

# **Sexual and Reproductive Health Strategy**

## **Phase One**

Published in October 2001  
by the Ministry of Health  
PO Box 5013, Wellington, New Zealand  
ISBN 0-478-26205-1 (Book)  
ISBN 0-478-26204-3 (Internet)  
HP 3468

This document is available on the Ministry of Health's Web site:  
<http://www.moh.govt.nz>

# Foreword

---

Current sexual and reproductive health providers ensure that New Zealanders get access to a quality service, but there are gaps, and the sector as a whole lacks strategic direction and the leadership it needs to move forward.

This document represents the first phase of the Sexual and Reproductive Health Strategy, providing the overall direction the Government wishes to take to achieve positive and improved sexual and reproductive health outcomes in New Zealand. It recognises the good work that is already being done, but, more importantly, it guides future work with a clear understanding that the development of the Strategy is ongoing.



The document provides the Ministry of Health, District Health Boards and other organisations across the health sector with the basis to develop service specific plans and funding decisions. District Health Boards and the Ministry will work collaboratively to develop service specifications and a funding framework for delivering sexual and reproductive health services at individual and population levels throughout the country.

For many years now providers in the sexual and reproductive health sector have been concerned that services are fragmented, with gaps in provision, such as limited specialist services in the South Island. This Government recognises that sexual and reproductive health is a complex area, requiring a long-term approach. I acknowledge that a strategy document will not provide instant answers to these long-term problems, but the Government can provide leadership, working with the sector through specific issues progressively.

The issue is not simply one for the health sector. Other sectors beyond health can contribute to the improvement of sexual and reproductive health. The education sector, for example, and families and communities influence sexual and reproductive health outcomes. Positive sexuality and sexual and reproductive health affect people and populations differently, so one model does not fit all. Māori and other communities have issues specific to them. We can only address this by working co-operatively to improve sexual and reproductive health for all New Zealanders.

The process we are undertaking in the development of a Sexual and Reproductive Health Strategy has two phases. The first phase is the release of the overarching direction in this document. It will be followed by the development of a series of action plans to address key issues, such as reducing sexually transmitted infections (including HIV/AIDS), sexual abuse and unwanted/unintended pregnancies, and maximising the health of at-risk groups, such as Youth, Māori and Pacific peoples.

We are following the successful model established with mental health, and more recently with the Primary Health Care Strategy. It is anticipated that the first of the action plans be released early next year.

I know that you will join with me in ensuring that we use the opportunities presented by the Sexual and Reproductive Health Strategy to move toward common goals of improved health, reduced inequalities and high quality care, consistent with the overall objectives of the New Zealand Health Strategy.

A handwritten signature in black ink that reads "Annette King". The signature is written in a cursive, flowing style.

Annette King  
Minister of Health

# Contents

---

Foreword	iii
Introduction	1
Why do we need a Sexual and Reproductive Health Strategy?	2
Vision	2
Principles and obligations	3
Strategic Context	4
International agreements	4
Relationship to the New Zealand Health and Disability Strategies	4
Relationship to other health sector strategies	5
Acknowledging the special Māori–Crown relationship under the Treaty of Waitangi	5
Intersectoral relationships	6
Strategic Directions	7
Strategic direction one: Societal attitudes, values and behaviour	8
Strategic direction two: Personal knowledge, skills and behaviour	9
Strategic direction three: Services	10
Strategic direction four: Information	11
The Next Phase – Developing Action Plans	12
Sexual and Reproductive Health Issues in New Zealand	13
Sexual behaviour	13
Fertility	13
Teenage pregnancy	16
Abortion	16
Overseas comparisons	18
Sexually transmitted infections	19
Information from sexual health clinics	19
Information from laboratory surveillance	21
HIV/AIDS	23
Appendix: Members of the Sector Reference Group	25
Represented members of sector reference group unable to attend meetings	25
References	26



# Introduction

---

Positive sexuality and healthy sexual and reproductive health are Government priorities. As we are sexual beings, positive sexual identity and sexuality are fundamental to our sense of self, self-esteem and ability to lead a fulfilling life. The Government's concern focuses on two key areas:

1. New Zealand's increasing number of sexually transmitted infections (STIs), particularly chlamydia, gonorrhoea and HIV
2. the high level of unintended/unwanted pregnancies.

Sexual health problems such as STIs may have life-long consequences; in the case of HIV infection the consequence is death. Rates of chlamydia and gonorrhoea have increased significantly in the past few years in New Zealand. Rates of both diseases are disproportionately high in young people, Māori and Pacific peoples. Despite a lack of national laboratory data, the data that are available indicate that New Zealand faces a chlamydia epidemic. Antibiotic resistance to standard treatments for gonorrhoea is increasing. STIs may lead to infertility from pelvic inflammatory disease, cancer and other chronic diseases.

Unintended/unwanted pregnancy (abortion and adolescent pregnancy) is frequently preventable. Adolescent pregnancy not only creates more social and economic problems for the mother, but also increases the child's risk of poor outcomes in education, health and welfare. New Zealand has a very high adolescent pregnancy rate relative to comparable countries.

International research illustrates some of the long-term difficulties for the mother, the child and society that are associated with childbearing during adolescence. Compared with babies born to older mothers, babies born to adolescent mothers are at a higher risk of low birth weight and infant mortality, and are more likely to grow up in homes that offer lower levels of emotional support and cognitive stimulation. For the mothers, giving birth during adolescence is associated with limited educational attainment, leading to socioeconomic disadvantage, increased welfare dependency, maternal depression and less competent parenting (Woodward et al 2001). Such outcomes have been attributed to the adverse socioeconomic circumstances that frequently accompany early childbearing.

Recent New Zealand research supports the international findings. In the Christchurch Child Development Study young women who became pregnant were more likely to be Māori, to have experienced an adverse family background, and to have done less well at school (Woodward et al 2001). Another longitudinal study found that, while many children to teenage mothers did well, as a group these children were more likely to have left school early, to have been long-term unemployed, to have engaged in violent offending and to have been young parents themselves (Jaffee et al 2001).

Disabled people face particular problems in acquiring a positive sexual identity and in accessing mainstream sexual and reproductive health services. For groups such as disabled youth this may begin with parents finding it difficult to acknowledge their disabled young people are sexual beings. In adulthood, while there is a wide variation in needs and responses as people have a wide range of impairments, common problems include inadequate or poor

access to information (for example, pamphlets not translated into Braille or websites accessible). Some services for young people are physically inaccessible and many disabled people are also particularly vulnerable to sexual abuse.

## Why do we need a Sexual and Reproductive Health Strategy?

New Zealand has had some success, for example, in maintaining a relatively low prevalence of HIV transmission, and some individual programmes have addressed unintended/unwanted pregnancy. We have learnt that success means an ongoing commitment – these issues do not go away.

The issues affect and impact on different communities and at different periods in people's lives. Therefore, a successful strategy must focus on population-specific actions. The issues affecting women in their thirties who seek an abortion are different from those affecting Māori women in their teens. Equally, addressing STI transmission among heterosexual males is different from prevention of HIV/AIDS for men who have sex with men.

We know that sweeping the uncomfortable issues under the carpet does not work, and we must do more than providing information to individuals. Focusing on prevention, early intervention, appropriate and accessible services, and practical information, are key parts of a comprehensive service that is required in this area. However, these components need to be arranged in a strategic way.

The approach we have taken focuses on key priority areas – groups of people most at need – and examines models based on international best practice that will be useful to address their need. The groups most likely to be in at-risk situations are youth, Māori, and Pacific peoples.

One model does not fit all. For youth, issues of sexual and reproductive health are interrelated around self-esteem, sexual identity, diversity, and youth suicide. The issues for young Māori in provincial and rural New Zealand are often different from young urban Pākehā. This strategy process recognises the specific issues and addresses how health sector agencies can work together and with other agencies to achieve improved health outcomes for New Zealanders. The process must evolve as issues change, and build on the lessons we have learnt over recent years. For these reasons the Government is developing a new strategic approach building from the *National Strategy on Sexual and Reproductive Health* (1996).

Given the continued need for action and the lessons we have learnt, this document is the first phase of a two-phase process to guide the health sector. **Phase one** provides the guiding principles and outlines the strategic direction. **Phase two** involves the development of population-specific plan for Māori and another document for Pacific peoples, which will guide and relate to specific action plans for the management of STIs, addressing unwanted/unintended pregnancy and HIV/AIDS. A plan for sexual abuse and sexual violence will also be developed.



We recognise that these action plans do not provide an exhaustive list of the sexual and reproductive health issues that New Zealand faces. Instead our approach is to identify priorities and continue to work through the problems on an ongoing basis.

## Vision

The vision for the Sexual and Reproductive Health Strategy is:

**Good sexual and reproductive health for all New Zealanders.**

## Principles and obligations

The principles that guide the Sexual and Reproductive Health Strategy come from the New Zealand Health Strategy. They include the following:

- sexual and reproductive health services as a public health service
- a comprehensive, free, specialist sexual health service close to the community
- sexually transmitted disease control to ensure that at risk groups have access to effective education programmes
- disease control of HIV/AIDS as a sexually transmitted infection
- an emphasis on effective and available services for Māori, Pacific peoples and young people should be emphasised (Minister of Health 2000).

# Strategic Context

---

The Sexual and Reproductive Health Strategy is being developed to accord with and complement related activities. It fits closely with existing health strategies, including the New Zealand Health Strategy, acknowledges the special relationship between Māori and the Crown under the Treaty of Waitangi, and builds on intersectoral relationships.

## International agreements

As New Zealanders we can pride ourselves on our commitment to responsible management of sexual and reproductive health issues. We are signatories to a number of international instruments, and this strategic approach follows the models and responsibilities that New Zealand has agreed to internationally. These include the:

- Charter for the Elimination of Discrimination Against Women
- Conference on Population and Development Programme of Action +5
- United Nations HIV/AIDS Declaration
- Beijing+5 Platform of Action
- United Nations Convention on the Rights of Children.

## Relationship to the New Zealand Health and Disability Strategies

The Sexual and Reproductive Health Strategy sits under the New Zealand Health and Disability Strategies. It fits within the following goals and objectives of the broader Health Strategy:

- Goal 6 ‘healthy lifestyles’, objective 32 to ‘improve sexual and reproductive health’
- Goal 2 ‘reducing inequalities in health status’, objectives 6–8 ‘ensuring accessible and appropriate services for Māori, Pacific peoples and people from lower socioeconomic groups’
- Goal 3 ‘Māori development in health’ (objectives 9–13)
- Goal 5 ‘healthy communities, families and individuals’, objective 21 to ‘further develop health promoting schools’
- Goal 8 ‘better physical health’, objective 47 to ‘reduce the incidence and impact of infectious diseases’
- Goal 10 ‘accessible and appropriate health care services’, objective 56 to ‘ensure access to accessible and appropriate services for young people/rangatahi’.

It also fits with the following objective of the New Zealand Disability Strategy:

- objective 9 to ‘support lifestyle choices, recreation and culture for disabled people’, action 9.1 to ‘support disabled people in making their own choices about their relationships, sexuality and reproductive potential’.

This strategy is in accord with the goal for Māori (Māori Health Strategy) and that for Pacific peoples (Pacific Health and Disability Action Plan) with regard to reducing inequalities in health. In addition, it fits with service priorities for public health and primary health care for accessible and appropriate services for people living in rural areas.

## Relationship to other health sector strategies

The Sexual and Reproductive Health Strategy relates to a number of existing strategies and other initiatives in the health and disability sector such as:

- the Primary Health Care Strategy
- the Pacific Health and Disability Action Plan
- the upcoming Youth Health Strategy
- the Integrated Approach to Infectious Diseases.

Such initiatives will address and implement some of the issues raised in this strategy.

## Acknowledging the special Māori–Crown relationship under the Treaty of Waitangi

The Government is committed to fulfilling its obligations as a partner to the Treaty of Waitangi, New Zealand’s founding document. Its special relationship with Māori is ongoing and is based on the underlying premise that Māori should continue to live in Aotearoa as Māori.

Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in developing and implementing strategies for Māori. Moreover, it is understood that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.

Māori should be able to define and provide for their own priorities for participation and be encouraged to develop the capacity for delivery of services to their communities. This principle needs to be balanced by the Crown’s duty to govern on behalf of the total population.

To date the relationship between Māori and the Crown in the health sector has been based on three key principles:

1. participation at all levels
2. partnership in service delivery
3. protection and improvement of Māori wellbeing.

The Sexual and Reproductive Health Strategy will work within the principles of the Treaty of Waitangi.

# Intersectoral relationships

Sexual wellbeing and reproductive health are complex. Many factors that influence sexual wellbeing lie outside the health sector, such as educational attainment and employment, meaning that a multifaceted intersectoral approach is required. It will involve co-ordination of policies and initiatives both within the health sector and across other government agencies. The health sector will be working with population agencies, such as the Ministry of Youth Affairs on the upcoming Youth Development Strategy Aotearoa, and policy delivery agencies such as the Ministry of Education on the implementation of the sexuality education component of the Health and Physical Education Curriculum in schools.

# Strategic Directions

---

A broad range of social and behavioural factors influence sexual behaviour and hence reproductive health. Many of these factors change over time and have particular relevance at certain stages of the life cycle.

For example, over the last few decades in New Zealand (and in many other developed countries) the age of first intercourse has lowered markedly; in more recent years, people have also tended to start a family later in life. The result has been a longer period when less stable sexual relationships might exist, increasing the number of sexual partners and the risk of acquiring and transmitting an STI. At the same time the growing preference for starting a family at an older age has necessitated the prolonged use of reversible methods of contraception, some of which may have a significant failure rate.

These changing social characteristics mean that we must continue to update our approaches to sexual and reproductive health. Because behavioural and environmental factors change throughout the life cycle and are interrelated, in developing this document we have used a conceptual framework to guide our understanding, based around the following three categories.

1. **Predisposing factors** are those characteristics of people or communities that motivate behaviours relating to sexual and reproductive health. There are links among education, knowledge and behaviour; attitudes, beliefs and values; socioeconomic status; sexual abuse and violence; mental health and disability; and alcohol and drug abuse. As already indicated, the links among low educational attainment, unemployment and early parenthood are well recognised.
2. **Reinforcing factors** are those consequences of action, including feedback received in response to the behaviour, which may encourage a change or continuation of the behaviour. Personal sexual satisfaction/pleasure, and responses from partners, friends and family are significant in reinforcing behaviour. As we operate in a complex community, other important factors are the construction of gender roles in the sexual relationship; relationships with parents or caregivers and peers; and prevailing attitudes and messages from the community and media.
3. **Enabling factors** are the environmental characteristics that facilitate healthy behaviour, and the skills and resources required to realise that behaviour. Access to information is only one part of the jigsaw. Practical skills – for example, in using condoms – are also important. Another enabling factor is access to sexual health services, in terms of both location and affordability. For disabled people, issues relating to enabling are particularly significant, and sometimes distinctive. They may face barriers in accessing information and appropriate services, as well as attitudinal barriers. For example, disabled people often feel they are regarded as ‘asexual’ or ‘neuter gender’ by many people.

A comprehensive sexual and reproductive health strategy can only be achieved by delivering a comprehensive population-based approach. Such an approach recognises that common strategies, interventions and programmes run across all areas of sexual and reproductive health and cannot be separated out.

The following four **strategic directions** provide a framework for work on sexual and reproductive health and for the development of more detailed action plans.

These directions provide a common framework, but as already indicated, the specific actions need to consider the characteristics and mechanism of particular groups or communities of interests. For example these include young people (12–25 years), Māori, Asian groups, heterosexual males, young women, and disabled people.

## Strategic direction one: Societal attitudes, values and behaviour

Increase the awareness and understanding of all members of society about the complex nature of sexuality, sexual behaviour and motivation.

- Explore societal views and aspirations for sexual and reproductive health.
- Explore the role of communities in improving sexual and reproductive health.
- Focus on the determinants of sexual and reproductive health including societal issues, structural issues (social, environmental, educational, cultural, emotional and spiritual) and power imbalances in relationships.
- Increase the ability of families/caregivers to support their children and young people to make healthy sexual and reproductive health decisions for themselves.
- Examine these issues with reference to the specific age, ethnicity, disability and population group cultural norms.
- Addressing negative attitudes towards disabled people by groups such as parents and professionals, and determining how issues faced by disabled people related to their sexuality and sexual and reproductive health needs can be addressed.

## Discussion

Community attitudes, social and cultural values, social support and media representations can have a significant impact, both positively and negatively, on people's sexual behaviours.

Society has a responsibility to create a supportive social environment; to achieve this environment we need to discuss and debate our values. One ideal is for society to promote the right of every New Zealander to make their own decisions about their sexual behaviour, free from discrimination, coercion and violence, while at the same time considering the rights and welfare of others, particularly partners and children.

Communities of interest must be engaged in identifying the problems and desired outcomes in their own terms, prioritising their concerns, and planning and implementing programmes to address those concerns. Issues related to power, race, gender, age and culture add complexity to outcomes.

Different sectors of the community have differing levels of awareness about different sexual and reproductive health issues and sexuality constraints. The approach that is used to increase the awareness in one sector may not be appropriate for others.

Education, health promotion programmes and services for all sectors should encourage discussion not only about sexual behaviour between partners but also to promote positive sexuality. They should provide information about and skills for:

- practising safer sex from initiation of sexual behaviour
- alternative ways to express relationships and sexual intercourse
- reducing numbers of partners or decreasing sexual partner change
- the emotional, social and spiritual dimensions of sexuality.

## Strategic direction two: Personal knowledge, skills and behaviour

Increase individuals' understanding and skills and teach them to value themselves (personal identity and self worth).

- Ensure appropriate health and education across the lifespan for everyone, which aims to increase healthy sexual and reproductive health choices.

### Discussion

Individuals need personal and social skills to enable them to exercise more control over their own health. The development of these personal skills (including skills for seeking help and information, for negotiating safer sexual activity, and for using condoms) involves education of the individual in establishing and maintaining healthy relationships as well as passing on knowledge.

Families/caregivers may need assistance to develop the skills to advise and guide children. In addition, they may need help to cope with the changes in their own lives, which may affect sexual behaviour.

Social skills development and sexuality education should start early in childhood, even before school attendance. An example is ensuring children are aware of the correct names for parts of their bodies. Practical information and social skills development should continue so that young people (12–25 years) can make healthy decisions for themselves. Disabled children and young people are at particular risk of missing out on social skills development and sexuality education, partly because they may not be seen as sexual beings and because there is often an over focus on their impairments and overcoming development delay in other areas.

Lacking knowledge or skills to practise safe sex may contribute to high numbers of STIs, to HIV/AIDS and to unintended pregnancy. All population groups need information on sexual

health and safer sexual practice, on the risks associated with STIs and HIV and on the means of prevention, early diagnosis and treatment of STIs and HIV. They also need specific information to ensure their partner is treated.

In addition to the societal factors mentioned above, other factors affecting sexual behaviour include young age, low educational attainment, use of drugs or alcohol, coercion and inequality within relationships because of gender, age, ethnicity, employment or lack of it, or low self-esteem. The effects of loneliness, of the need to feel cared for, and of the need for passion or fun, should be acknowledged.

## Strategic direction three: Services

Ensure sector development and the necessary number and range of interventions and services that are working together regionally and nationally to improve sexual and reproductive health and provide consistent messages.

- Provide accessible and appropriate primary and specialist health services.
- Ensure services are non-judgemental and responsive to diversity in society, gender, age, ethnicity, sexual orientation and sexual practices.
- Create an environment in which service providers can work in collaboration, and integration can occur in primary health care.
- Ensure workforce development occurs with increase in staff numbers and/or improvements made as required, consistent with this strategy.
- Ensure primary services continue to be delivered in a variety of sites, including general practitioner teams, iwi-based services, Family Planning, population-specific non-government organisations and hospital-based sexual health services.
- Ensure that services can address the sexual and reproductive health needs of disabled people.
- Ensure easy access to products and supplies, including treatments for specific infections, condoms and contraceptives.
- Ensure standards are set and national guidelines established.

## Discussion

The primary focus of improvements to sexual and reproductive health services should be on improving access to services, improving the quality of service delivery, and increasing knowledge and understanding of outcomes and their determinants. It is essential to minimise cost as a barrier – delivery of services has to be affordable. In addition, better integration and linkage between both the existing reproductive health services and sexual health services should be encouraged.



## Strategic direction four: Information

Increase the evidence base.

- Maintain and improve monitoring and surveillance systems by ensuring the appropriate information is collected (including ethnicity information).
- Undertake relevant research, including evaluation of this strategy.
- Ensure confidentiality and that information is non-identifiable.
- Improve reporting of STI rates and factors relevant to their transmission.

### Discussion

Accurate and timely information is increasingly viewed as an essential health tool for improving clinical and professional practice and for ensuring that messages and delivery systems are working as intended. Just as the range of services is limited and varies geographically, so too is the information collected in New Zealand shaped and constrained by these characteristics. One example is the information on the rates of STIs other than HIV.

Information can also assist in understanding regional and cultural aspects of unwanted/unintended pregnancy. For example, is there a lack of access to contraception, or is there inaccurate information within a community about fertility control, which might help explain higher rates in a given area?

Finally, quality information can assist in the development of best practice guidelines, and in ensuring that overseas experience is made relevant to the issues particular to New Zealand, especially among Māori and Pacific peoples.

# The Next Phase – Developing Action Plans

---

Phase One of the Sexual and Reproductive Health Strategy is the overarching direction and framework for the series of action plans covering priority areas in sexual and reproductive health to be completed. The action plans will form the basis for funding of services by the Ministry of Health and the District Health Boards.

As stated in the introduction, the Government's key concerns are the increasing number of people affected by STIs, particularly chlamydia, gonorrhoea and HIV/AIDS, and the high level of unwanted/unplanned pregnancy. Given this Phase Two is based on addressing those with the most health need first: those groups in at-risk situations, young people, Māori, Pacific, and disabled people.

The priorities are developing specific plan for STIs and unintended/unwanted pregnancies. A broader plan covering sexual and reproductive issues for Māori will begin immediately. A plan for Pacific peoples will also be initiated. The HIV/AIDS plan is currently under way. Sexual violence and abuse plans will be developed, including addressing the particular vulnerability of disabled people, as a follow-on from this initial work. In addition, a longer-term study will be initiated, which will explore the broader societal issues outlined in strategic direction one.

The plans will be integrated. For example, the Māori plan will contribute to and draw on the initiatives developed for specific issues, and vice versa. It is envisaged that the Māori plan will follow a whānau development approach to Māori rangatahi within sexual health services. This approach will provide the support and services that the rangatahi need, while at the same time increasing the skills and experience of the community. The Māori Health Strategy, which is currently being developed by the Ministry, reinforces a whānau-based approach to health service delivery.

The issues of parents and young people feeling shy, embarrassed and awkward about sexual and reproductive health are common issues across all cultures; for Pacific peoples, they are experienced in a completely different cultural context to that of Māori and Pākehā. The strategic direction is not one size fits all, but encourages the development of services and programmes to 'increase awareness and understanding' in culturally appropriate and relevant ways for Pacific communities.

The integration of population-specific plans and issue specific action plans will mean that each area responds comprehensively to the needs of Māori, Pacific peoples and youth/rangatahi when addressing issues of STIs or unwanted/unintended pregnancy. Each of the plans will address the strategic directions outlined in this report.

The Ministry of Health will develop these plans in conjunction with the sector reference group, working closely with the wider health and social sectors. Members of the reference group will also form the core of smaller expert advisory groups that will assist in developing each of the plans, to provide overall consistency and coherence.

# Sexual and Reproductive Health Issues in New Zealand

Information about sexual and reproductive health status and behaviour in New Zealand comes from a number of sources and is incomplete. There is a need for further information on births and associated mortality, and on abortions, including information on the woman's age, district/area and the procedure. Here, drawing on available data, we outline the issues in relation to:

- sexual behaviour
- fertility, including teenage pregnancy
- abortion
- sexually transmitted infections, including HIV/AIDS.

## Sexual behaviour

In a cross-sectional study within a birth cohort (Dunedin Multidisciplinary Health and Development Study) of 477 males and 458 females, it was estimated that the median age for first sexual intercourse was 17 years for males and 16 years for females. At 15 years of age, 32 percent of females and 28 percent of males had had penetrative sexual intercourse (Dickson et al 1998). This study also concluded that of the females who had had sexual intercourse before the age of 16 years, 70 percent regretted doing so.

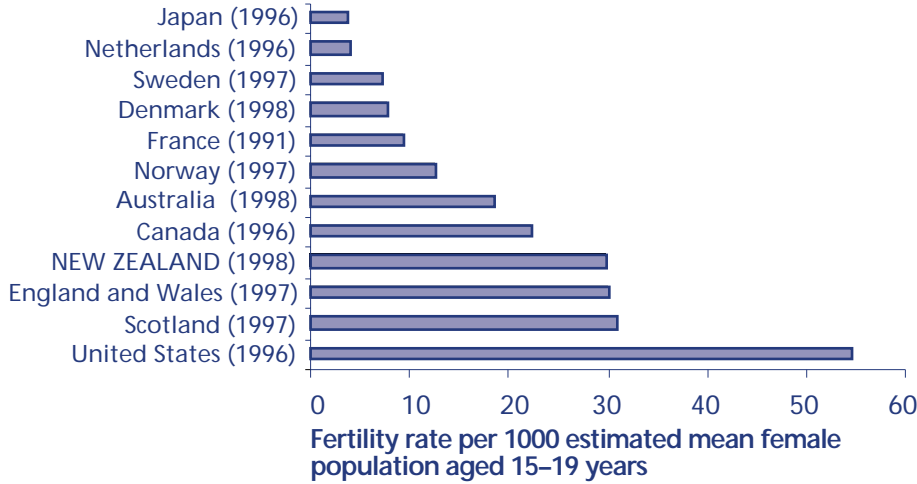
Another New Zealand study (self-report survey of 654 fourteen-year-old students in Hawke's Bay) found that 39.4 percent of the students had had sex/intercourse. Māori students were nearly three times as likely as European students to be sexually active. Of the sexually active students, 20.1 percent reported more than five partners. In addition, 11.9 percent reported having first had sex at age 12 or younger (Fenwick and Purdie 2000).

No information is available on age of initiation for young gay males or females.

## Fertility

New Zealand has a higher total fertility rate than other OECD countries. Rates of births to teenage mothers (15 to 19 years) in New Zealand are also higher than most other OECD countries (Dickson et al 2000). As figure 1 shows, the 1998 rate in New Zealand was similar to the rates in England, Wales and Scotland, but exceeded those in Australia, Canada and the Scandinavian countries.

**Figure 1: Fertility rates of mothers aged under 20 years in selected OECD countries**



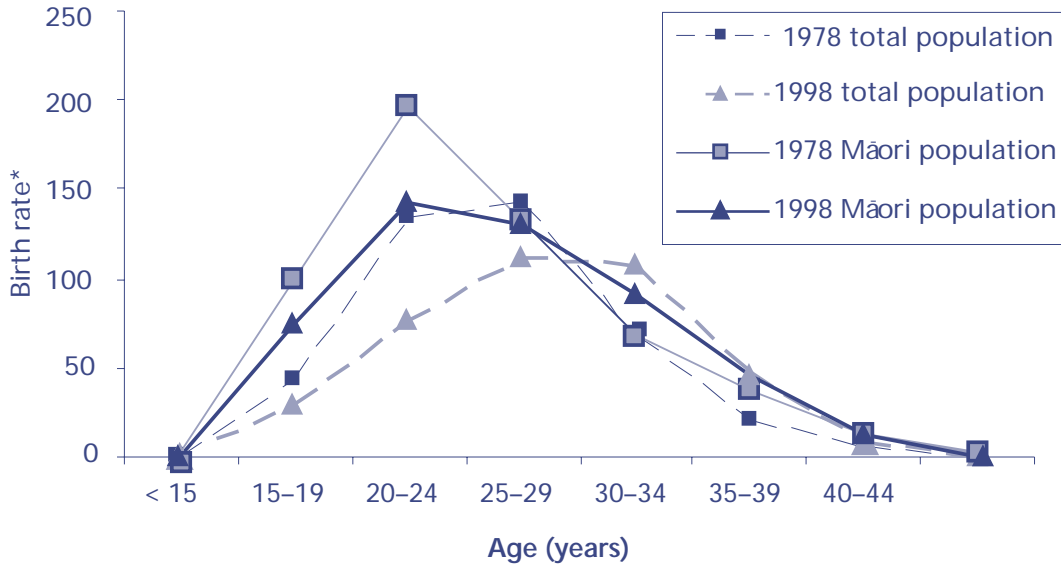
Source: Statistics New Zealand 1999

The total number of live births registered in New Zealand between 1978 and 1998 peaked in 1990, and has been approximately stable since 1994 (figure 2). Age-specific patterns have changed between 1978 and 1998, with more women now having children when they are over 30. In 1978, birth rates were highest for women aged 20–24 years and 25–29 years. By 1998, birth rates were highest for women aged 25–29 years and 30–34 years.

More specifically the Māori population shows the same trend towards having children when older. In 1978 the highest rate was amongst women aged 20–24 years; by 1998 the rate was higher among women over 30 years of age.

Changes in data collection have affected the numbers of recorded Māori births and the associated rates. These Māori birth rates were based on the ethnicity of the child prior to 1991, and on the ethnicity of the mother from 1991. In addition, from 1 September 1995 the birth registration form included a new question to determine ethnicity based on self-identification. As a result, more Māori births may now be recorded than previously from the degree-of-blood question. Thus any change in patterns may reflect differences of definition rather than an actual change in fertility.

**Figure 2: Age-specific birth rates in the total population and Māori population, 1978 and 1998**

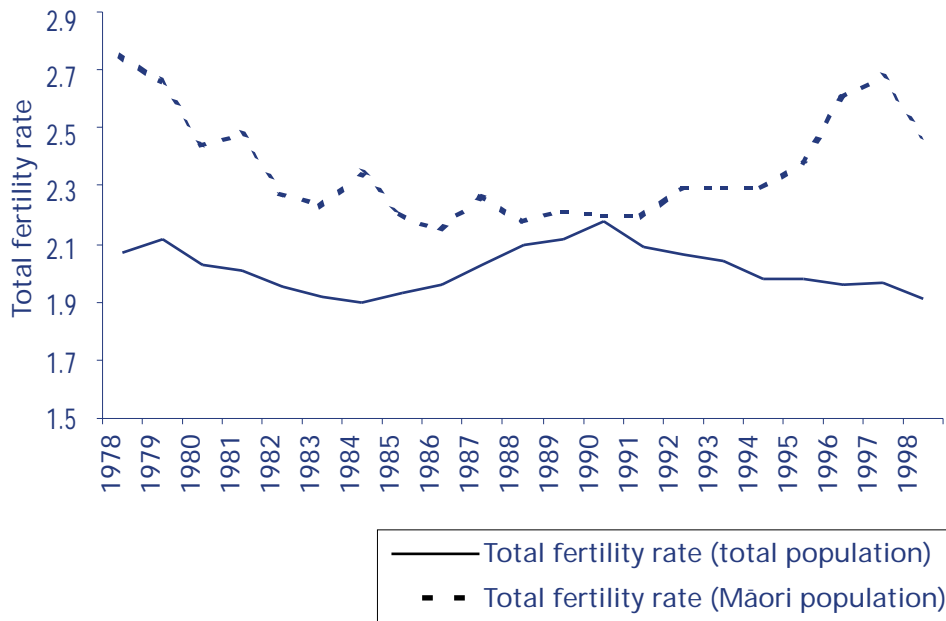


\*Age-specific rates per 1,000 estimated mean female population in each age group

Source: Statistics New Zealand 1996, 1999

Overall the birth rates for Māori are slightly higher than those for the total population (figure 3). Again, any change in patterns may reflect differences in definition since the 1995 change to determine ethnicity through self-identification.

**Figure 3: Total fertility rates, 1978-1998**



Source: Statistics New Zealand 1996, 1999

In the total population the fertility rate for women aged 20–24 years declined from 95.2 per 1000 in 1991 to 75.6 per 1000 in 1998. In contrast, there was little change in the fertility rate for women aged 15–19 years over this period.

The fertility rate for Māori women aged 20–24 years declined from 1996 to 1998, but it remains almost twice the rate for the total population in the same age group.

## Teenage pregnancy

New Zealand researchers (Dharmalingham et al 1997) have concluded that teenage pregnancy is more common among:

- Māori women
- women who left school before the age of 15
- women who had intercourse before the age of 15
- women who did not use contraception at first intercourse.

In 1998, there were 1245 live births to mothers aged under 18 years (a rate of 9.5 per 1000 females aged 13–17 years). Births to females under 18 made up 2.2 percent of all live births in 1998.

In 1998, the fertility rate for Māori females aged 13–17 years was 26.2 per 1000, more than five times that of non-Māori (4.9 per 1000).

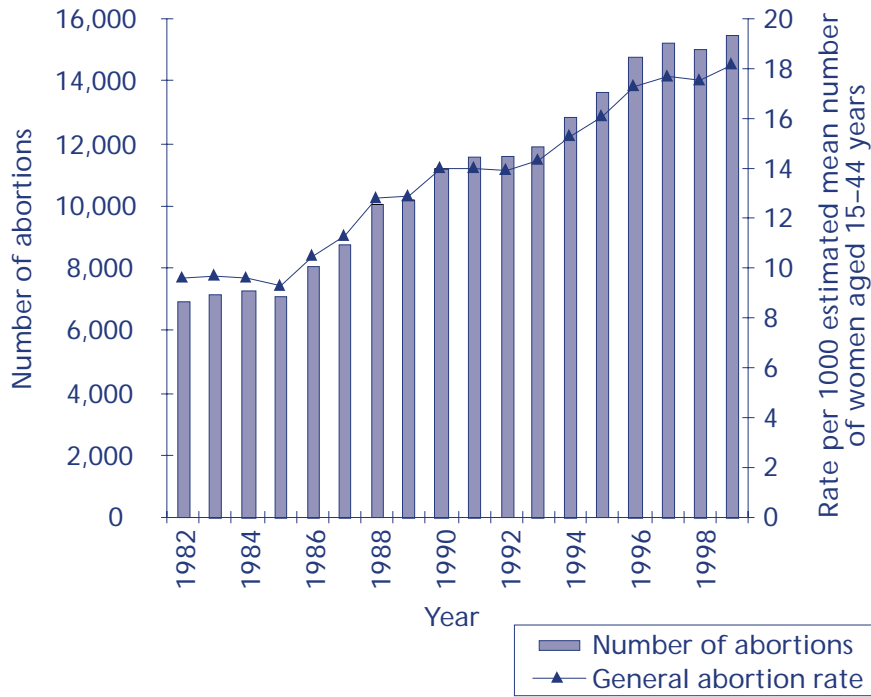
Age-specific fertility rates for Pacific women are produced by Statistics New Zealand for census years only. In 1996 the fertility rate for Pacific females aged 13–17 years was 17.0 per 1000, nearly twice the average rate.

## Abortion

The number of abortions has increased since 1982; in the mid-1990s it was twice the number in 1982. Between 1982 and 1998 the number (and rate) of abortions has been fairly constant in three periods: 1982–1985, 1990–1993, 1996–1998. The years between these periods have seen relatively rapid increases in the number (and rate) of abortions (figure 4).

There were 16,103 abortions performed in New Zealand in 2000, compared with 15,501 in 1999. The abortion rates rose in all age groups between 1999 and 2000. The abortion rate for 15–19-year-olds rose by 8 percent from 21.6 to 23.5 per 1000, while the rate rose by 3 percent for women in their twenties and 7 percent for women in their thirties. This increase compares with a drop of 1.2 percent during 1998 and an annual average increase of 5.6 percent from 1993 to 1997.

**Figure 4: Induced abortions and abortion rates, 1982–1998**



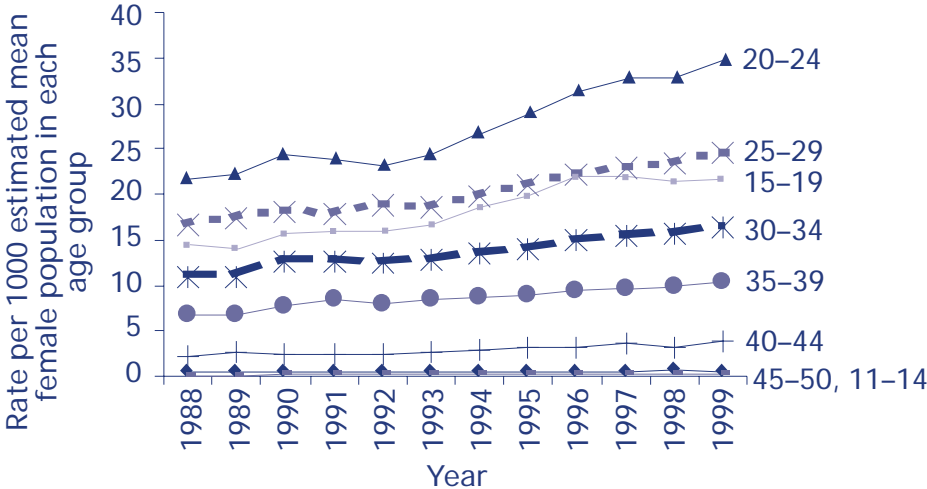
Source: Abortion Supervisory Committee 2000

In 1999 Asian (298 per 1000), Māori (247) and Pacific women (255) had higher rates of abortion than the national average (212) and than the European rate (202). Statistics New Zealand cautions that ethnicity data are not directly comparable, so these figures are broadly based comparisons only.

Among women aged 15–19 years the abortion rate increased from 13.9 per 1000 in 1989 to 21.5 per 1000 in 1998 (figure 5). There is an indication that the rate is beginning to decline in more recent years.

The age group with the highest rate of abortions is women aged 20–24 years. With a rate of 34.8 abortions per 1000 women in 1999 this group accounts for approximately 3 out of 10 abortions in any year. The next highest rates are among women aged 25–29 years (24.5 per 1000) and 15–19 years (21.7 per 1000). Between 1998 and 1999 the abortion rate for teenagers altered little, while the rate for women aged 20–39 years increased by about 5 percent.

**Figure 5: Age-specific abortion rates, 1988–1998**



Source: Statistics New Zealand 1999

A New Zealand study found that 43 percent of women presenting for an abortion had a family income of less than \$22,000, and more than half had a community services card (Young et al 1994). Among the women who were not using any method of contraception, 32 percent were not using it because of financial reasons.

## Overseas comparisons

In 2000 the abortion rate was 19.0 per 1000 estimated mean number of women between 15–44 years. In comparison New Zealand has:

- lower rates than in Australia (22.2 in 1995/96) and the United States (22.9 in 1996)
- rates similar to the Swedish rates (18.1 in 1999)
- higher rates than in the Netherlands (7.4 in 1999), Germany (8.0 in 1998) and Finland (10.5 in 1999) (Statistics New Zealand 2001).

Such international comparisons should be interpreted with caution as rates are affected by statistical coverage and the laws covering abortion.

Anecdotal evidence from overseas suggests abortion rates are increasing worldwide. It has also been suggested that the contraceptive pill scare, which linked the third generation pill to deaths, was a major factor in this trend (Abortion Supervisory Committee 2000). In addition, abortion numbers in New Zealand are influenced by people on working holidays and visitor permits.



# Sexually transmitted infections

Information on STIs in New Zealand is incomplete as national statistics on people diagnosed are not collected and some laboratories do not provide information for surveillance. With the exception of AIDS (see below), STIs are not notifiable infectious diseases.

The Ministry of Health commissions the Institute of Environmental Science and Research (ESR) to undertake the surveillance of STIs. ESR collates anonymous data on STIs diagnosed at all sexual health clinics and, since 1998, at an increasing number of Family Planning Clinics and some youth and student health clinics. These data do not include people diagnosed at other health services including general practices. Comprehensive information from diagnostic laboratories (including from general practitioners) is only available for Waikato, Bay of Plenty and, more recently, Auckland.

AIDS is reported to the AIDS Epidemiology Group at Otago University. The AIDS Epidemiology Group collates information from the laboratories that conduct confirmatory HIV testing. It also seeks information from the doctor requesting the test, in regard to demographics and risk behaviours of people found to be infected with HIV.

Sexual health services are provided by a range of providers and access to different providers varies around the country, therefore the clinic information cannot provide population rates of disease but may provide information on risk groups for disease and some trend information.

## Information from sexual health clinics

Sexual health clinics are services provided by District Health Boards or by an Independent Practitioner Association such as in Wellington. Results from 32 clinics are collated by ESR. For 2000 this surveillance information (Turley et al 2000) shows:

- 92 percent of sexual health clinic attendees were aged 15–44 years
- there was a total of 73,135 visits to clinics, a 5.7 percent increase from the 68,956 visits in 1999
- 59.2 percent of attendees were female.

In regard to specific STIs, from 1996 to 2000 the number of both chlamydia and gonorrhoea cases seen at sexual health clinics increased (see below for details). In contrast, the number of people diagnosed with genital herpes decreased from 802 in 1996 to 684 in 2000. Similarly, the number of cases of syphilis fell from 23 in 1999 to 13 in 2000, of which two were male.

In some cases, young people, Māori and Pacific peoples were represented in disproportionately high numbers.

- Those aged under 25 years accounted for 71 percent of gonorrhoea and chlamydia cases and 61 percent of genital warts cases reported.
- A disproportionately high proportion of bacterial STIs (chlamydia and gonorrhoea) has been found among Māori and Pacific peoples.

- Multiple infections were more common for people aged under 25 years, as well as for Māori and Pacific peoples.

Here we focus specifically on the data for chlamydia and gonorrhoea.

## Chlamydia

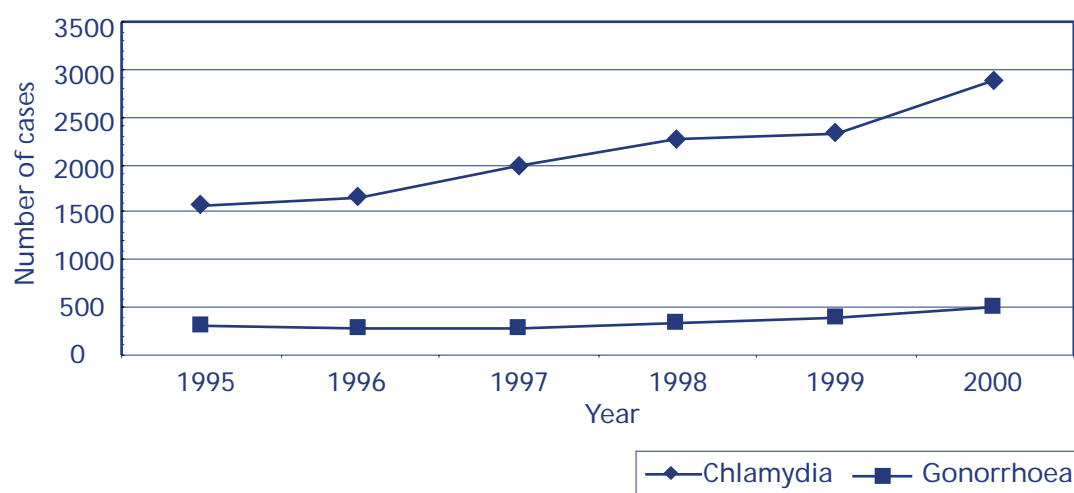
At sexual health clinics in 2000 the most frequently diagnosed STI was infection due to *Chlamydia trachomatis*. There were 2871 cases confirmed, with a further 783 probable cases.

The number of confirmed chlamydia cases increased each year from 1995 to 2000. Rising from 1579 confirmed cases in 1995, numbers reached 2331 in 1999 then increased by a further 23 percent in 2000 (figure 6). The increase occurred in all age, sex and ethnic groups. Of the 2871 cases diagnosed at clinics in 2000:

- 2017 (70 percent) were in people aged 15–24 years, 977 in people aged 15–19 years and 1040 in those aged 20–24 years
- 54 percent of cases were females
- 1450 (54 percent) were of European ethnicity, 1043 (36 percent) were Māori, 226 (8 percent) were Pacific peoples and 111 (4 percent) were of other ethnicities.

The incidence of chlamydia diagnosed at sexual health clinics is disproportionately high among Māori compared with the incidence that might be expected based on the proportion of Māori reported in the 1996 census.

**Figure 6: Number of cases of chlamydia and gonorrhoea seen at sexual health clinics, 1995–2000**



Source: Turley et al 2000

Part of the increase in chlamydia cases may be due to improvements in diagnostic methods such as the introduction of more sensitive DNA amplification test methods, or change in service provision, screening practices or surveillance. However, it seems that these changes alone do not explain the continued increase in chlamydia cases.

## Gonorrhoea

The number of people diagnosed with gonorrhoea at sexual health clinics has been increasing since 1996. In 2000, there were 492 confirmed cases, increasing by 28 percent from the 384 cases reported in 1999. The majority of these cases (338, or 69 percent) were aged under 25 years with 180 cases in young people aged 15–19 years and 155 cases aged 20–24 years.

Of the total of 492 cases, 246 (50 percent) were Māori, 140 (28 percent) were European and 78 (16 percent) were Pacific peoples.

Where multiple infections were diagnosed, the most frequent infections were gonorrhoea and chlamydia, found in 213 people.

## Information from laboratory surveillance

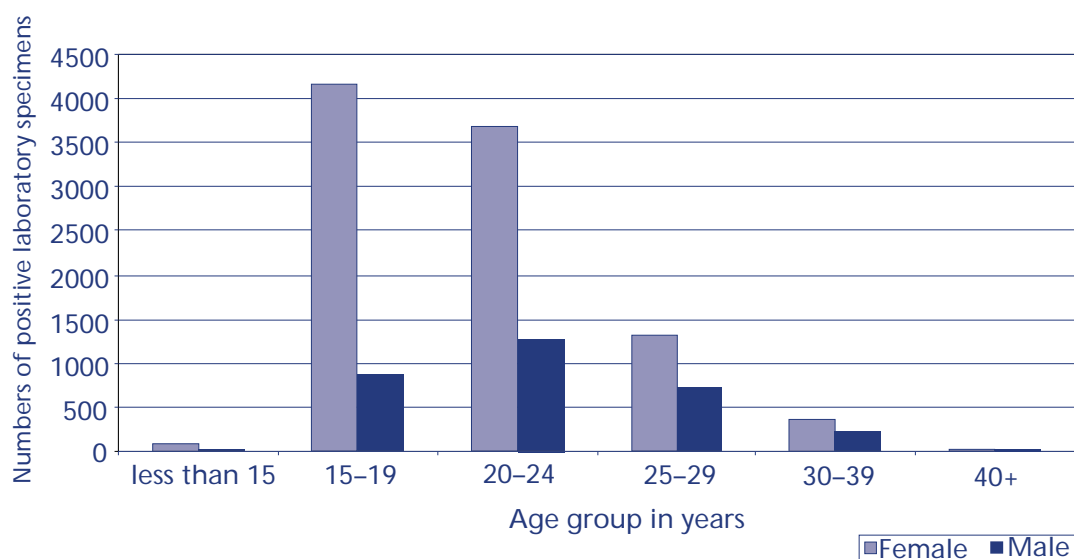
During 2000, laboratories in Waikato, Bay of Plenty and Auckland provided STI information on a voluntary basis. With these data it is possible to estimate the population incidence rate.

## Chlamydia

The laboratories in Waikato and Bay of Plenty reported 2812 positive cases of chlamydia, with 74 percent of specimens from females. Over two-thirds (71 percent) of positive tests were for people aged 15–24 years. The estimated population rate of confirmed chlamydia infection for the combined area was 50 per 100,000.

Figure 7 provides the details on age-specific rates. The data have been collated since July 1998; changes over time are unlikely to represent an increase in infections (Turley et al 2001).

**Figure 7: Rates of chlamydia by sex and age group for Waikato and Bay of Plenty, 2000**



## Gonorrhoea

In 2000, laboratories in Waikato and Bay of Plenty reported 280 cases of gonorrhoea. Case numbers decreased during the six months from July to December 2000.

Amongst the 280 cases, 156 (56 percent) were female. The highest rate was in females aged 15–19 years (56 cases, a rate of 278 per 100,000), followed by females aged 20–24 years (47 cases, rate of 240 per 100,000). The corresponding rate for males was 190 per 100,000 for those aged 15–19 years and 183 per 100,000 for those aged 20–24 years.

## Auckland laboratory information

Information is available on the number of positive specimens tested for gonorrhoea in laboratories in the Auckland region since 1997. The number of cases increased from January 1997 to June 2000; in the six remaining months of 2000 the number was lower.

In total 669 cases of gonorrhoea were diagnosed in the Auckland region in 2000, giving a total population rate of 62 per 100,000. This number is more than double the 308 cases reported in 1997.

Highest rates were in males aged 20–24 years (131 cases, or a rate of 318 per 100,000) and females aged 15–19 years (a rate of 271 per 100,000). The next highest rates were among males aged 15–19 years (a rate of 198 per 100,000) and females aged 20–24 years.

## Ectopic pregnancy

Data on ectopic pregnancy provide a very limited indicator for the burden of STIs. It is a late complication of some STIs (chlamydial and gonococcal infection) but may also be unrelated to STIs.

In 1998 there were 964 hospitalisations for ectopic pregnancy amongst females aged 15–44 years, giving an age-standardised rate of 107 per 100,000. The age-standardised rate for Māori females (178 per 100,000) was about twice the rate for European and other ethnicities (91 per 100,000) (Ministry of Health 1999).

The 1998 rate for Māori females represents a rise of almost 25 percent from 144 per 100,000 in 1996. In contrast, the rates for European females and females of other ethnicities decreased by 10 percent, from 101 per 100,000 in 1996. Likewise, the rate for Pacific females decreased by 5 percent, from 130 per 100,000 in 1996 to 122 per 100,000 in 1998.

## HIV/AIDS

HIV is transmitted through the exchange of body fluids such as blood and semen, which can occur through sexual contact or sharing of needles, from mother to infant during the birth process and from contaminated blood products. Other viruses such as hepatitis B and C are also transmissible by sexual and blood-borne routes. In addition, the presence of another STI is known to increase the risk of transmission of HIV.

The population groups at higher risk of exposure and transmission of HIV in New Zealand are:

- men who have sex with men
- injecting drug users
- people who received blood products before screening was introduced
- people who come from or are exposed to people from areas of the world where heterosexual transmission is high, such as refugees from some areas
- the partners of the above groups.

A pregnant woman with HIV may also vertically transmit the infection to her baby. So far the risk of transmission of HIV amongst the New Zealand population outside of these groups has been low.

Since monitoring of AIDS began in New Zealand, HIV/AIDS has primarily affected men who have sex with men (80 percent of total AIDS cases were contracted through homosexual contact). Until recently the annual number of females found to be infected has been stable. Through to the end of December 2000, a total of 1478 people in New Zealand were found to be infected with HIV, of whom 189 were female. During 2000 there were 88 people found to be infected with HIV.

Since data collection began, the risk behaviour categories at the time of diagnosis of HIV infection have been identified as follows:

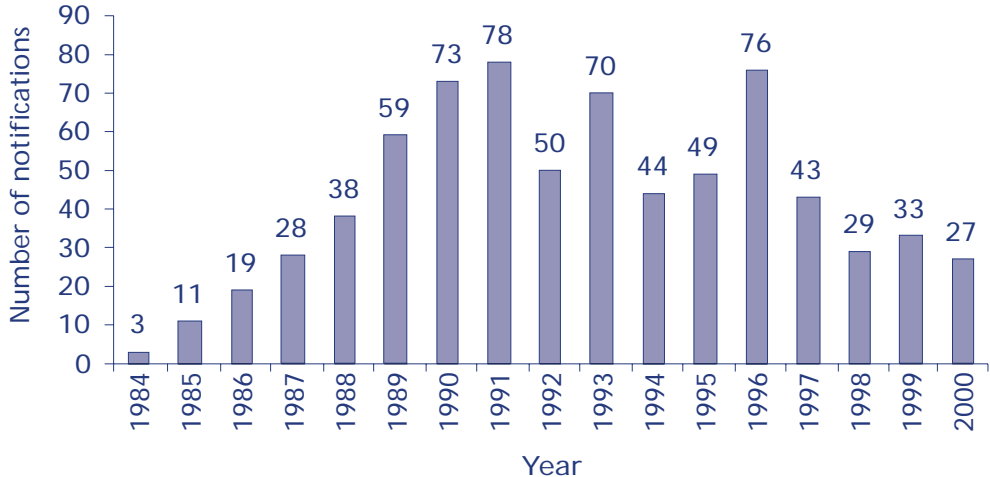
- homosexual or bisexual for 778 males
- homosexual and injecting drug user for 15 males
- injecting drug user for 40 people (male and female)
- heterosexual contact for 253 people
- blood products for 46 people
- perinatal transmission for 12 people
- another route of transmission for 9 people.

For the remaining HIV cases, information on risk behaviour is not available (AIDS Epidemiology Group 2001).

In regard to the ethnicity of people found to be infected with HIV from 1996 to 2000, 46.9 percent were European, 5.8 percent Māori, 3.1 percent Pacific peoples and 38.1 percent were other ethnicities. For 5.7 percent the information was unknown.

The number of notified of AIDS cases each year has decreased after peaking over 1989–1996, as figure 8 shows.

**Figure 8: Number of AIDS notifications in New Zealand, 1984–2000**



Source: *AIDS–New Zealand*, issues up to 47

Advances in HIV management medications have largely been responsible for the decrease in the notifications of AIDS cases over recent years. There is growing international concern with the increasing number of drug resistant strains of HIV being reported. This could lead to current drug therapies being obsolete in the future, increasing the AIDS cases.

While new drug therapies have reduced the number of people living with AIDS, it is also important to recognise that the risk of HIV transmission continues to increase as more people are infected. The refugee community is the most at risk of heterosexual and maternal transmission, while the risks for men who have sex with men continues to grow.

# Appendix: Development of the Document and Members of the Sector Reference Group

---

The document builds from the stock take of sexual and reproductive health services undertaken by the Health Funding Authority, and follows the direction established by the New Zealand Health Strategy and the New Zealand Disability Strategy.

A broadly representative Sector Reference Group was used to provide advice, submissions and feedback along with an internal Ministry Project Team, which included representatives from the Public Health Directorate, the Personal and Family Health Directorate, and the Disability Issues Directorate.

## Sector Reference Group

The Sector Reference Group was:

Nigel Dickson, Department of Preventive Medicine, Otago University

Pania Ellison, Te Puawai Tapu

Kitty Flannery, President, New Zealand Venereological Society

Alan Flemming, Principal, St Bernard's School

Rick Franklin, Association of Sexual Health Services, Clinical Director of Auckland Sexual Health Service

Gill Greer, CEO, New Zealand Family Planning Association

Kevin Hague, Director of the New Zealand AIDS Foundation

Ingi Hayward, Northland Health Peer Sexuality Education Programme

Catherine Healy, New Zealand Prostitutes Collective

Pippa Mackay, recent Chairperson New Zealand Medical Association

Fuimaono Karl Pulotu-Endemann, Pacific Consultant

Gillian Tasker, Christchurch College of Education

Olivia Tusa, Hutt Valley Health

## Represented members of sector reference group unable to attend meetings

Jane McDonald (for Kitty Flannery)

Paparangi Reid (for Pania Ellison)

Christine Roke (for Gill Greer)

# References

---

- Abortion Supervisory Committee. 2000. *Abortion Supervisory Committee's Report to Parliament*. Wellington: Abortion Supervisory Committee.
- AIDS Epidemiology Group. 2001. *AIDS New Zealand*. Issue 47. Dunedin: University of Otago.
- Dharmalingham A, Dickson J, Fish J, et al. 1997. *New Zealand Women 1955–1995. Family, Employment, Education*. Report presented to National Council of Women Conference.
- Dickson N, Paul C, Herbison P, et al. 1998. First sexual intercourse: age, coercion, and later regrets reported by a birth cohort. *British Medical Journal* 316: 29–33.
- Dickson N, Sporle A, Rimene C, et al. 2000. Pregnancies among New Zealand teenagers: trends, current status and international comparisons. *New Zealand Medical Journal* 113: 241–5.
- Fenwick R, Purdie G. 2000. The sexual activity of 654 fourth form Hawkes Bay students. *New Zealand Medical Journal* 460–3.
- Jaffee SR, Caspi A, Moffitt TE, et al. 2001. Why are children born to teen mothers at risk for adverse outcomes in young childhood? Results from a 20 year longitudinal study. *Development and Psychopathology* 13: 377–97.
- Minister of Health. 2000. *New Zealand Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 1999. *Progress on Health Outcome Targets: Te haere whakamua ki ngā whāinga hua mōte hauora. The state of the public health in New Zealand 1999*. Wellington: Ministry of Health.
- Statistics New Zealand. 1996. *Demographic Trends*. Wellington: Statistics New Zealand.
- Statistics New Zealand. 1999. *Demographic Trends*. Wellington: Statistics New Zealand.
- Statistics New Zealand. 2001. *Abortion: Summary of latest trends, 2001*. Wellington: Statistics New Zealand.
- Turley M, McNicholas A, Garrett N. 2000. *STI in New Zealand, Surveillance Report, 2000*. ESR report to Ministry of Health.
- Woodward LJ, Horwood LJ, Fergusson DM. 2001. Teenage pregnancy: cause for concern. *New Zealand Medical Journal* 114: 301–3.
- Young LK, Farquhar CM, McCowan LM, et al. 1994. The contraceptive practices of women seeking termination of pregnancy in an Auckland clinic. *New Zealand Medical Journal* 107: 189–92.