need to understand and to revisit issues of respect, long term relationships, the value of love, adoption, whangai and where tangata. Babies and making babies is a societal '*taonga*'; the '*door to the next generation*' is in our hands.

Our young people know when they need help; we need to encourage people to be aware of their bodies, aware when things are not right, aware when they have taken risks that may lead to problems in the days, weeks or years ahead. Problems that can be cured right now in both themselves and their partner before it goes any further or gets worse.

Our rangatahi can be very understanding towards people who think they are gay; although many feel anger and aggression over this issue. Clearly anger doesn't help this problem and probably makes it worse. This issue needs to be understood more clearly.

In terms of important issues regarding sexual health these include contraception, infections, pregnancy and availability of information. Other important issues include clarification of the law in regards to sex, peer pressure and unwanted and unintentional sex and the influence of alcohol and decision making.

It is clear that the service should be free or at least cheap, that the service should be available in time and in location. Our young people do not want to hear lectures; they want answers. They want help. Services should be non-judgemental and confidential.

Generally the current services delivered are regarded well; there is a need for more information, education and advice and contraception should be readily available.

For sexually transmitted infections it is felt that there is plenty of imagery available on the TV but what is needed is availability of clinics and clinics for men; basically clinics where they need to be and staffed by Maori.

Unwanted pregnancies can be avoided and our rangatahi think that this is the way to go; but failing this there is a need for support and guidance, with adoption as an option. The support of family and parents is important and needs to be promoted and whanau hui encouraged in these situations.

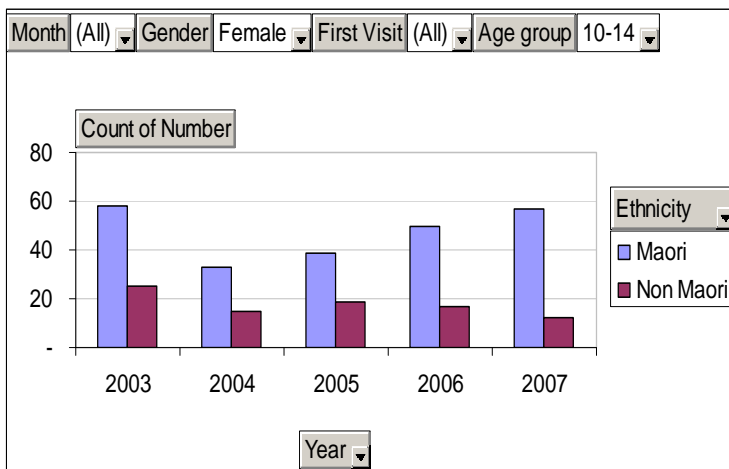
Guys need to get checked, perhaps the failure to do so is due to stigma, shame and shyness. Services need to have an emphasis on confidentiality and the availability of weekend clinics .

Our people need to know that there is a personal responsibility when it comes to sexual health and that observing this responsibility has a beneficial effect on all our friends, family and everyone connected with us now and for the future. Our rangatahi recognise that saying no is OK *'Its OK to say no'*. Friendship and love between two people is not dependent on their being a sexual relationship and we need to *'let girls know they don't need to do it for guys to like them'*.

Appendix Three: Community Clinic Consultation Data – Female

The information in Figures 5, 6 and 7 comprise of the number of Females who have accessed the Community Clinic aged 10 -24 yrs for a sexual health screen. This information includes first presentation and seen before visits. This data shows that Maori females are the highest group accessing the Community Clinic.

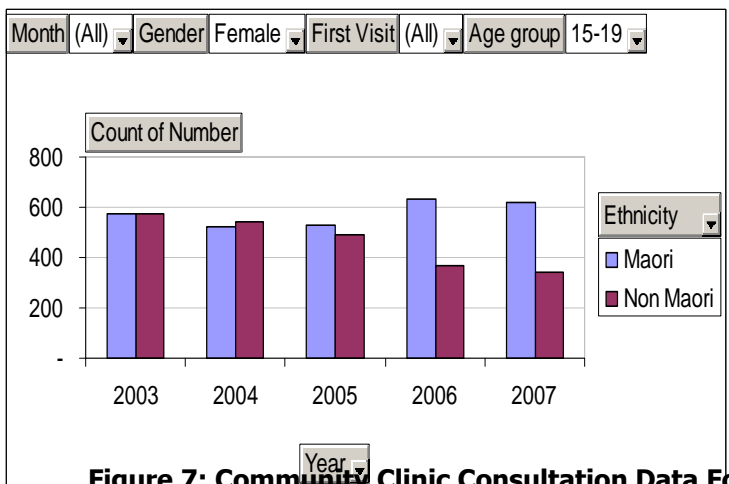
Figure 5: Community Clinic Consultation Data Form – Female visits – 10 – 14 yrs



| | |
|-------------|--------|
| Month | (All) |
| Gender | Female |
| First Visit | (All) |
| Age group | 10-14 |

| Year | Ethnicity | | Grand Total |
|-------------|-----------|-----------|-------------|
| | Maori | Non Maori | |
| 2003 | 58 | 25 | 83 |
| 2004 | 33 | 15 | 48 |
| 2005 | 39 | 19 | 58 |
| 2006 | 50 | 17 | 67 |
| 2007 | 57 | 12 | 69 |
| Grand Total | 237 | 88 | 325 |

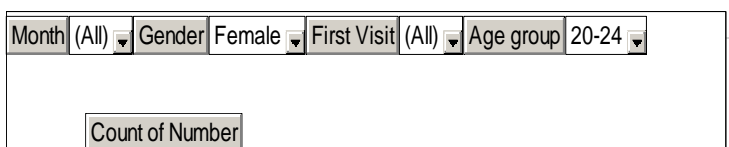
Figure 6: Community Clinic Consultation Data Form – Female visits – 15 – 19 yrs



| | |
|-------------|--------|
| Month | (All) |
| Gender | Female |
| First Visit | (All) |
| Age group | 15-19 |

| Year | Ethnicity | | Grand Total |
|-------------|-----------|-----------|-------------|
| | Maori | Non Maori | |
| 2003 | 574 | 571 | 1,145 |
| 2004 | 525 | 542 | 1,067 |
| 2005 | 529 | 493 | 1,022 |
| 2006 | 633 | 368 | 1,001 |
| 2007 | 622 | 343 | 965 |
| Grand Total | 2,883 | 2,317 | 5,200 |

Figure 7: Community Clinic Consultation Data Form – Female visits – 20 – 24 yrs



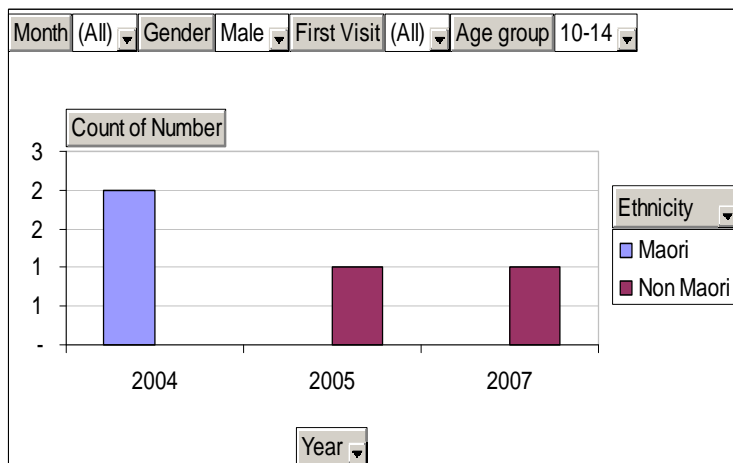
| | |
|-------------|--------|
| Month | (All) |
| Gender | Female |
| First Visit | (All) |
| Age group | 20-24 |

| Count of Number | Ethnicity | | |
|-----------------|-----------|-------|-----------|
| | Year | Maori | Non Maori |
| 2003 | 435 | 312 | 747 |
| 2004 | 383 | 316 | 699 |
| 2005 | 400 | 297 | 697 |
| 2006 | 410 | 251 | 661 |
| 2007 | 388 | 209 | 597 |
| Grand Total | 2,016 | 1,385 | 3,401 |

Appendix Four: Community Clinic Consultation Data – Male

The information in Figures 8, 9 and 10 comprise of the number of Males who have accessed the Community Clinic aged 10 -24 yrs. This information includes first presentation and follow up visits. The Annual Surveillance Report identified increased clinic visit rates in males

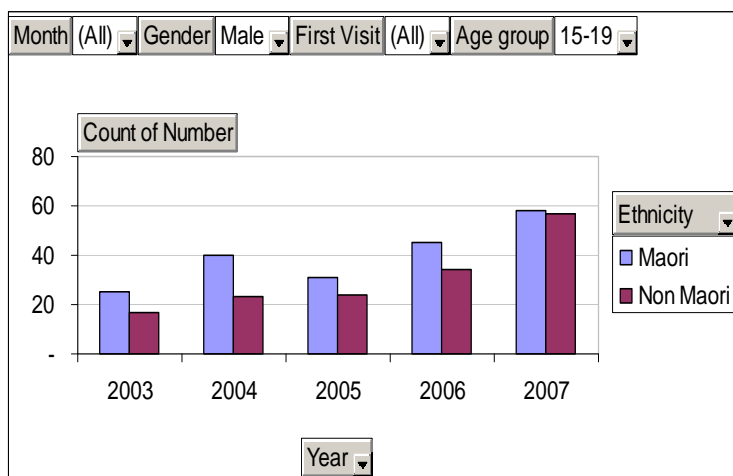
Figure 8: Community Clinic Consultation Data Form - Male visit 10 – 14yrs



| | |
|-------------|-------|
| Month | (All) |
| Gender | Male |
| First Visit | (All) |
| Age group | 10-14 |

| Count of Number | Ethnicity | | |
|-----------------|-----------|-------|-----------|
| | Year | Maori | Non Maori |
| 2004 | 2 | 0 | 2 |
| 2005 | 0 | 1 | 1 |
| 2007 | 0 | 1 | 1 |
| Grand Total | 2 | 2 | 4 |

Figure 9: Community Clinic Consultation Data Form – Male visits 15 – 19yrs



| | |
|-------------|-------|
| Month | (All) |
| Gender | Male |
| First Visit | (All) |
| Age group | 15-19 |

| Count of Number | Ethnicity | | |
|-----------------|-----------|-------|-----------|
| | Year | Maori | Non Maori |
| 2003 | 25 | 17 | 42 |
| 2004 | 40 | 23 | 63 |
| 2005 | 31 | 24 | 55 |
| 2006 | 45 | 34 | 79 |
| 2007 | 58 | 57 | 115 |
| Grand Total | 199 | 155 | 354 |

Figure 10: Community Clinic Consultation Data Form – Male visits 20 – 24 yrs



| | |
|-------------|-------|
| Month | (All) |
| Gender | Male |
| First Visit | (All) |
| Age group | 20-24 |

| Count of Number | | Ethnicity | | |
|-----------------|--------------------|------------|------------|-------------|
| | | Maori | Non Maori | Grand Total |
| Year | | | | |
| | 2003 | 50 | 29 | 79 |
| | 2004 | 34 | 59 | 93 |
| | 2005 | 46 | 50 | 96 |
| | 2006 | 40 | 49 | 89 |
| | 2007 | 48 | 30 | 78 |
| | Grand Total | 218 | 217 | 435 |