



# AUCKLAND WOMEN'S HEALTH COUNCIL

## NEWSLETTER

JULY 2015



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- The end of the Antenatal HIV Screening Programme
- Cartwright Conference - Friday 7 August 2015

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## **FREE LONG LASTING CONTRACEPTIVES FOR TEENS**

In an article that appeared in late June in the *British Journal of Obstetrics and Gynaecology*, senior academics at the University of Otago made the case for an opt-out programme that would see teens started on long-acting reversible contraceptives (LARCs) before they become sexually active. (1)

The three long-acting contraceptives the academics had in mind are the copper IUD which lasts for 10 years, the Mirena IUD which lasts for five years, and the Jadelle implant which lasts for five years. The latter device became funded by PHARMAC five years ago.

The resulting publicity in the New Zealand media focused solely on one side of this highly-charged debate and totally ignored the contrary view put forward on the same page and in the same issue by Alison Edelman who argued that pre-emptive use of such contraceptives without need or benefit may cause more harm than good. Referring to the three Otago University lecturers as “researchers” further confused the situation as it implied that the proposal was based on new research results when this was not the case at all. (2)

As women’s health groups around the country expressed their disbelief and outrage at the prospect of young girls being targeted as candidates for an opt-out programme involving the use of long-term hormonal contraceptives, Dr Neil Pickering was quoted as saying “We would see it happening as a normal part of a person’s health care through school, just in the same way children are vaccinated.” This

would save adolescents from having to go and seek care, he said. (2) Of course, the adolescents he was referring to were all female. Perhaps he was thinking of 12-year-old school girls having the HPV vaccine Gardasil in one arm while a contraceptive implant is inserted in the other arm.

For some of us the suggestion brought back memories of the bad old days when young Maori and Pacific young women were often injected with Depo Provera without their knowledge or consent.

Fortunately, this time round Family Planning was against the idea of young women being part of an opt-out contraceptive programme. Family Planning’s chief executive Jackie Edmond said most young women aren’t having sex before they turn 16. “We’re overkilling it putting implants in people who aren’t intending to or aren’t having sex,” she said. (3)

### **Teen pregnancy rates declining**

It is worth noting at this point that a recent report published in January 2015 by the Social Policy Evaluation and Research Unit stated that while New Zealand has the second-highest teen pregnancy rate in the developed world, rates were declining in all regions except Northland. In 2013, the proportion of all births that were teen births was 5.9% - the lowest ever recorded – and 71% of the births were to 18 and 19 year old mothers. (4)

The Abortion Supervisory Committee reports over recent years have also recorded a declining teenage abortion rate. The rate has halved between 2007 and 2013.

So let’s not get too carried away here about the teen pregnancy “problem.”

### Who takes responsibility?

Jackie Edmond also commented on the issue of young women being made to take full responsibility for contraception even before they become sexually active, thus giving young men a free pass, as it were.

Following on from this, radio show host Kerre Mclvor wrote in her column in the *Herald on Sunday* that Family Planning “believe young women should be able to have a choice when it comes to contraception and that young men should be using condoms, no matter what form of contraception young women are on. Well, good luck with that message getting through.” (5)

She was one of the few commentators to question the health implications of hormones being released into the bodies of young women who are still growing, developing physically as well as emotionally.

### The risks

The link between oral hormonal contraceptives and breast cancer has been known for a decade or more. Extreme caution must be used before health authorities begin planning a mass programme of inserting hormonal implants in young teenage girls. Then there is the issue of it being much easier to implant these devices than it is to remove them.

Kerre Mclvor went on to say: “Sex is about so much more than not getting pregnant and I think the researchers are missing the point on that. It’s about a desire to be wanted, a desire to belong, and, far too often, it’s about power and control.

One of the correspondents to my radio show had an excellent take on the issue: vasectomies are a low cost, relatively simple operation these days. What’s more, they’re reversible. So why not offer free, universal vasectomies to all 13-year-old boys who can then reverse the vasectomy if they want children in the future? Surely that’s a suggestion as worthy of debate as inserting IUDs in the uterus of the nation’s adolescent girls, or pumping them full of hormones.” (5)

It certainly is. So let’s begin the debate about a school-based programme for Gardasil and vasectomies for 13-year-old boys.

### References

1. BJOG Debate. *British Journal of Obstetrics and Gynaecology*. June 2015
2. <http://www.stuff.co.nz/life-style/parenting/big-kids/tweens-to-teens/69838572/optout-contraceptive-programme-proposed-to-curb-teen-pregnancy-rates>
3. <http://www.3news.co.nz/nznews/contraceptives-before-girls-are-sexually-active-an-overkill-2015070111#axzz3g0fA1v2i>
4. [http://www.superu.govt.nz/sites/default/files/Teen\\_births\\_summary\\_report.pdf](http://www.superu.govt.nz/sites/default/files/Teen_births_summary_report.pdf)
5. [http://www.nzherald.co.nz/lifestyle/news/article.cfm?c\\_id=6&objectid=11475884](http://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=11475884)



## Diagnosing cancer – turtles, birds or rabbits?

In an article entitled “Overkill” in the 11 May 2015 issue of the *New Yorker* Atul Gawande describes how an avalanche of unnecessary medical care is harming patients physically and financially, and asks what can we do about it. (1) Atul Gawande, a surgeon and public health researcher, has been a *New Yorker* staff writer since 1998. He was in New Zealand at the Auckland Writers’ Festival in May this year talking about his latest book “Being Mortal.”

In his lengthy article Atul Gawande refers to the latest book by H. Gilbert Welch, a Dartmouth Medical School professor, who is also an expert on overdiagnosis. In his book “*Less Medicine, More Health*,” (2) Welch explains the phenomenon in this unique and unforgettable way:

“We’ve assumed that cancers are all like rabbits that you want to catch before they escape the barnyard pen. But some are more like birds—the most aggressive cancers have already taken flight before you can discover them, which is why some people still die from cancer, despite early detection. And lots are more like turtles. They aren’t going anywhere. Removing them won’t make any difference.

We’ve learned these lessons the hard way. Over the past two decades, we’ve tripled the number of thyroid cancers we detect and remove in the United States, but we haven’t reduced the death rate at all. In South Korea, widespread ultrasound screening has led to a fifteen-fold increase in detection of small thyroid

cancers. Thyroid cancer is now the No. 1 cancer diagnosed and treated in that country. But, as Welch points out, the death rate hasn’t dropped one iota there, either. (Meanwhile, the number of people with permanent complications from thyroid surgery has skyrocketed.) It’s all over-diagnosis. We’re just catching turtles.

Every cancer has a different ratio of rabbits, turtles, and birds, which makes the story enormously complicated. A recent review concludes that, depending on the organ involved, anywhere from fifteen to seventy-five per cent of cancers found are indolent tumors—turtles—that have stopped growing or are growing too slowly to be life-threatening. Cervical and colon cancers are rarely indolent; screening and early treatment have been associated with a notable reduction in deaths from those cancers. Prostate and breast cancers are more like thyroid cancers. Imaging tends to uncover a substantial reservoir of indolent disease and relatively few rabbit-like cancers that are life-threatening but treatable.

We now have a vast and costly health-care industry devoted to finding and responding to turtles. Our ever more sensitive technologies turn up more and more abnormalities—cancers, clogged arteries, damaged-looking knees and backs—that aren’t actually causing problems and never will. And then we doctors try to fix them, even though the result is often more harm than good.

The forces that have led to a global epidemic of overtesting, overdiagnosis, and overtreatment are easy to grasp. Doctors get paid for doing more, not less. We’re more afraid of

doing too little than of doing too much. And patients often feel the same way. They're likely to be grateful for the extra test done in the name of "being thorough" – and then for the procedure to address what's found." (1)

The story of one of Atul Gawande's patients, Mrs E provides a telling and very insightful example of the human cost of all this testing.

Mrs E, a woman in her fifties, had had surgery for a thyroid lump. The biopsy revealed that the lump was benign. But the pathologist examining the specimen found a pinpoint "microcarcinoma" next to it. It was just five millimetres in size. Some experts argue that we should stop calling these microcarcinomas "cancers" as they are very unlikely to turn into dangerous cancers.

The surgeon told Mrs E about the tiny cancer that had been found and ordered regular ultrasounds every few months to monitor her thyroid. When another five millimeter nodule was found he recommended removing the rest of her thyroid. When the surgeon had to cancel the planned surgery Mrs E was referred to Atul Gawande. He advised her that she really didn't need surgery and the operation posed a greater risk of causing harm – vocal-cord paralysis and life-threatening bleeding – than any microcarcinoma she had. Removing her thyroid would also result in the need to take a daily hormone-replacement pill for the rest of her life. She would be better off being monitored with regular scans.

But Mrs E was too fearful of the tiny "cancers" she was told she had, and opted for surgery. "Given that the

surgery posed a greater likelihood of harm than of benefit, some people would argue that I shouldn't have done it," Atul Gawande writes. "I took her thyroid out because the idea of tracking a cancer over time filled her with dread, as it does many people. A decade from now, that may change. The idea that we are overdiagnosing and overtreating many diseases, including cancer, will surely become less contentious. That will make it easier to calm people's worries. But the worries cannot be dismissed. Right now, even doctors are still coming to terms with the evidence."

Mrs E had post-surgery complications. Two hours after the operation she began to bleed and had to be rushed back into the operating room to find and fix the cause of the bleeding. While she suffered no permanent harm and made a full recovery, she had to take a pill for the rest of her life.

She was also extremely grateful. "She thanked me profusely for relieving her anxiety. I couldn't help reflect on how that anxiety had been created. The medical system had done what it so often does: perform tests, unnecessarily, to reveal problems that aren't quite problems to then be fixed, unnecessarily, at great expense and no little risk."

However, these issues are now starting to be addressed. The third international conference on preventing overdiagnosis will take place in Washington in September. (3)

## References

1. <http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>
2. H. Gilbert Welch. "Less Medicine, More Health." Beacon Press 2015.
3. <http://www.preventingoverdiagnosis.net/?p=830>

## Antenatal HIV Screening Without the Screening Programme

The latest issue of “*Screening Matters*,” (1) the National Screening Unit’s newsletter, contains an article which euphemistically referred to “changes” to antenatal HIV screening.

The NSU is actually dismantling the screening programme, but antenatal HIV screening will continue as “an integral part of antenatal care.” This means there will be no more “comprehensive monitoring reports and district health boards (DHBs) will no longer receive funding for an HIV co-ordinator.”

As the AWHC pointed out in our May newsletter, the antenatal HIV screening programme was only detecting one HIV+ woman each year, and that these women were in high risk groups and should have been offered an HIV screening test as a standard part of their antenatal care.

It is seven years since antenatal HIV screening was rolled out DHB by DHB after a child became infected with HIV through perinatal transmission after the mother who came to New Zealand from a high risk country was not offered an HIV test. At the time a number of women’s groups felt that establishing a formal antenatal HIV screening programme was using a sledge hammer to kill an ant. We also had concerns around the need for women to make an informed decision to have an HIV test.

However, the solution to the problem is not to dismantle the screening programme, remove the monitoring and reporting processes, but continue

routine antenatal HIV screening. This is unethical and totally unacceptable for a number of reasons.

Women are not always asked to give their consent to an HIV test which is usually included in the first blood test that is done following confirmation of pregnancy. Past monitoring of HIV screening revealed that around 87% of pregnant women are being tested for HIV, but it is not clear how many of these women are asked to consent to an HIV test or know they have been tested. GPs order the majority of these first blood tests, and some women subsequently learn from their LMC midwife that they have had an HIV test.

Then there is the harm caused when a woman gets a non-negative result and is asked to return to the laboratory and provide another blood sample for a second test. As reported in previous articles on this issue GPs are not always able to answer the woman’s questions about her test results and sometimes get defensive.

The NSU’s Policy and Quality Standards for the Antenatal HIV Screening Programme were updated in June 2010 and stated in the monitoring & evaluation section that:

“Monitoring and evaluation of the Programme will follow the screening pathway and assess *process* (the organisational aspects of the Programme and policy implementation) and *outcomes* (health outcomes and process utility). The main aspects of monitoring and evaluation include:

- Screening uptake – by DHB, requester type, age, ethnic group & NZDep score.
- Information provision and informed consent

## AWHC GENERAL MEETING 25 June 2015

- Screening results in DHBs: (a) confirmed newly diagnosed HIV positive pregnant women; (b) pregnant women with non-negative results who were not infected.
- Referral management and follow up of women
- Interviews with clinicians and women who had: (a) positive results; (b) required to be retested but were not infected in order to mitigate any adverse effects resulting from the screening process. (1)

So all of the above will be abandoned and women will now be routinely screened without oversight of those doing the screening.

While the NSU claims that “if testing shows a reactive or positive result, the screening laboratory will provide practitioners with guidance on the next steps” this is obviously not always the case. This is very worrying as it is the retesting needed when the first HIV test returns a non-negative result that is causing the most harm.

Being tested without your knowledge or consent is far more common and may contravene the Code of Consumers’ Rights, but very few women choose to complain to the Health and Disability Commissioner. Once the monitoring ceases there will be no information collected on the amount of harm caused by antenatal HIV screening, nor on the numbers of women being screened, and whether there is any benefit to anyone at all.

### References

1. <https://www.nsu.govt.nz/news/screening-matters-issue-52-june-2015>
2. [https://www.nsu.govt.nz/system/files/page/hiv\\_pqs.pdf](https://www.nsu.govt.nz/system/files/page/hiv_pqs.pdf)

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- Ethics committees
- Realignment of tobacco control services
- HPV Screening
- 2015 Cartwright conference

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.



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# UP AND COMING EVENTS

**DISTRICT HEALTH BOARD** meetings for July/August 2015:

**Waitemata DHB (Website address: [www.waitematadhb.govt.nz](http://www.waitematadhb.govt.nz))**

The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 12 August 2015 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 22 July 2015.

**Auckland DHB (Website address: [www.adhb.govt.nz](http://www.adhb.govt.nz))**

The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 5 August 2015 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

**Counties Manukau DHB (Website address: [www.cmdhb.org.nz](http://www.cmdhb.org.nz))**

The Hospital Advisory Committee meeting will be held at 9am on Wednesday 29 July 2015 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 19 August 2015 at 19 Lambie Drive, Manukau.



**ETHICS COMMITTEE** meetings – dates for the four MOH ethics committees are at: <http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes>



**The Auckland Women's Health Council and Women's Health Action** will be co-hosting a Cartwright conference to mark the 27<sup>th</sup> anniversary of the Cartwright Report –

**“The Future of Screening: Balancing the benefits and risks of cancer screening.”**

**Date: Friday 7 August 2015.**

**Venue: Potters Park Event Centre 164 Balmoral Road, Balmoral, Auckland**

Please register online at <http://www.eventbrite.co.nz/e/the-future-of-cancer-screening-in-new-zealand-tickets-16706180636>

Or contact Women's Health Action on 09 520 5295 or [info@womens-health.org.nz](mailto:info@womens-health.org.nz)