

Equity in sexual and reproductive health – an ongoing challenge

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The quest for equity in health is ongoing at individual, organisational and government levels. Health equity is defined as the absence of systematic disparities between groups with different levels of underlying social advantage and disadvantage.¹ The social, economic, cultural, ethnic, geographical, political and many other issues that influence health and wellbeing are diverse.^{2,3} For sexual and reproductive health this is particularly challenging.⁴ For example, the issues that a rural teenager faces accessing sexual health care that feels right for them could be very different from those of a university student living in a city.

Two New Zealand studies on contraception are included in this issue of the *Journal of Primary Health Care*. One explores issues around access to and use of contraception for a group of Māori teenagers who became pregnant.⁵ The other studies women's experiences with the long acting reversible contraceptive implant (LARC), Jadelle®, after having this inserted at Family Planning Clinics throughout the country.⁶ LARCs, including Jadelle®, intrauterine devices and the Depo Provera injection, are increasingly recommended as first-line contraceptives as they have high efficacy, not being dependent on daily pill taking.⁷

In the study of contraception use among a group of pregnant Maori teenagers, many described difficulty accessing contraception before their pregnancy.⁵ Some who had, described difficulty understanding how to use it. Very few had used LARCs. Following delivery, most of these teens were using contraception with more than 50% choosing LARCs (Depo Provera® or Jadelle®). However one year after delivery 20% were not using contraception and 10% were pregnant again. Were their sexual and reproductive health needs being met?

In the other study, after one year using Jadelle® ~80% of participants were positive about their

experience, although 18% had the implant removed, mainly because of side effects.⁶ About 25% of participants were Māori, mostly young - a higher proportion than in the general population. After one year of use, in this study Māori of all ages had the lowest rate of Jadelle® implant removal.

While one study highlights ongoing difficulties accessing suitable contraception the other indicates a high level of satisfaction with one of the newer and more reliable contraceptive methods available in New Zealand.

While the teenage pregnancy rate in New Zealand is still higher than other western countries, it is dropping.⁸ The rate among Māori is higher than the national teenage pregnancy rate but it is falling and the difference between the two is narrowing.⁹ The number of women seeking termination of pregnancy is also falling.¹⁰ The range of sexual and reproductive health education and clinical services in New Zealand has increased significantly including school based sex education programmes and sexual health clinics; Family Planning education programmes in schools and community, and Family Planning clinical services; sexual health clinics; other public health nurse sexual health services; Māori health providers of education and clinical services; iwi based health care services; along with general practice, emergency clinics, Student Health and community pharmacy services. Many sexual and reproductive health services are subsidised with public funding, and are often fully funded for young people.

The range of contraceptive methods has increased, including the introduction of two fully subsidised LARCs - the contraceptive implant Jadelle® and the most reliable copper intrauterine device (IUD), the TT380® IUD. Other contraceptives are also subsidised, but not all.¹¹

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The Mirena® intrauterine system, also a LARC, and the progestogen-only pill Cerazette® are not subsidised so are unavailable to many. Access to publicly funded sterilisation for both men and women is increasingly difficult to access or unavailable. Cost of contraceptives and of the medical service to access that contraception is variable in other western countries too.^{12,13} Access is also related to geography, availability of transport, culture, literacy, personal safety, etc.

With access to contraception the ability to control our fertility, prevent unplanned pregnancies, and plan our families is the most achievable it has ever been for people in New Zealand. This has major benefits for the health and well being of individuals, particularly women, but also men, their families and the community. However some people have better access to sexual and reproductive health services than others. We need to adapt our services and develop new initiatives to meet the need arising from those inequalities. The social determinants of health are broad. While equity in sexual and reproductive health is improving it remains an ongoing challenge.

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