Submission to ADHB, WDHB and CMDHB
On the Consultation Document
Auckland Regional Sexual Health Service Workforce Review

19 May 2015

To: Nicola Hill, Level 5, Administration Suite, HR Department, Auckland City Hospital
NHill@adhb.govt.nz

From: Dr Peter Saxton
Director, Gay Men's Sexual Health research group
University of Auckland
E p.saxton@auckland.ac.nz
M 027 604 1930

Introduction

Thank you for receiving this submission. The Gay Men's Sexual Health research group (GMSH) has a strong interest in the Auckland Regional Sexual Health Service (ARSHS) Workforce Review. We conduct behavioural and epidemiological research into HIV and sexual health/sexually transmitted infection (STIs) in New Zealand with a focus on men who have sex with men (MSM). Our funders include the Ministry of Health, the Health Research Council and the New Zealand AIDS Foundation.

MSM are a key population of interest for this proposal for a number of reasons, including:

- MSM experience the highest prevalence of HIV infection in this country;[1,2]
- STIs including syphilis, gonorrhoea, LGV and human papillomavirus (HPV) disproportionately affect MSM [3,4] and the ongoing syphilis outbreak continues to worsen.[5]

We are writing in response to the consultation document issued 29 April 2015.

People seeking sexual health care have unique and urgent needs

1. Sexually transmitted infections (STIs) are a serious public health issue.[6] The US CDC has named gonorrhoea as the third most urgent antibiotic-resistance threat.[7] New Zealand has high rates of chlamydia and gonorrhoea notifications compared with other OECD countries. Auckland in particular has reported sharp increases in syphilis and a rise in HIV diagnoses.

2. Sexual health concerns are highly sensitive and embarrassing for many people, not just for the young and marginalised. Many people will avoid seeking sexual health screening if they perceive barriers such as cost, access, privacy or lack of sensitivity. This is exacerbated due to the stigma associated with sexual health problems that is not experienced for other health concerns. Delays

in seeking sexual health advice and treatment due to any of these barriers foster ongoing spread of STIs in the community, and will significantly worsen public health outcomes.

3. Internationally, public health best practice has for decades therefore emphasised "rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times".[8] At a practical level this means reducing not increasing barriers to care.

Policy framework in New Zealand

4. Locally and publicly there is high level support for increasing and improving sexual health services and outcomes. This is witnessed in the independent expert report by NZ Sexual Health Society,[9] the report of the Parliamentary Select Committee,[10] and the Rainbow Health report.[11] The recent "Roastbusters" scandal illustrates the high public and media concern about addressing serious sexual health issues appropriately.[12] We strongly recommend that the current proposals are audited against these expert reports in order to guarantee good fit with Auckland's future sexual health care needs.

Proposed overall 30% volume reduction

5. We support improving the quality of sexual health care in primary care by GPs. However, on the evidence presented we disagree that a 30% reduction in the SHSs is justified or sustainable given Auckland's sexual health care needs.

6. We query the justification and sustainability of the proposed 30% reduction in contracted volume. This is reportedly based on an analysis by the ADHB and WDHB Hospital Funder Group yet we cannot examine its assumptions as this has not been made available.

7. SHS attendees already have a choice between seeing a GP and the SHS for sexual health services and they prefer the SHS as an alternate entry point to care. Reasons for preferring SHSs are likely to include privacy, expertise, comprehensiveness, access, and an absence of stigma, prejudice and judgementalism.

8. We ask what evidence there is that individuals who currently attend SHSs would seek sexual health screening or treatment at a GP? What evidence is there that GPs will provide the same quality of service (comprehensiveness, prevention advice, non-judgementalism) as do the SHSs? In other words, that the shift in service provision will not reduce the quality of sexual health care?

9. Current evidence supports the contrary positon – that many GPs do not feel competent discussing sexual health, especially with males.[13] We ask what measures ADHB/WDHB have put in place to improve GP training around sexual health screening, advice and contact tracing?

10. New Zealand currently underinvests in sexual health physicians (SHPs). Expert advice from the NZ Sexual Health Society in 2011 recommended a doubling in FTE SHPs nationally from 8.4 to 16 based on UK benchmarking and a population of 4 million.[9] The proposed cuts in FTE SHPs do the opposite and further worsen New Zealand's specialist capacity.

Disproportionate proposed reduction in Central Auckland

11. We particularly disagree with the proposed reduction from 45 to 20 weekly clinics in Central Auckland and contest the assertion that this reflects demographic changes in key priority groups.

12. Central Auckland is where the majority of men who have sex with men (MSM) are concentrated. An analysis of Census and survey data indicate intense geographic microclustering of MSM in Auckland inner city districts[14] and there is no evidence this has changed. Decisions about the regional allocation of sexual health services must reflect all priority groups, ie. sexual orientation not just age or ethnic distribution.

13. The availability of the NZAF clinic in Ponsonby for MSM does not offset this problem as their service is currently oversubscribed and has no increased capacity in the current proposal.

14. The reduced hours for sexual health services in Auckland Central will disproportionately impact on MSM as many will not be able to access the new reduced clinic time options. This will decrease access to timely sexual health services for MSM. MSM on average have more rapid partner turnover than do non-MSM so delays in screening, diagnosis, treatment and contact tracing will result in relatively more onward transmission.[15] This is in a context where STIs among MSM in Auckland are already rising.

Priority groups

15. Although we disagree that a 30% reduction in volume is justified or sustainable based in the available evidence, we strongly support continuation of free sexual health services for MSM and other groups at elevated risk (MSM, persons aged <25, sex workers, transgender, Maori and Pacific, people living with HIV, people who inject drugs, "other risk groups").

16. MSM in particular are disproportionately affected by STIs as well as HIV, and incidence appears to be rising in New Zealand. In a 2011 community study 8.3% of Auckland MSM had been diagnosed with an STI in the previous 12 months;[4] in 2014 this had risen to 11.7%.[15]

17. Syphilis is especially concentrated among MSM with 86% of male cases occurring in this group and Auckland is experiencing an outbreak.[5] Syphilis is frequently unrecognised or misdiagnosed therefore it is paramount that specialist primary sexual health services remain accessible to MSM.

18. Lymphogranuloma venereum (LGV) is also increasing among MSM in Auckland and is very unlikely to be easily recognised by GPs.[16]

19. Rectal STIs such as gonorrhoea, chlamydia, HPV, HPV-related warts and pre-cancer/cancers are more prevalent among MSM. Many MSM may be uncomfortable asking their GP to screen for rectal STIs as they may be embarrassed or feel unsafe disclosing their sexual orientation. Likewise many GPs may not think to screen for rectal STIs in males or may be reluctant to do so.[17]

20. Importantly, SHSs are now the most common setting utilised by MSM for sexual health screening and treatment. In repeat community studies in Auckland, the proportion of MSM utilising a SHS for their last visit increased from 32.7% in 2008, to 35.6% in 2011, to 42.6% in 2014. In contrast utilisation of GPs decreased from 50.3% in 2008, to 47.4% in 2011, to 35.3% in 2014 (p for trend <0.001) (remainder used community settings such as NZAF).[18]

21. Critically, new HIV prevention interventions for HIV negative MSM such as pre-exposure prophylaxis (PrEP) will require careful infectious disease monitoring and prevention advice, and consequently are optimally provided through SHSs rather than GPs. Discussions around a potential pilot project in SHSs have already begun.

22. These factors make it imperative that accessible, comprehensive, gay-friendly sexual health services are available to MSM in Auckland if STI epidemics are to be controlled.

Surveillance and IT systems

23. We welcome the development of a Regional Clinical Governance Group for sexual health. We also welcome the proposal that a regional STI outbreak strategy will be informed by surveillance, monitoring and evaluation.

24. It is critically important that resources are provided to upgrade sexual health IT systems with great urgency so that information on MSM status of clients can be collected, extracted and reported easily. The present inability to analyse trends in STI among MSM makes it impossible to properly understand Auckland's epidemics and respond to them in a timely way.

25. Collecting and reporting MSM status is a basic requirement of STI systems worldwide and should be simple to implement if supported. The European CDC for example oversees multiple countries and high case numbers yet is able to report that 38% of all 47,387 gonorrhoea cases (male and female) occurred among MSM (ECDC 2013, p.20).[19] This has a profound effect on the commissioning, design and delivery (and effectiveness) of gonorrhoea prevention interventions.

26. The ability to report on the health status of MSM clients is also a key recommendation of ADHB's own report on Rainbow Health.[11] This report also highlighted the considerations required to meet the health needs of ADHB MSM and transgender clients.

27. As sexual orientation data are not yet routinely reported by GPs to ESR, the monitoring of STIs among MSM clients of SHSs is enormously valuable for understanding trends and designing effective public health responses.

28. Improvements to sexual health IT systems to report STIs by MSM status is recommended as a matter of the utmost priority.

Future consultation

29. We note that we have not been formally included in consultation. The current document refers to an initial consultation hui and client and provider survey in 2013 but we were not included in this, and we have only yesterday (18th May) received this document from a third party with feedback due today (19th May).

30. We note that MSM are listed as a priority group for sexual health. The Gay Men's Sexual Health research group at the University of Auckland has expertise to offer in this area and we believe it would be appropriate to include us in future consultation by ADHB and WDHB.

Thank you for considering this submission,
Yours sincerely,

Peter Saxton , PhD
Gay Men's Sexual Health (GMSH) research group, University of Auckland

[1] McAllister, S. M., Dickson, N. P., Sharples, K., Reid, M. R., Morgan, J. M., MacDonald, E. J. & Paul, C. (2008). Unlinked anonymous HIV prevalence among New Zealand sexual health clinic attenders: 2005–2006. *International Journal of STD & AIDS*, 19(11), 752-757.

[2] Saxton, P. J., Dickson, N. P., Griffiths, R., Hughes, A. J., & Rowden, J. (2012). Actual and undiagnosed HIV prevalence in a community sample of men who have sex with men in Auckland, New Zealand. *BMC Public Health*, 12(1), 92.

[3] Saxton, P. J., Hughes, A. J., & Robinson, E. M. (2002). Sexually transmitted diseases and hepatitis in a national sample of men who have sex with men in New Zealand. *NZ Med J*, 115(1158), U106.

[4] Dickson N, Ludlam A, Saxton P, Hughes A. Self-reported STIs and sexual health checks in a cross-sectional study of gay and bisexual men in New Zealand. *Sex Transm Infect* 2015;91:49-54.

[5] The Institute of Environmental Science and Research Ltd. Enhanced Surveillance of Infectious Syphilis in New Zealand Sexual Health Clinics - 2013 Porirua, New Zealand, 2014.

[6] The Institute of Environmental Science and Research Ltd. Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2013 Porirua, New Zealand, 2014.

[7] CDC. Antibiotic resistance threats in the United States, 2013.US Department of Health and Human Services, 2013. http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf#page=6

[8] UK Department of Health. A Framework for Sexual Health Improvement in England. London: UK Department of Health, 2013. https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

[9] NZ Sexual Health Society. Request for Action on the Development of a National Sexual Health Strategy and Action Plan. Auckland: NZSHS, 2011. http://www.nzshs.org/about/policy-submissions/188-development-of-a-sexual-health-strategy-and-action-plan/file

[10] Inquiry into improving child health outcomes and preventing child abuse, with a focus on preconception until three years of age (Parliamentary Select Committee Report 1.6A), Nov 2013.

[11] Stevens M. Rainbow Health: The Public Health Needs of LGBTTI Communities in Aotearoa New Zealand with Policy Recommendations. Auckland: Affinity Services; 2013. http://www.adhb.govt.nz/documents/Affinity_Services_Rainbow_Health_Report.pdf

[12] IPCA. Police response to media enquiries about 'Roastbusters'. IPCA: Wellington, 2014; IPCA. Report on Police's handling of the alleged offending by 'Roastbusters'. IPCA: Wellington, 2015.

[13] Woodbridge MR, Dowell AC, Gray L. 'He said he had been out doing the traffic': general practitioner perceptions of sexually transmitted infection and HIV testing strategies for men. *J Prim Health Care*. 2015: 7(1):50-56.

[14] Hughes A, Saxton P. Geographic micro-clustering of homosexual men: Implications for research and social policy. *Soc Pol J New Zealand*. 2006; 28:158-178.

[15] Saxton P, Dickson N, Hughes A, Ludlam A. Gay Auckland Periodic Sex Survey (GAPSS) and Gay men's Online Sex Survey (GOSS): Basic frequency tables 2002-2014. Auckland, New Zealand: The University of Auckland; 2014.

[16] Basu I, Bromhead C, Balm M, et al. Lymphogranuloma venereum in men who have sex with men: evidence of local transmission in New Zealand. *N Z Med J*. 2015:128.

[17] Saxton P, Morgan J, Ludlam A. Time to modernise response to sexually transmitted infections. *N Z Med J*. 2015:128.

[18] Saxton P. Changes in behaviour over 30 years. Paper presented at: 30th Anniversary HIV Clinical Update, Auckland, 8 May 2015. https://www.eiseverywhere.com/ehome/111782/Presentations/

[19] European Centre for Disease Prevention and Control. A comprehensive approach to HIV/STI prevention in the context of sexual health in the EU/EEA. Stockholm: ECDC; 2013.