



Request for Action on the
Development of a
National Sexual Health Strategy
and Action Plan

New Zealand Sexual Health Society report to the
Ministry of Health on sexually transmitted
infections in New Zealand

Prepared by the New Zealand Sexual Health Society, June 2011

Contents

Executive Summary	3
NZ has a high burden of STIs	3
Factors that need to be addressed in order to improve current status	3
NZSHS recommendations	3
Background	4
Why we need a national strategy	5
1. High burden of STIs	5
2. Lack of integration of current policies and strategies	5
3. Incomplete STI surveillance	6
4. Lack of best practice guidelines for primary care practitioners	7
5. Lack of best practice specifications for sexual health services	9
6. Lack of formal workforce planning	10
7. Lack of integration of regional public health with sexual health services	13
Conclusion	14
What key actions are needed?	14
What will be gained?	14
What do we wish to avoid?	14
Appendix 1: The High Burden of STIs in NZ.....	16
Chlamydia and Gonorrhoea	16
Infectious Syphilis	17
Viral STIs	17
HIV/AIDS.....	17
Summary	18
Appendix 2: About the NZSHS	19
Objectives of the society.....	19
Activities.....	19

Executive Summary

NZ has a high burden of STIs

- High prevalence of chlamydia and gonorrhoea in young people, Maori and Pacifica (see Appendix 1)
- Increasing incidence of HIV and infectious syphilis in men who have sex with men (MSM)
- Unacceptably high levels of notifications of neonatal STIs
- High levels of stigma and ignorance regarding STIs

Factors that need to be addressed in order to improve current status

- Incomplete surveillance and no analysis or action on current surveillance reports
- Lack of co-ordination and integration between strategies for sexual health, HIV and reproductive health
- Lack of national best-practice guidelines and primary care resources to improve case management of sexually transmitted infections
- A lack of comprehensive best practice specifications for sexual health services and failure to implement current specifications across all DHBs
- Lack of workforce planning for sexual health sector
- Lack of integration between sexual health and regional public health services

NZSHS recommendations

- A comprehensive sexual health strategy integrated with reproductive health and HIV strategies
- Consistent national minimum data collection of key sexual health indicators
- Full burden of disease assessment and economic evaluation of a national strategy
- A national research program and national clearinghouse on sexual health
- Provision of a full range of community information strategies

Background

Sexually Transmitted Infections (STIs) are common in New Zealand and have a variety of possible complications, including chronic pain, infertility, neonatal morbidity and genital tract cancer. Although the epidemiology differs slightly for each STI, population groups that suffer the greatest burden of reported infections are young people, Maori and men who have sex with men (MSM). The increase in notifications of bacterial STIs including chlamydia, gonorrhoea and infectious syphilis in New Zealand over many years is an indication that current provision of sexual health care is inadequate. Management of STI complications will continue to contribute to the financial burden of District Health Boards (DHBs) already experiencing tight fiscal constraints. Poor sexual health impacts heavily on individuals, families, relationships and communities, as well as the New Zealand economy.

A plethora of current policies, strategies, guidelines and resources address particular aspects of sexual and reproductive health and HIV but no policy or strategy to date specifically addresses control of sexually transmitted infections. An effective STI strategy needs to be placed within a comprehensive and evidence-based framework that also attends to reproductive health issues such as unwanted pregnancies, HIV and other inter-connected, multidimensional influences that contribute to sexual ill-health. Unfortunately New Zealand lags behind England, Scotland, Australia and several northern European countries that have taken a strategic national approach to sexual health.

Why we need a national strategy

In New Zealand, where the overall population is among the healthiest in the world, we have unacceptably high levels of sexual ill health. There is a clear link between sexual ill health, poverty and social exclusion and therefore STI's disproportionately affect Maori, youth, MSM and marginalised groups. Variations in the quality of and ability to access sexual health services across the country contribute to the burden of ill-health amongst affected populations.

A comprehensive national strategy would address not only pressing issues inhibiting optimal clinical management of sexually transmitted infections, but also issues regarding the inadequacy of systemic infrastructure that is hindering the establishment of a properly configured, effective and efficient sexual health sector.

1. High burden of STIs (see Appendix 1)

New Zealand's high burden of STIs is in part enabled by:

- Incomplete STI surveillance
- The lack of integration and coordination between current policies and strategies
- A lack of best practice guidelines and resources for primary care practitioners
- Failure by some DHBs to implement best practice specifications for sexual health services
- Poor workforce planning
- Lack of integration between regional public health and sexual health services
- Low priority within the Ministry of Health. There is no sexual health portfolio manager in the communicable diseases team.

2. Lack of integration of current policies and strategies

Many current sexual health policies, and others affecting sexual health are not consistent with best practice. The main problems with current policies and strategy are that they:

- Focus on single issues/infections (e.g. HIV)
- Fail to co-ordinate and link inter-dependent strategies (e.g. mental health, reproductive health or substance abuse with sexual health)
- Are too broad in their approach and do not include specific objectives, action plans and timelines.
- Appear to not be implemented fully or evaluated appropriately

- Are not developed with appropriate community and stakeholder participation
- Fail to address:
 - marked differences in the application of sexual/reproductive health guidelines between services and DHBs
 - significant gaps in accurate and comprehensive data on which to base policies and evaluation

3. Incomplete STI surveillance

Epidemiological surveillance refers to the organised ongoing collection, analysis and interpretation of relevant health data in a population, which is used to plan and evaluate health policy and practices. If data collection and analysis are inadequate then emerging diseases and outbreaks may be overlooked and any interventions to address identified health problems cannot be properly evaluated. It has been well highlighted to the Ministry of Health by NZSHS in the past that epidemiological surveillance of STIs in New Zealand is inadequate, and various submissions have been made outlining how improvements could be made but thus far no action has been taken.

The available STI surveillance data are collected and collated by ESR. However as some basic risk and demographic information is not being collected, for example sexual behaviour, the value of the reports that can be generated is limited. Similarly there are weaknesses in the way the data are collected are analysed, for example the number of clinic visits are used to derive disease rates rather than the number of people actually being tested.

Another major limitation of current STI surveillance is that whilst information on people with bacterial and viral STIs in all public sexual health clinics, and some student health services and FPA clinics are readily available, data on the number diagnosed and treated in primary health care organisations are not. Part of the gap in STI surveillance from primary care is covered by voluntary laboratory reporting of cases of chlamydia and gonorrhoea, however although these are available from most laboratories, there is a lack of coverage in some areas as there is no legislative requirement for them to provide this. Furthermore, there is no information from primary care services on diagnoses of infectious syphilis and viral STI's. We find it unacceptable that a developed country such as New Zealand does not have any reporting requirements for a serious infection such as syphilis, despite the fact that there is a current outbreak of this in our MSM population.

In summary while surveillance systems for STIs should be able to provide information about (a) the number of cases of STIs in the whole population, and in groups based on age, sex, ethnicity, place of residence and sexual behaviours (i.e. MSM), (b) diagnostic and screening activity in different health service settings, and (c) the impact of interventions, this is not the case at present in New Zealand. Complete STI surveillance is also needed to inform cost-benefit analyses of proposed STI interventions.

Useful surveillance systems for STIs should be evaluated in terms of their ability to provide information about:

- The number of cases in defined populations
- Rates of infection in groups identified to be at high risk of infection
- Diagnostic and screening activity in different health service settings i.e. population coverage
- The measurable impact of interventions

The weaknesses in many aspects of the current level of epidemiological surveillance of STIs in New Zealand mean that not all of these objectives can be achieved.

For example we do not know:

- The overall burden of STIs in the whole population or in specific high-risk groups
- Whether current healthcare and prevention services are being accessed appropriately by those most at need
- Whether current prevention and health promotion activities are having any impact on incidence and prevalence of sexually transmitted infections
- What proportion of cases of reproductive tract complications such as pelvic inflammatory disease, ectopic pregnancy and sub-fertility is directly attributed to sexually transmitted infections

This information is important in order to calculate more accurately cost-benefit analyses of proposed STI interventions. It is hoped that the long-delayed introduction of the public health bill will address some of the gaps in STI surveillance in New Zealand but this will not be a complete solution to the problem.

NZSHS recommends that a comprehensive review of epidemiological surveillance of STIs in New Zealand be undertaken to inform an action plan to correct these deficiencies and deficits.

4. Lack of best practice guidelines for primary care practitioners

Because the majority of STI's in New Zealand are diagnosed and treated by primary care practitioners, there is an urgent need for nationally endorsed and centrally funded guidelines for the management of sexually transmitted infections for clinicians working in this sector. Good evidence-based New Zealand best practice guidelines are an essential component of effective STI management. Effective STI management is important to reduce potential complications, and can help prevent onward transmission of infection. Partner notification is an important component of effective STI management. Studies overseas and in New Zealand have identified that primary care practitioners often may not adequately manage partner notification and would welcome better

resources and training in the management of partner notification. A UK study found that with a little training, practice nurses can manage partner notification as effectively as fully-trained sexual health clinic staff and therefore it would be worthwhile for New Zealand to explore the issue of how to better resource primary care practitioners to manage STI's.

While currently there are some specific New Zealand best practice STI guidelines available for use by primary care clinicians, their existence is due to the voluntary hard work of a few dedicated professionals and their continued good will. These include the primary care guidelines (produced by a partnership between Counties Manukau District Health Board and Auckland Sexual Health Service) and the guidelines produced by the New Zealand Herpes Foundation and Viral STI Foundation. There does not however appear to be a commitment for long-term centralised funding and updating of these resources. For these reasons future access to these resources cannot be guaranteed. Recently DHB funding for the NZHF resources was going to be withdrawn and the decision was only reversed after extensive lobbying from clinicians working in sexual health care.

The STI management guidelines most commonly used by sexual health specialists in New Zealand are the US Centre for Disease Control guidelines (<http://www.cdc.gov/std/treatment/>) and guidelines produced by the British Society for Sexual Health and HIV (<http://www.bashh.org/>). For HIV management sexual health specialists tend to refer to the Australian commentary on the HIV guidelines produced by the US Department of Health and Human Services (DHHS), which can be found on the website of the Australasian Society of HIV Medicine (http://www.ashm.org.au/default2.asp?active_page_id=252#).

The CDC guidelines and the BASHH guidelines do not have a New Zealand commentary and therefore not all the recommendations regarding management are applicable to a New Zealand context. However in the absence of New Zealand national guidelines, they remain very useful resources and could form the basis of both specialist and primary care guidelines for New Zealand.

NZSHS recommends:

- The continuation of funding pathways for current NZ evidence-based STI guidelines where they exist
- That funding be established to develop and maintain up to date national evidence-based STI guidelines for primary care practitioners
- That funding be established to develop appropriate resources for primary care practitioners to assist with STIs management e.g. patient information leaflets, partner notification resources

5. Lack of best practice specifications for sexual health services

There are many examples of good and innovative sexual health services across New Zealand. However, there are wide regional variations in terms of availability, quality and access to sexual health services. Lack of knowledge about where or how to access available services may discourage or delay attendance, delay referral and result in poor or sub-optimal management of sexual-health problems.

Whilst New Zealand does have some guidelines for DHBs in the form of the tier 2 specifications, they are not comprehensive enough and lack specific detail when compared with similar documents in other countries like the UK. Furthermore the less comprehensive New Zealand tier 2 specifications are not fully implemented in all regions and all DHBs. All DHB's in New Zealand should be required to provide sexual health services of a specified minimum standard to reduce inequalities in regional access to primary and secondary services.

As an example, while primary care organisations diagnose and treat the greatest numbers of people with chlamydia and gonorrhoea, young men are under-screened in primary care settings and partner notification is often not adequately managed by primary care practitioners. Cost is often a barrier for young people accessing primary health care and this issue needs to be addressed in any sexual health strategy. To illustrate this, a Waikato study found that chlamydia test uptake in the under-25 year age group was much higher in GP practices where sexual health consultations were free.

The challenge is to secure a cohesive, seamless approach to clinical services. The fundamental principle should be that every person should have a choice when accessing sexual health services and be able to self refer to all such services. NZSHS recommends that delivery of sexual health services be guided by robust best practice specifications that make best use of physical premises and human resources, with geographical outreach and extended user-friendly opening hours becoming the norm. In particular, a greater focus on rapid access to a primary care centred model of care would be helpful. It would also contribute to the provision of better, sooner, more convenient access to sexual health care.

It is important that appropriate clinical standards be developed for dealing with sexually transmitted infections. Performance targets are also important to help monitor service development and ensure that patients get the quick, responsive service they need.

Service specifications exist for other countries operating services in a similar way and these could be used as templates to guide New Zealand practice.

NZSHS recommends that sexual health service specifications be developed to ensure properly configured diagnostic and clinical management approaches that:

- Accurately diagnose and treat sexual health problems
- Respect concerns about patient confidentiality
- Restore and maintain optimal sexual health
- Reduce inequalities in Maori sexual health status
- Provide sexual health education and promotion that is both individual and community based
- Allow for effective partnership with primary care medical practitioners including Maori providers for ongoing management of conditions
- Carry out and train other providers in partner notification to prevent the spread of infection
- Provide easily accessible counselling to aid adjustment to ongoing conditions

6. Lack of formal workforce planning

Medical Workforce

There is a national shortage of Sexual Health Physicians (SHPs) and they are unevenly distributed throughout the country. New Zealand now has a population of nearly 4 million people but has only 8.4 full-time equivalents (FTE) SHPs. There are 34 sexual health clinics, and fewer than half of these have associated consultant SHP positions. The majority of consultant SHP positions are in Wellington, Hamilton, Auckland and Christchurch, thus many sexual health clinics in smaller centres do not have any consultant SHP cover. These clinics are therefore unable to offer secondary sexual health services, and there is no opportunity for clinical supervision and ongoing education for their staff. Registrars are being trained in sexual health medicine only in Auckland, Hamilton and Wellington and in the latter 2 services they are employed only part time. Of particular note is the fact that over the past 15 years, the workforce situation has deteriorated. In previous years there was a consultant SHP position in Dunedin, a registrar training post in Christchurch, and a 0.6 FTE training post in Wellington. A recent study found that there is considerable variation in the quality and quantity of undergraduate medical training in sexual health medicine in Australian and New Zealand medical schools and this could be addressed by an appropriately trained specialist workforce and a commitment to the development of such a workforce.

Unfortunately there are no current recommendations for workforce development of sexual health medicine in New Zealand. However, recommendations for appropriate workforce development have been made for genitourinary medicine (the equivalent speciality) in the UK (most recently 2001/2002) and, based on UK information, the 1989 DOH document Area Health Board Service Planning Model for Sexually Transmissible Diseases makes recommendations for further workforce development in sexual health medicine in New Zealand. Both these documents estimate that there should be one FTE SHP for every 100 –120 000 population depending on HIV workload.

The UK data, however, is only partially applicable to New Zealand because here the majority of HIV care is provided by infectious diseases physicians, and in the UK the majority of sexual health care is provided by sexual health clinics, whereas in New Zealand primary health care practitioners provide a significant proportion of care. The above figure therefore needs to be adjusted, and a conservative estimate, based on the limited available data, would be that 1 FTE SHP is required per 250 000 population, thus a minimum of 16 FTE SHPs would be needed to provide adequate specialist sexual health care for New Zealand at its current population of approximately 4 million.

Health promotion workforce

The Sexual Health, Health Promotion workforce is currently fragmented and under resourced. While there are examples of sexual health specific health promotion and education positions many public health units across the country have generic youth health promotion roles of which sexual health is one of many health areas of focus. This poses difficulties as the focus often falls on other health areas such as mental health or alcohol and drugs leaving very little time for sexual health promotion.

In terms of workforce development this is almost non-existent. Linkages between district health board health promoters have been maintained through the PASHANZ network which has been run by health promoters in addition to their day to day activities. This group meets twice yearly, once via teleconference and then adjoining the New Zealand Sexual Health Society conference. This is used as a platform for information sharing and discussing any regional issues that may be of interest to others around the country. Attendance of face to face meetings at the NZSHS conference is often poor as funding for travel is not readily available to health promoters.

Nursing workforce

The New Zealand Sexual Health Nursing workforce varies greatly between the district health boards. This is due to the different ways in which professional development is supported and funded, access to clinical skills supervision and training and the lack of specific post graduate education also has an impact. The nursing profession has the potential to complement the medical, health promotion and counselling professionals working in sexual health, by providing clinical care through the complete patient journey and providing nursing support to patients requiring complex management by Sexual Health Physicians. Within some DHBs this is already occurring but there is no national plan for developing the nursing workforce and current development relies on the ad hoc sharing of resources such as professional development workbooks, standing orders and guidelines.

There are potential inconsistencies in how the various nursing roles and levels of practice are defined and acknowledged. There is no national definition of the levels of competencies for staff

nurses or senior nurses working in Sexual Health. The development of a national competency guideline would ensure nurses in Invercargill will have the same professional opportunities as those in Auckland.

Maori and Pacific Island Workforce

With regard to Sexual Health, both Maori and Pacific Island people are over-represented in STI statistics, particularly bacterial STIs such as chlamydia and gonorrhoea. An essential part of sexual health work in New Zealand should be to redress this imbalance. Currently there are no Maori or Pacific Island SHPs, and there are insufficient other Maori or Pacific Island sexual health workers. Further information is required regarding preferences of Maori or Pacific Island patients for the method of provision of sexual health care and ethnicity of providers, and promotion of sexual health as a career option for Maori and Pacific Island health workers is required.

It is envisaged that public sexual health clinics will continue to be the backbone for primary and secondary sexual health care services and that primary health care practitioners will continue to provide a significant proportion of sexual health care in the community.

NZSHS recommends:

- There should be a minimum of 16 FTE SHPs nationally based on the current New Zealand population
- Every sexual health clinic should have specialist SHP staff with FTE based on the regional population
- Every sexual health clinic should have expert sexual health nursing staff in post
- Every sexual health clinic should have dedicated health promotion staff closely linked to the clinic
- Sexual health clinics should have a major role in training and support of primary health care providers and undergraduate medical students
- At least one registrar training post should be available in every main centre
- Within sexual health physician positions there should be specific provision of time for research and public health related activities, as this is essential to the maintenance of academic excellence, as well as being crucial to achieving the public health goal of prevention and control of STIs
- The numbers of Maori and Pacific Island SHPs and health workers in the field of sexual health should be increased in order to better provide culturally appropriate sexual health care to these groups
- Core teaching competencies & minimum standards for sexual health education should be developed

7. Lack of integration of regional public health with sexual health services

Sexual health services in New Zealand have no formal connection to public health services resulting in:

- A lack of resources for specialised contact tracing
- No public health input to disease surveillance
- No ability to respond to disease outbreaks e.g. current infectious syphilis outbreak in MSM
- A lack of co-ordinated health promotion strategies to reduce disease
- The separation of clinical services and health promotion in many centres

The lack of connection between sexual health services and public health means that even the incomplete surveillance data that is collected cannot be acted upon. For example, a current outbreak of infectious syphilis in MSM has been identified and high rates of gonorrhoea in the eastern North Island have consistently been reported through ESR disease surveillance data. Despite this, no appropriate action has been taken in the formulation and implementation of a control strategy for these infections. Appropriate follow-up is absolutely essential if we are to have an impact on the overall sexual health of New Zealand.

With respect to health promotion, if public health is disconnected from clinical services we cannot hope to have a co-ordinated strategy for improving prevention, early detection and control of STIs in our communities.

NZSHS recommends:

- Formal connections between sexual health and public health
- Funding for public health responses to disease outbreaks
- The alignment of sexual health promotion activities with clinical services and public health action

Conclusion

What key actions are needed?

- A comprehensive sexual health strategy integrated with reproductive health and HIV strategies
- Consistent national minimum data collection of key sexual health indicators
- Full burden of disease assessment and economic evaluation of a national strategy
- A national research program and national clearinghouse on sexual health
- Provision of a full range of community information strategies

What will be gained?

A comprehensive and evidence-based national strategy would provide leadership in the co-ordination of action to improve services, information and support, reduce inequalities and improve health. It would also:

- Enable comprehensive and appropriate sexual health data collection
- Reduce preventable STI complications including PID, chronic pelvic pain, infertility, neonatal morbidity, and genital tract cancers such as vulval anal and cervical cancer
- Reduce the transmission and prevalence of STIs and HIV
- Reduce the economic costs associated with sexual ill-health
- Reduce discrimination associated with early parenthood or sexuality and gender identity and the associated poor health
- Reduce the stigma associated with STIs and HIV
- Improve the overall sexual health and wellbeing of the NZ community

What do we wish to avoid?

- An ongoing economic drain on health services with unacceptable poor sexual health status of some sectors of the population
 - Increasing HIV and infectious syphilis rates
 - Avoidable mental illness burdens from STI's

- Complications of bacterial STI
- Complications of viral STI
- Continued inequitable access to specialist and primary care sexual health services
- Continuing gaps in knowledge due to inadequate data collection
 - Inability to adequately monitor STI prevalence and incidence
 - Inability to identify and manage disease outbreaks
 - Inability to measure the impact of interventions
- Less effective strategies due to lack of integration and co-ordination
- A continued climate of lassitude and inaction regarding our STI problem

Appendix 1: The High Burden of STIs in NZ

Chlamydia and Gonorrhoea

Notwithstanding the data limitations we know that the burden of bacterial STIs is very high in New Zealand. The estimated national chlamydia rate for New Zealand in 2009 (803 per 100,000 population) was two to four times higher than the national chlamydia rates most recently published for Australia, the United Kingdom, and the United States. For gonorrhoea, the estimated national rate for New Zealand in 2009 (66 per 100,000 population) was approximately twice the national rates observed in Australia and the United Kingdom. Infectious syphilis notifications have increased by a staggering 293% since 2005.

Bacterial STIs are of particular importance because of their possible health consequences e.g. pelvic inflammatory disease, infertility, ectopic pregnancy, chronic pelvic pain, epididymo-orchitis, and foetal/neonatal infection. Chlamydia and gonorrhoea disproportionately affect young people and those of Maori and Pacific ethnicity and this issue needs to be addressed in any sexual health strategy.

Increasing rates of antibiotic resistance pose a further threat to gonorrhoea control. In 2002 the overall rate of ciprofloxacin resistance in New Zealand was 6.8% but this had increased to 30% by 2009. Ciprofloxacin resistance continues to increase particularly in areas of high gonorrhoea prevalence such as Auckland and ceftriaxone is now the recommended first-line drug to treat gonorrhoea in many regions of New Zealand. Whilst ceftriaxone is available on MPSO to primary care practitioners to treat uncomplicated gonorrhoea, many are unaware of this. The drug is also recommended to be used as first-line treatment of pelvic inflammatory disease (particularly in areas of high gonorrhoea prevalence) however primary care practitioners cannot access ceftriaxone for this indication. Already overseas there are reports of increasing resistance to ceftriaxone and this will further limit treatment options for gonorrhoea and PID once resistant isolates spread within our population.

Interestingly a Waikato study has found that admission rates for PID and chlamydia-related pelvic infections rose between 2005 and 2008 for young women aged 15 to 24. Although this did not appear to have an impact on other reproductive complications such as infertility and ectopic pregnancy these trends need to be closely monitored (Morgan J et al, in-press Sexual Health).

A further worrying trend is the unacceptably high number of babies diagnosed with chlamydia and gonorrhoea infections. One hundred and forty chlamydia cases and 6 gonorrhoea cases were reported in 2009 for those aged under- 1 year. This is a complication of undiagnosed and untreated infection in the mother before delivery and probably reflects inadequate training of lead maternity caregivers.

This issue needs to be further investigated.

Infectious Syphilis

The incidence of infectious syphilis has increased annually in recent years in New Zealand, particularly in the Auckland region according to ESR data. However the ESR data is an underestimate as a study in Auckland found that approximately 30% of cases did not present to a public sexual health clinic and therefore would not have been reported (unpublished). Published data from studies conducted in Auckland and Wellington indicate that the majority of New Zealand acquired cases of infectious syphilis occur in men who have sex with men (MSM). This is of real concern because syphilis is known to enhance transmission of HIV and MSM are at particular risk. Unfortunately ESR does not report data on sexual behaviour and so there is limited information on the epidemiology of infectious syphilis in New Zealand.

Syphilis can also cause adverse pregnancy outcomes and congenital infection and whilst syphilis is currently uncommon in the heterosexual population it is known about 10% of MSM also have sex with women thereby posing a risk for heterosexual transmission. As about 50% of infectious syphilis cases are asymptomatic, the diagnosis may be missed if regular screening of high-risk groups is not undertaken.

Despite repeated attempts to bring this serious public health issue to the attention of the Ministry of Health, no action has been taken. Members of the NZHS have taken matters into their own hands by setting up a steering group to implement a voluntary enhanced surveillance system of public sexual health clinics in order to improve knowledge of the epidemiology of infectious syphilis in New Zealand.

Viral STIs

Reported cases of viral STIs such as genital warts (human papilloma virus) and genital herpes (herpes simplex virus) have remained fairly stable since 1996. However these figures are unreliable due to the asymptomatic nature of most of these infections. The more serious complications of viral STIs include cervical, vulval and anal cancer, and serious neonatal disease from maternal transmission of herpes simplex virus. They also cause significant psychosexual morbidity because of the stigma associated with those infections largely due to lack of public knowledge and awareness.

Unfortunately coverage rates for the quadri-valent HPV vaccination remain unacceptably low in some sectors of the population for a variety of reasons and therefore health sequelae as a result of HPV infection are likely to be with us for some time yet.

HIV/AIDS

Notifications of HIV infection in New Zealand have increased since 2000 after a period of relative stability. This trend is due to increased infections in MSM as heterosexual notifications have declined during the same time period, probably as a result of immigration screening which was introduced in 2007. The majority of HIV infections in MSM are now acquired in New Zealand and this probably reflects a decrease in condom use. There have been similar trends noted for syphilis and HIV in MSM in other developed nations and if it continues will have a major impact on the healthcare and pharmaceutical budget within New Zealand.

Summary

- New Zealand has much higher rates of bacterial STIs than with other OECD countries
- Complications of bacterial STI are potentially costly and there is some evidence that rates of PID are increasing
- Unacceptable numbers of neonates continue to be diagnosed with bacterial STI's
- Notifications of infectious syphilis and HIV in MSM are increasing annually

Appendix 2: About the NZSHS

The New Zealand Sexual Health Society (NZSHS) Incorporated is a group of professionals working or interested in the field of Sexual Health. Membership is multidisciplinary and includes doctors, nurses, counsellors, educators, health promoters and others in Public Health working in the field of sexually transmissible infections, including HIV/AIDS, and sexual and reproductive health.

The New Zealand Sexual Health Society Inc. was formerly the New Zealand Venereological Society (NZVS). This change occurred in 2006 to more fully express the wider aims of this society.

The Society became incorporated in April 2010.

Objectives of the society

- To advocate for and promote Sexual Health for all in New Zealand.
- To promote high standards of clinical practice within Sexual Health in New Zealand
- To promote the speciality of Sexual Health amongst colleagues and peers
- To encourage research within New Zealand with regard to Sexually Transmissible Infections (STIs).

The Society organises an annual conference, which includes an Annual General Meeting (AGM) and an academic programme. The Society's executive committee is elected at the AGM. Members must be financial to participate in the AGM or at Special General Meetings.

Activities

- Promoting STI/HIV prevention and Sexual Health for all through education
- Acting as advocates for those most at risk of STIs and HIV/AIDS
- Ongoing central lobbying to ensure an continued commitment to the tenets of Sexual Health including free, confidential and widely available specialist clinical services
- Regular education forums for health professionals to provide ongoing education and support
- Advisory role to the Ministry of Health and other government agencies in relation to proposed legislative or policy changes affecting Sexual Health
- Monitoring the epidemiology of STIs and HIV/AIDS, and hence lobbying for appropriate intervention strategies
- Promoting the implementation of health education programmes

- Promoting the development of national guidelines for STI management
- Informing and updating NZSHS members through the NZSHS Bulletin