

8. Sexual and reproductive health

This section presents information and data from *Sexual & reproductive health issues, programmes and services in Counties Manukau: a profile and proposed action plan*¹⁰. Sexual and reproductive health is a priority area for action identified in the *Counties Manukau District Health Board Strategic Plan* and *District Annual Plans* for 2003/04 and 2004/05.

The local prioritisation of sexual and reproductive health is backed by a series of national policy documents on the subject; the *Sexual and Reproductive Health Strategy (1996)*, *Sexual and Reproductive Health Strategy – Phase One (2001)*, and *Sexual and reproductive health: a resource book for New Zealand health care organisations (2003)*. Furthermore national statistics indicate rising numbers of bacterial sexually transmitted infections (STIs) diagnosed at sexual health clinics over recent years and annual increases in the numbers of abortions being performed.

Counties Manukau figures indicate sexual and reproductive health issues are of particular concern. About half of South Auckland secondary school students who are sexually active don't consistently use contraception. Gonorrhoea is more commonly diagnosed locally than elsewhere in New Zealand, and pelvic inflammatory disease and ectopic pregnancy admissions have increased in Counties Manukau over recent years. Local teenage pregnancy rates continue to exceed those of neighbouring DHBs. Several of these sexual and reproductive health issues are of particular relevance for Maori, Pacific and/or Asian communities. Within CM, Maori followed by Pacific have the highest rates of PID, ectopic pregnancy and teenage births. Pelvic inflammatory disease, other STIs, and ectopic pregnancy are a measure of unsafe sex practices in the population.

Areas for local improvement in service providers of sexual and reproductive health programmes have been identified and include: increased use of public education campaigns, the development of STI contact tracing services, increasing the practice-level availability of single dose antibiotic treatments for Chlamydia, and the use of opportunistic screening for Chlamydia amongst at-risk populations.

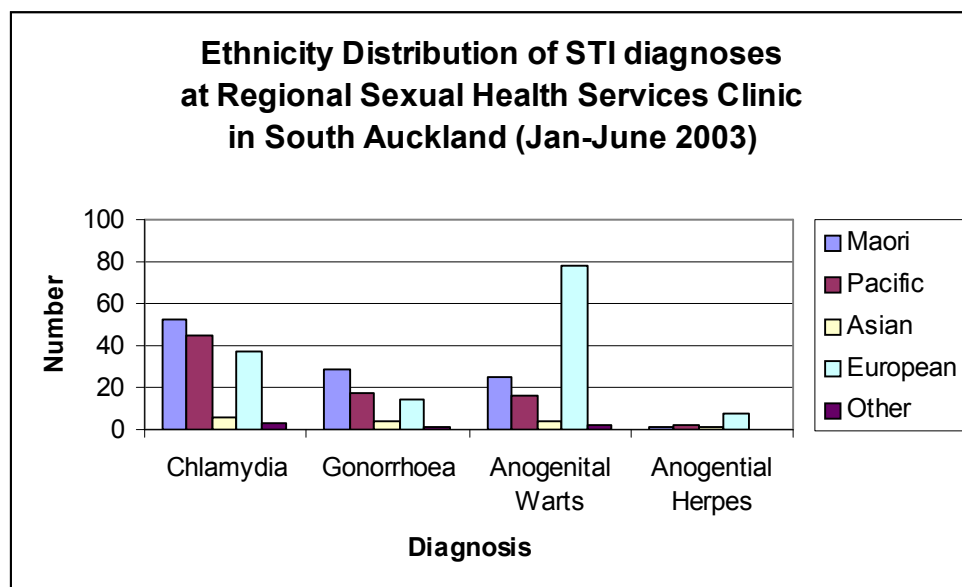
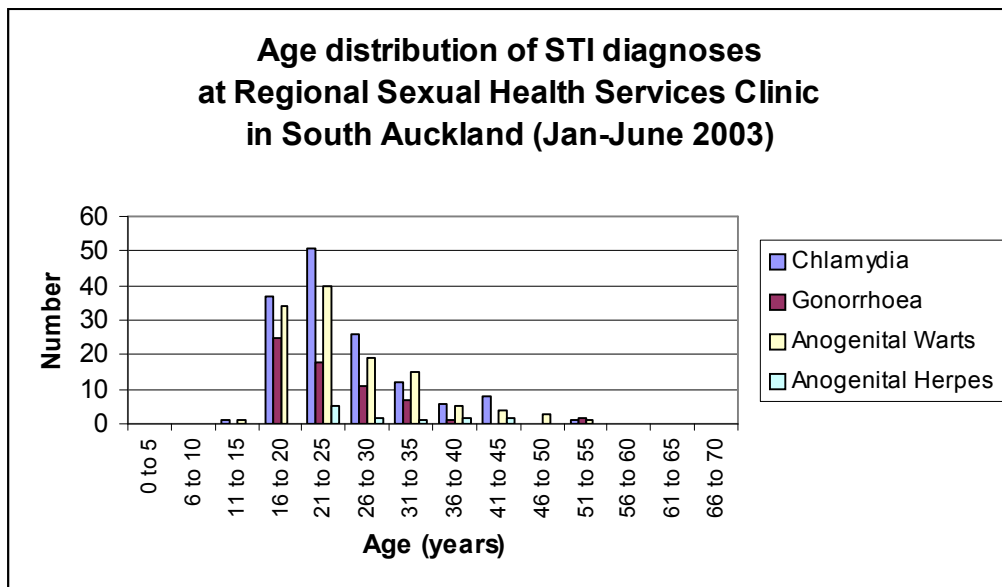
8.1. Sexually transmitted infections

Key facts regarding sexual activity and STIs were taken from the report *Sexual & reproductive health issues, programmes and services in Counties Manukau: a profile and proposed action plan*, and are listed below:

- Most young New Zealanders become sexually active prior to 18 years of age
- About half of sexually active South Auckland secondary school students don't consistently use contraception when having sex
- Substantial proportions of young people use oral contraceptives as their form of contraception, but may not be using barrier contraception
- The numbers of bacterial STIs diagnosed at sexual health clinics nationally have been rising over recent years
- Chlamydia is the most common STI nationally and in South Auckland
- Gonorrhoea forms a greater proportion of STI diagnoses in South Auckland than it does nationally
- Males are slightly over represented in local sexual health clinic STI diagnosis statistics
- Young people under the age of 30 years are the most common group in which STIs are diagnosed
- Gonorrhoea is more common in young people
- High numbers of Maori and Pacific patients have had bacterial STIs diagnosed at the South Auckland sexual health clinic

¹⁰ Moor C. *Sexual & reproductive health issues, programmes and services in Counties Manukau: a profile and proposed action plan*. CMDHB: 2004. See www.cmdhb.org.nz under publications/planning documents.

- Hospital admissions for PID and ectopic pregnancies appear to have been increasing over recent years.



Trends in the number and age-standardised hospitalisation rates (per 1000 women) of women with pelvic inflammatory disease (PID) and ectopic pregnancy are presented below by DHB, and by ethnic group for CMDHB.

[Pelvic inflammatory disease](#)

The age-standardised hospitalisation rates for PID have generally been highest in Northland since 1996 (Table 8.1.1 and Figure 8.1.1). Rates in the Auckland region have generally been highest in Auckland followed by CM, and have generally been higher than national rates.

Within CM, age-standardised hospitalisation rates for PID were generally highest in Maori followed by Pacific women (Table 8.1.2 and Figure 8.1.2). Rates in Maori were more than double the rates in Other women for most years.

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Table 8.1.1: Number and age-standardised hospitalisation rate (per 1000 women) for women with pelvic inflammatory disease from 1996 to 2004 by DHB

DHB of residence	Number								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Counties Manukau	215	178	205	260	217	285	259	254	281
Auckland	205	250	222	294	284	283	299	287	227
Waitemata	218	235	212	224	284	239	226	199	223
Northland	103	106	95	70	97	94	117	90	89
New Zealand	2,243	2,134	2,035	2,111	2,095	2,100	2,118	1,916	1,883

DHB of residence	Rate								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Counties Manukau	113	93	103	130	108	140	125	119	129
Auckland	98	116	102	137	130	128	131	124	92
Waitemata	99	106	94	97	123	103	95	81	89
Northland	156	160	144	104	152	144	183	136	136
New Zealand	115	108	103	107	106	106	106	95	92

Table 8.1.2: Age-standardised hospitalisation rate (per 1000 women) for pelvic inflammatory disease in CM from 1996 to 2004 by ethnic group

Ethnic group	Number								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Maori	68	39	62	75	63	83	82	66	88
Pacific	36	51	51	63	46	65	67	69	76
Other	111	88	92	122	108	137	110	119	117
Total	215	178	205	260	217	285	259	254	281

Ethnic group	Rate								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Maori	201	135	203	189	166	218	237	175	217
Pacific	126	173	135	177	134	155	170	162	195
Other	91	72	73	96	85	113	87	91	86
Total	113	93	103	130	108	140	125	119	129

Figure 8.1.1: Age-standardised hospitalisation rate (per 1000 women) for pelvic inflammatory disease from 1996 to 2004 by DHB

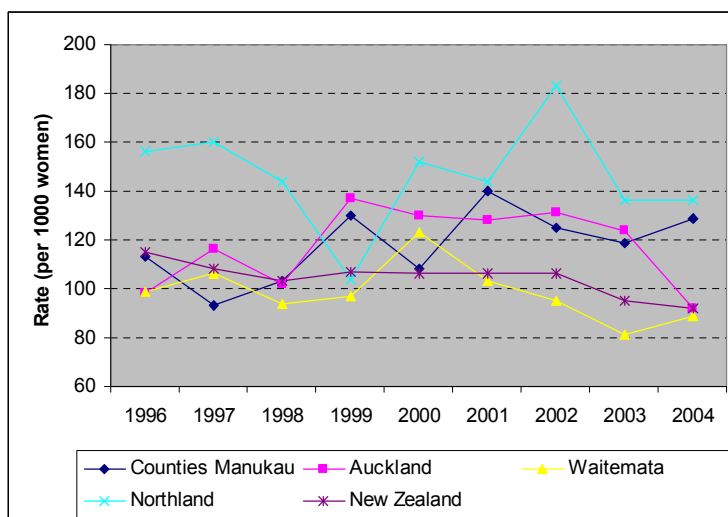
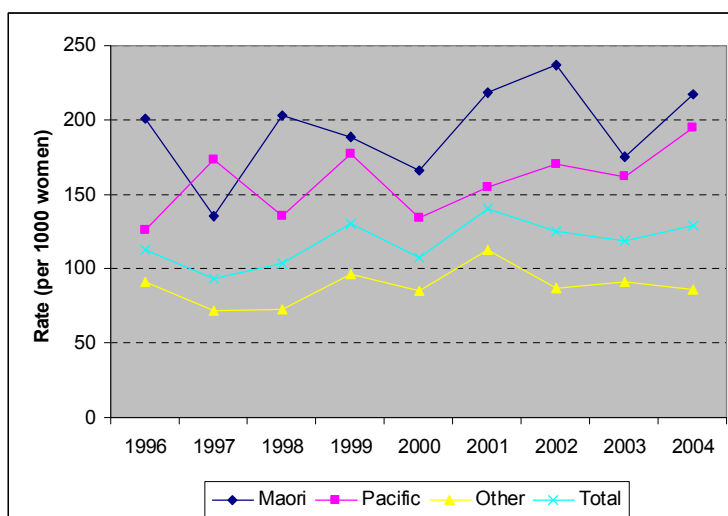


Figure 8.1.2: Age-standardised hospitalisation rate (per 1000 women) for pelvic inflammatory disease in CM from 1996 to 2004 by ethnic group



[Ectopic pregnancy](#)

Ectopic pregnancy rates are higher in populations that have had infective damage of the fallopian tubes. As such they can be used as a marker of unprotected intercourse. The age-standardised hospitalisation rates for ectopic pregnancy have been highest in Northland since 1997 (Table 8.1.3 and Figure 8.1.3). Rates in the Auckland region were highest in CM until 2000, and generally highest in Auckland from 2000 to 2004. Rates in CM, Auckland, and Waitemata have generally been higher than national rates since the year 2000.

Within CM, age-standardised hospitalisation rates for ectopic pregnancy were generally highest in Maori followed by Pacific women (Table 8.1.2 and Figure 8.1.4), while rates in Other women have been the lowest since 1996.

Table 8.1.3: Number and age-standardised hospitalisation rate (per 1000 women) of women having an ectopic pregnancy from 1996 to 2004 by DHB of residence

DHB	Number								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Counties Manukau	131	102	127	124	112	116	122	121	135
Auckland	94	109	105	112	139	148	134	147	180
Waitemata	79	90	106	133	127	141	133	127	127
Northland	41	38	42	47	54	40	46	46	49
New Zealand	976	978	989	1,041	1,083	1024	1,067	972	1,060

DHB	Rate								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Counties Manukau	65	50	62	59	54	55	58	56	62
Auckland	42	45	44	46	58	62	55	58	69
Waitemata	34	38	45	56	54	60	56	52	51
Northland	61	57	68	73	84	67	78	79	85
New Zealand	48	47	48	51	54	51	54	49	53

Table 8.1.4: Number and age-standardised hospitalisation rate (per 1000 women) of CMDHB women having an ectopic pregnancy from 1996 to 2004 by ethnic group

Ethnic group	Number								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Maori	35	23	48	36	34	29	35	36	32
Pacific	27	27	33	28	24	29	36	28	34
Other	69	52	46	60	54	58	51	57	69
Total	131	102	127	124	112	116	122	121	135

Ethnic group	Rate								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Maori	93	60	117	91	79	69	83	88	76
Pacific	75	66	88	68	55	63	77	60	70
Other	55	41	36	47	42	47	41	45	53
Total	65	50	62	59	54	55	58	56	62

Figure 8.1.3: Age-standardised hospitalisation rate (per 1000 women) for ectopic pregnancy from 1996 to 2004 by DHB of residence

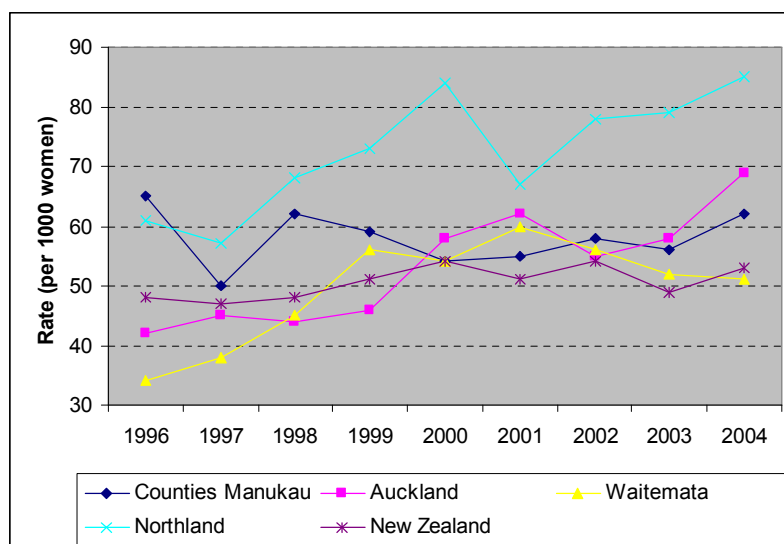
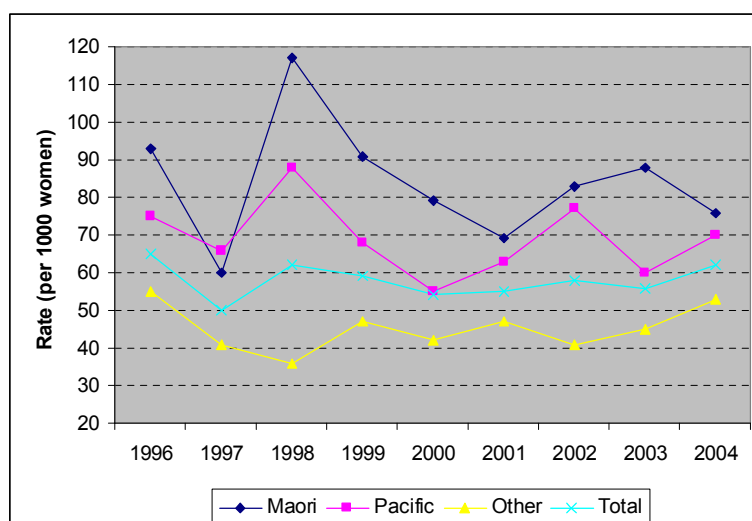


Figure 8.1.4: Age-standardised hospitalisation rate (per 1000 women) for ectopic pregnancy in CM from 1996 to 2004 by ethnic group



8.2. Teenage pregnancy

Key facts regarding teenage births were taken from the report *Sexual & reproductive health issues, programmes and services in Counties Manukau: a profile and proposed action plan*, and are presented below:

- Teenage births are of concern as early parenthood may limit opportunities for the mother and child. In addition there are higher proportions of unintended and unwanted pregnancies amongst young people.
- Annual numbers of teenage births in CM have remained relatively static over the last decade.
- Greater numbers of young Maori and Pacific women have a child during their teenage years than young Pakeha women.

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- A greater rate of teenage births is found in the more socio-economically deprived areas of the CM region.
- Low birth weight and preterm deliveries are over-represented in teenage births.

Trends in teenage birth rates (per 1000 women aged 15-19 years) are presented below by DHB, and by ethnic group for CMDHB. Teenage birth rates have been consistently much higher in CM than for the rest of the Auckland region since 1996 (Table 8.2.1 and Figure 8.2.1). Rates for CM teenagers have also been consistently higher than national rates, while rates for Auckland and Waitemata have been consistently lower than national rates, since 1996.

Within CM, teenage birth rates have been consistently higher in Maori followed by Pacific, with lowest rates in Others, which were approximately one fifth that of Maori teenagers (Table 8.2.2 and Figure 8.2.2).

Table 8.2.1: Number and rate (per 1000 women aged 15-19 years) of teenage deliveries from 1996 to 2004 by DHB of residence

DHB	Number								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Counties Manukau	534	550	508	586	534	514	515	555	567
Auckland	345	330	296	261	267	258	222	236	239
Waitemata	299	299	268	280	264	321	298	311	342
Northland	227	205	198	212	194	191	192	222	200
New Zealand	4,046	4,041	3,793	3,808	3,608	3,632	3,572	3,698	3,774

DHB	Rate								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Counties Manukau	48	50	46	53	48	43	42	44	43
Auckland	36	34	30	26	26	25	21	21	21
Waitemata	26	27	24	25	23	25	23	23	25
Northland	62	55	52	58	53	51	51	57	50
New Zealand	38	38	36	36	34	33	32	32	32

Table 8.2.2: Number and rate (per 1000 women aged 15-19 years) of teenage deliveries from 1996 to 2004 in CM by ethnic group

Ethnic group	Number								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Maori	207	183	223	274	257	240	242	263	262
Pacific	111	129	152	176	153	157	160	166	180
Other	216	238	133	136	124	117	113	126	125
Total	534	550	508	586	534	514	515	555	567

Ethnic group	Rate								
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Maori	80	72	90	114	106	94	94	97	93
Pacific	48	55	63	72	61	55	56	56	58
Other	34	38	22	22	20	18	17	18	17
Total	48	50	46	53	48	43	42	44	43

Figure 8.2.1: Teenage delivery rate (per 1000 women aged 15-19 years) from 1996 to 2004 by DHB of residence

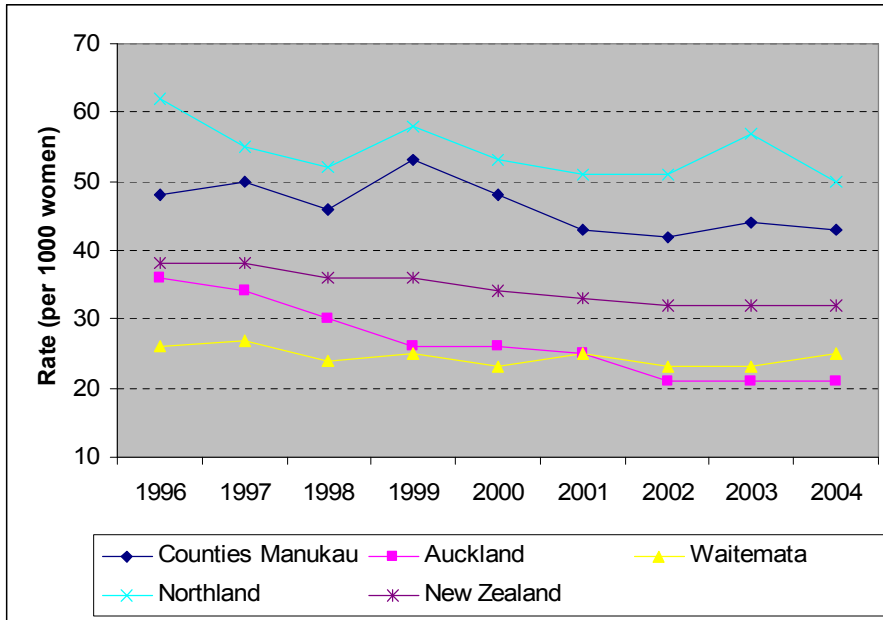
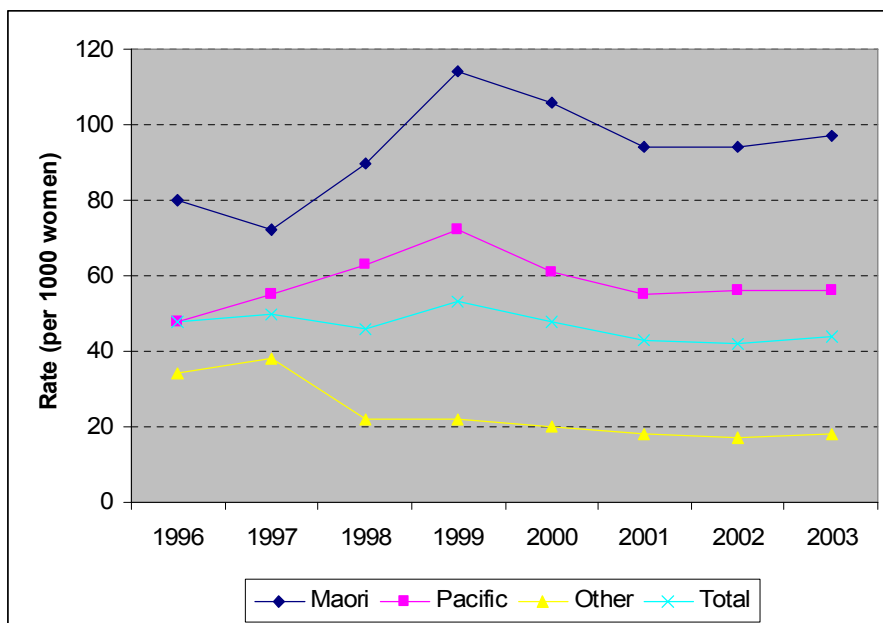


Figure 8.2.2: Teenage delivery rate (per 1000 women aged 15-19 years) from 1996 to 2004 in CM by ethnic group



8.3. Termination of pregnancy

Termination of pregnancy (TOP) may be performed in public hospitals for medical or legal reasons and therefore some data is available from routine data. However most first trimester (≤ 12.6 weeks gestation at referral) TOPs in Auckland are performed at the Epsom Day Unit (EDU), and some are done privately (eg Auckland Medical Aid Centre (AMAC)). There is limited data available from these sources.

There were approximately 2,300 TOPs performed on CMDHB residents at EDU in 2004, and a further 167 TOPs in public hospitals. AMAC is estimated to have done 450 in 2004. Using overall EDU data it is possible to estimate the age-ethnicity make-up of CM women having a TOP, if one assumes that CM women will have the same pattern as the rest of Auckland. This combined with public hospital data (but not AMAC) has been used to derive an estimate of CMDHB TOP use (Table 8.3.1).

Table 8.3.1: Estimated number and rate per 1000 women of pregnancy terminations for CMDHB women in public hospitals or EDU by age group and ethnicity, 2004

Ethnicity	Estimated number of terminations by age (yrs)								Total
	<15	15-19	20-24	25-29	30-34	35-39	40-44	>45	
Maori	0	80	130	90	60	30	10	0	400
Pacific	0	100	170	120	80	50	10	0	530
Other	10	270	440	320	260	170	70	5	1,535
Total	10	450	740	530	400	250	90	5	2,465

Ethnicity	Estimated rate/1000 women by age (yrs)								Total
	<15	15-19	20-24	25-29	30-34	35-39	40-44	>45	
Maori	0	22	42	31	20	12	4	0	23
Pacific	1	25	48	35	24	14	5	0	26
Other	1	30	54	41	26	16	6	0	27
Total	1	27	50	38	25	15	5	0	26

Note: estimates only, derived from Auckland metropolitan age-ethnicity rates supplied by EDU. Total by age is per women 15-44; age-specific denominators for rates <15 are 10-14, >45 45-49.

Within CM 20-24 year olds had the highest rate of TOP – the age profile is similar to the national picture. Other women had the highest rate of TOP in 15-19 year-olds and had the highest overall rate. Within the Other group Asians make up around 30% of EDU figures, but the data was not clear enough to calculate rates – it would seem though that Asian women in Auckland would have the highest age-specific TOP rates. The age and ethnicity profile for AMAC is unknown – adding the estimated 450 procedures to the totals in Table 8.3.1 gives 2,915 TOPs, or an overall population rate of 31/1000 15-44 year old women. This is much higher than the Statistics NZ figure for New Zealand as a whole for 2003 of 21/1000 women aged 15-44¹¹.

Looking specifically at the 15-19 year old group, and combining with the 2004 figures in Table 8.2.2 one can derive a teenage pregnancy rate - at least for all pregnancies that result in a delivery or termination – spontaneous miscarriages for example are not included. Note that AMAC terminations are excluded – the actual rates will be slightly higher than shown. For CMDHB that is 43 + 27 = 70 pregnancies per 1000 15-19 years olds – or the equivalent of 7% of all 15-19 year olds each year falling pregnant. The Maori teenage rate is much higher at 115 per 1000 – or 11.5%; Pacific 83 per 1000 or 8.3%, and Other 43 per 1000 or 4.3%. The proportion of pregnancies resulting in a termination is very high for European/other teenagers – at 54% more are terminated than delivered. For Pacific teenagers the figure is 26%, for

¹¹ <http://www.stats.govt.nz/popn-monitor/abortions/abortions-summary-latest-trends.htm>

Maori 15%. The low European/other teenage pregnancy rate then, is made up of a relatively low pregnancy rate, coupled with a relatively high termination rate.

[Summary - Section 8 sexual and reproductive health](#)

Teenage birth rates have been consistently much higher in CM than for the rest of the Auckland or nationally. Rates of sexually transmitted disease, pelvic inflammatory disease and ectopic pregnancy, all markers of unprotected intercourse are high in CM. Survey data backs this up, indicating about half of sexually active South Auckland secondary school students don't consistently use contraception when having sex.

Maori and Pacific teenagers have higher rates than European or other groups in most of the indicators measured. With a pregnancy rate of around 12% for Maori teenagers, coupled with the high exposure to infection with unprotected intercourse Maori young women are at particular risk. While HIV rates are relatively low in our community, the high rates of chlamydia and increasing gonorrhoea rates are indicators we cannot ignore.

Teenagers of European/other extraction are far more likely to seek a termination if they fall pregnant –over half did so in 2004, compared to a quarter of Pacific and a sixth of Maori.