

11 Reproductive and sexual health issues

Reproductive health issues are particularly prominent in the youth population in comparison to other age groups, in part because this is the life stage when most people become sexually active and some have children. This chapter covers two main issues: pregnancy and sexually transmissible diseases. Issues concerned with sexual behaviour, such as sexual activity and contraceptive use, are discussed in Chapter 18.

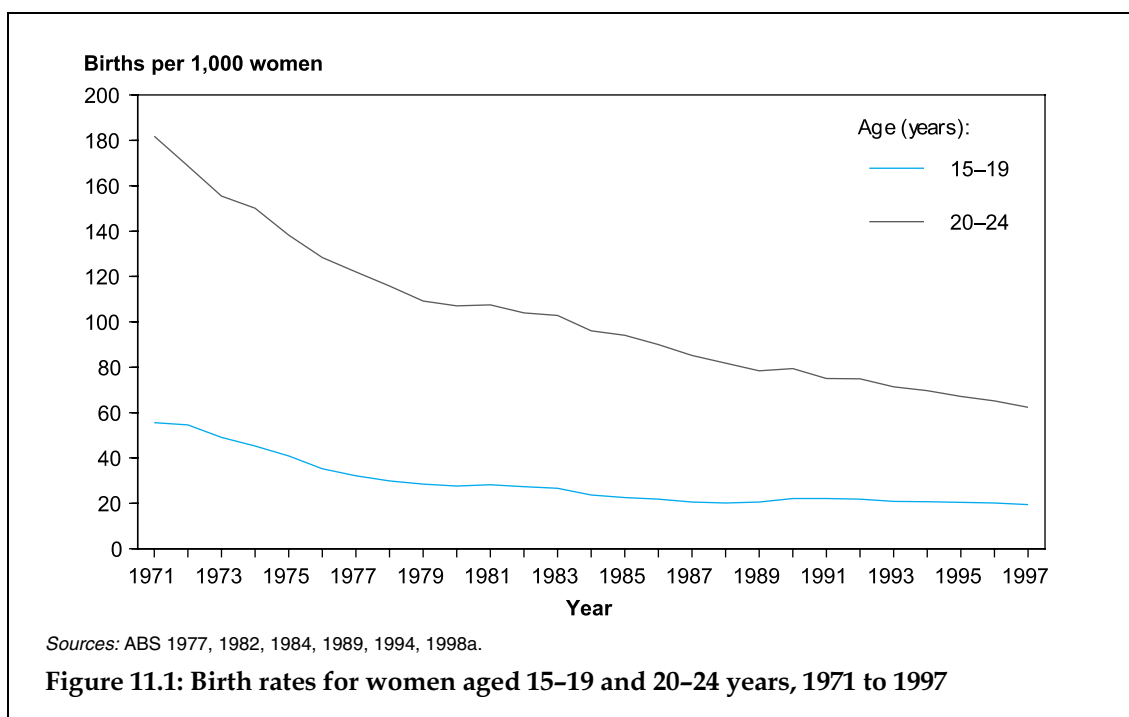
Pregnancy

Pregnancy and its outcomes are major concerns for women of reproductive age. The Australian Bureau of Statistics (1998a:10–12) estimates that, among the 4.8 million women of reproductive age (15–49 years) in 1997, approximately 500,000 conceptions occurred, with three possible outcomes: miscarriage (150,000 estimated cases); ‘viable’ (after 20 weeks gestation) pregnancy (250,000) and abortion (95,000). Of the 250,000 viable pregnancies, 248,246 resulted in a live birth (244,689 single births and 3,557 multiple births), and 1,800 pregnancies ended in a stillbirth. This section examines the data on each of these possible outcomes for women in the youth population.

Fertility

Information on the fertility of Australian women – their number of live births – is published annually by the ABS, from birth registrations data. In 1997, there were just under 252,000 registered live births in Australia, of which 5% were to teenage women and 9% were to women aged 20–24 years, a total of 35,754 births (ABS 1998a:28). Fertility in Australia has been declining since the ‘baby boom’ after World War II, which peaked in 1961. Teenage fertility, however, continued to increase until 1971. The subsequent decline in teenage fertility has been attributed partly to the reinterpretation of abortion laws and a greater willingness of medical practitioners to prescribe contraceptives (particularly the contraceptive pill) to unmarried women (ABS 1998a:19, ABS 1998b:30).

A common measure of fertility by age of the mothers is the age-specific birth rate, expressed as the number of births per 1,000 women. These rates for women aged 15–19 and 20–24 years, from 1971 to 1997, are shown in Figure 11.1.



- The birth rate for women aged 20–24 years decreased nearly 70% over this period, from 182 to 62 births per 1,000 women.

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- For teenage women, the birth rate decreased from 55 per 1,000 in 1971 to 20 in 1988 (a decline of 55%), and has been stable at that level since then.
- In addition to improved methods of and greater access to contraception and abortion, a number of social and economic factors are responsible for the decline in fertility, including the rising cost of raising children and women's educational and career aspirations (ABS 1998a:20).

Stillbirths

A possible outcome of a 'viable' pregnancy (after 20 weeks gestation) is the birth of a dead child. The likelihood of having a stillbirth or 'foetal death' is greater for older (40+ years) and younger (below age 20) women. As noted above, in 1997 there were a total of 1,800 stillbirths, 0.7% of all viable pregnancies.

The AIHW National Perinatal Statistics Unit (NPSU) publishes detailed statistics on 'foetal deaths' (foetuses of at least 20 weeks gestation or 400 g birthweight), the most recent being for 1996. These data indicate that 145 of the 1,818 foetal deaths in that year were to women aged less than 20 years, and 366 to women aged 20–24 years. These figures translate to foetal death rates (foetal deaths per 1,000 live births) of 10.8 and 7.9 respectively, compared with the rate of 7.1 for all maternal ages (Day et al. 1999: 110).

Pregnancy complications

Another outcome of pregnancy is miscarriage or spontaneous abortion. Based on an estimate of 30% of all conceptions ending in this way, the ABS believes there are 150,000 miscarriages annually in Australia. Accurate information on this outcome is very difficult to collect, as miscarriages very early in pregnancy may not even be noticed by the woman. One indicator of miscarriages, and one which is available by the age of the woman, is the number of hospitalisations for spontaneous abortions (Table 11.1).

Table 11.1: Hospitalisations^(a) for spontaneous abortion by age of woman, 1997–98

Age (years)	Number	Rate per 100,000 women	Rate per 1,000 births
12	—	—	—
13	2	2	} 179 ^(b)
14	15	12	
15	62	48	
16	164	129	155
17	265	210	119
18	334	266	94
19	411	325	82
20	476	371	80
21	553	424	82
22	534	400	65
23	648	475	67
24	733	523	64
12–24	4,197	248	77

(a) By principal diagnosis.

(b) For ages 13–15.

Source: AIHW National Hospital Morbidity Database.

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- In 1997–98, there were just under 4,200 hospitalisations of women aged 12–24 years with a principal diagnosis of spontaneous abortion. This was 248 hospitalisations per 100,000 women in that age group.
- The rate per 100,000 women increased with age, as would be expected, with women aged 20 and over being more likely to experience pregnancy and thus at greater risk of spontaneous abortion.
- A more appropriate rate may be hospitalisations per 1,000 live births. This rate was much higher for the youngest cohorts—179 per 1,000 births for women aged 13–15 years, 155 for women aged 16 years, and 119 for women aged 17 years. For women aged 22 and older, this rate was around 65 per 1,000 births.

Abortions

Induced abortion, or ‘elective pregnancy termination’, is another outcome of pregnancy. This outcome may be considered to be in part an indicator of lack of access to, or knowledge of, reproductive health facilities that would enable women to better control their fertility and avoid unwanted pregnancy. Complete national information on induced abortions is not available, however, because only South Australia and the Northern Territory collect such data. In South Australia in 1996, there were 5,535 induced abortions and 18,784 confinements for all ages. Therefore, about 30% of all pregnancies (excluding miscarriages) ended in abortion. The proportion among teenagers was 51% (AIHW 1998:52).

Duration of pregnancy

The duration of a woman’s pregnancy, when the outcome is a live birth, is a major determinant of the subsequent health of the child, but may also be used as an indicator of the health status of the mother. The normal gestation period is from 37 to 41 weeks, and durations of less than 37 weeks may indicate poor health in the mother. Data on duration of pregnancy is published by the NPSU, the latest being for 1996 (Table 11.2).

Table 11.2: Duration of pregnancy by maternal age, all confinements, 1996 (per cent)

Duration (weeks)	Maternal age (years)		
	Less than 20	20–24	All ages
Less than 32	2.1	1.5	1.4
32–36	6.6	5.3	5.3
37–41	88.8	90.6	91.0
42 and over	2.5	2.7	2.3
Total	100.0	100.0	100.0
<i>Number of confinements</i>	<i>13,373</i>	<i>45,863</i>	<i>253,413</i>

Note: These data include live births and stillbirths.

Source: Day et al. 1999:66.

- For 91% of all mothers, the duration of pregnancy was within the ‘normal’ range, 37 to 41 weeks. The figure for women aged 20–24 years was also 91%, but for teenage mothers it was lower, 89%.
- Nearly 9% of teenage mothers had pregnancies lasting less than 37 weeks, compared with 7% of all mothers.

Birthweight

Birthweight and duration of pregnancy are positively correlated, with a longer duration of pregnancy resulting in higher birthweight. Low birthweight is a risk factor for poorer health for the infant, and, as with duration of pregnancy, also indicates poor health in the mother.

The NPSU data on birthweight by age of mother for 1996 (Day et al. 1999: 90) indicate that teenage mothers were more likely to have lower birthweight babies: 9% of the births to teenage mothers and 7% of those to mothers aged 20–24 years weighed less than 2,500 g, and thus were classified as 'low' birthweight. For all births, the figure was 6%.

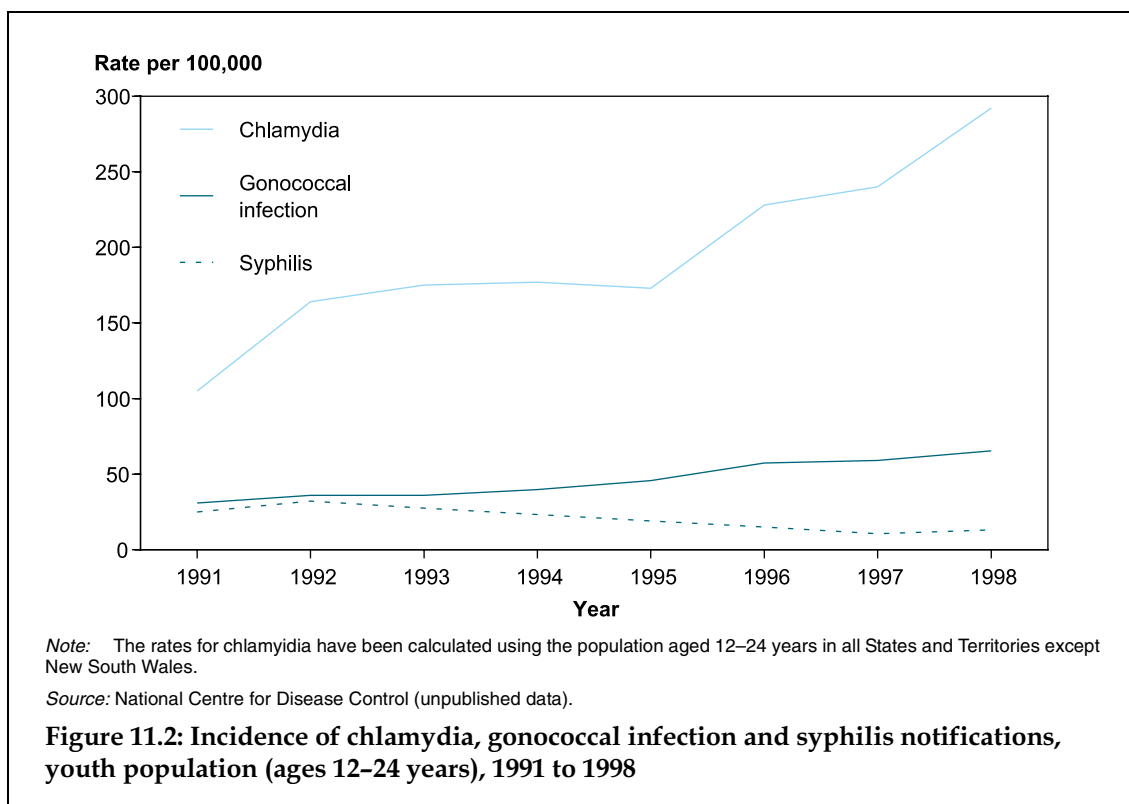
Sexually-transmissible diseases

Another issue regarding the sexual health of the youth population is their exposure to communicable diseases which may be contracted through sexual activity. Of the main sexually transmissible diseases, gonococcal infection, syphilis, and chlamydial infection are transmitted solely or mainly through sexual contact, whereas HIV/AIDS and hepatitis B and C may also be transmitted by other means, such as blood or saliva; hepatitis A is mainly transmitted through food contamination, but may also be spread through sexual contact.

Notifications

As discussed in Chapter 6, many communicable diseases are notifiable on a national basis, which means that any diagnosis of the disease must be reported to the relevant State/Territory health authorities. These reports are compiled by the Commonwealth Department of Health and Aged Care, so that national incidence levels for specific age and sex groups, such as the youth population, are available. The trends in the annual number of notifications for those diseases transmitted mainly through sexual contact – chlamydia, gonococcal infection and syphilis – for the youth population from 1991 to 1998 are shown in Figure 11.2. The incidence of the other diseases that are transmitted in part (but not exclusively) through sexual contact is covered in the discussion of morbidity in Chapter 6.

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- Chlamydia is one of the more common communicable diseases in Australia, although it is not notifiable in New South Wales (O'Brien et al. 1999:13). Therefore the rates used here are based on the youth population in the rest of Australia.
- The incidence of chlamydia has been increasing over time for the total population and especially for the youth population since 1995. This increase may be related to increased rates of testing and notification, rather than to actual increases in the prevalence. In 1998, nearly 60% of all cases reported were among the youth population, with a rate of 292 per 100,000 (compared with 173 in 1995 and 105 in 1991).
- Notifications of chlamydia were 2.4 times greater for females than for males among the youth population in 1998 (compared with 1.6 times for the total population).
- Notifications of gonococcal infection among the youth population have also increased in this period, although less dramatically than for chlamydia. From 1991 to 1998, the rate for the youth population doubled, from 31 to 65 per 100,000.
- A high proportion, 42%, of all notifications of gonococcal infection were among the youth population.
- In the total population, notifications of gonococcal infection were 1.9 times greater for males than for females in 1998. In the youth population there was little difference between males and females.
- In contrast, notifications for syphilis among the youth population declined from 32 per 100,000 in 1992 to 11 in 1997. During this period, the proportion of youth among all notifications declined from 42% to 28%.
- For the whole population, notifications for syphilis were 1.1 times greater among males than females in 1998. Among the youth population, however, notifications were 1.3 times greater for females than males.

Knowledge

Some information on the knowledge young people have about sexually transmissible diseases (STDs) is available from a nationally representative sample survey of 3,550 Year 10 and Year 12 students in 1997 by the Australian Research Centre in Sex, Health and Society at La Trobe University. Similar information was collected in a 1992 survey of 1,741 students in Year 10 and Year 12 conducted by the National Centre in HIV Social Research, allowing for comparability on some data items over time.

A question in the 1997 survey asked the students to identify from a list of various diseases the ones which could be sexually transmitted, and the responses are compiled here in Table 11.3.

Table 11.3: Students' correct identification of whether a disease is sexually transmitted, 1997 (per cent)

Disease (correct answer)	Year 10		Year 12	
	Males	Females	Males	Females
Gonorrhoea (yes)	44.2	47.5	69.5	69.5
Glandular fever (no)	62.1	72.5	72.8	83.2
Genital herpes (yes)	77.0	87.0	93.7	95.3
Flu (no)	81.8	87.2	87.1	93.5
Venereal disease (yes)	35.9	34.3	54.9	52.6
Measles (no)	77.9	82.9	83.2	91.4
Syphilis (yes)	40.1	39.4	69.8	69.0
Chicken pox (no)	81.3	84.3	85.4	93.3
HIV/AIDS (yes)	98.2	99.2	99.6	99.3
Chlamydia (yes)	30.6	37.3	53.7	66.1
Mumps (no)	69.1	75.6	81.3	87.9
Tuberculosis (no)	36.8	37.9	56.7	62.2
Genital warts (yes)	70.7	84.8	88.4	93.2
Impetigo (no)	45.1	53.2	45.1	56.7
Pelvic inflammatory disease (yes)	41.5	46.7	38.2	49.9

Source: Lindsay et al. 1997:20.

The report on the survey made the following comments on these results (Lindsay et al. 1997:17-19):

- Nearly all students were aware that HIV/ AIDS could be transmitted sexually, but knowledge about other STDs was poorer than knowledge about HIV/ AIDS.
- Year 12 students, as expected, had better knowledge about STDs than did Year 10 students.
- Female students had better knowledge than males on most diseases.
- The proportion of students correctly identifying chlamydia (one of the most common STDs) and pelvic inflammatory disease was quite low.
- Over two-thirds of the Year 12 students, but fewer than half of the Year 10 students, knew that gonorrhoea and syphilis are STDs. Recognition of the term 'venereal disease' was low.
- Most students correctly indicated that common illnesses such as flu, measles, chicken pox and mumps are not transmitted sexually. However, recognition was lower with glandular fever, tuberculosis and impetigo.

Perceptions

The surveys in 1992 and 1997 measured students' perceptions of their exposure to the risk of these diseases by asking if they believed they might become infected with such a disease (Table 11.4).

Table 11.4: Students believing they were likely or very likely to become infected with HIV or to get an STD or hepatitis, 1992 and 1997 (per cent)

Sex	Year 10		Year 12	
	1992	1997	1992	1997
To become infected with HIV				
Males	8.1	3.9	4.7	4.7
Females	11.7	7.7	9.5	6.9
To get an STD				
Males	11.5	10.0	11.4	8.9
Females	15.3	11.4	14.9	14.1
To get any form of hepatitis				
Males	n.a.	10.8	n.a.	9.9
Females	n.a.	12.2	n.a.	15.5

Source: Lindsay et al. 1997:42–6; question on hepatitis not asked in 1992.

- Not many students see themselves as being at risk of HIV infection; about 4% of males and 7% of females in the 1997 survey expressed this concern. Some of the more common reasons given by students for this were that they did not inject drugs, or at least did not share needles, and that they had not had sexual relations, or at least used condoms (Lindsay et al. 1997:43).
- The proportions who believed they were likely or very likely to get an STD or hepatitis were slightly higher, but still less than 16%.
- Students who engaged in risk-taking behaviour, such as injecting drugs, were more likely to see themselves at risk of contracting one of these diseases (Lindsay et al. 1997:44).

Health status

The health status of students concerning STDs was examined in the surveys in a variety of ways, including asking students if they have had an HIV antibody test, been diagnosed with an STD, and been diagnosed with hepatitis (Table 11.5).

Table 11.5: Students who have had an HIV antibody test, been diagnosed with and STD, and been diagnosed with hepatitis, 1992 and 1997 (per cent)

Sex	Year 10		Year 12	
	1992	1997	1992	1997
Had an HIV antibody test				
Males	2.2	3.0	5.5	5.1
Females	1.9	2.5	3.2	5.8
Been diagnosed with an STD				
Males	n.a.	1.3	n.a.	2.4
Females	n.a.	0.8	n.a.	2.2
Been diagnosed with hepatitis				
<i>Males</i>				
Hepatitis A	n.a.	1.1	n.a.	0.8
Hepatitis B	n.a.	1.2	n.a.	0.6
Hepatitis C	n.a.	0.5	n.a.	0.3
Not sure which type	n.a.	0.9	n.a.	0.4
<i>Females</i>				
Hepatitis A	n.a.	0.1	n.a.	0.1
Hepatitis B	n.a.	0.5	n.a.	0.4
Hepatitis C	n.a.	0.3	n.a.	0.1
Not sure which type	n.a.	0.9	n.a.	0.9

Note: For sample sizes see Table 11.3; sample sizes may vary slightly due to exclusion of non-responses.

Source: Lindsay et al. 1997:50, 51; questions on STD and hepatitis not asked in 1992.

- Low proportions of students have had an HIV antibody test – around 5% of Year 12 students and 2% of Year 10 students. There were small increases in the proportions for Year 10 males and females and Year 12 females, but these were not statistically significant.
- In 1997, the students were asked if they had ever been diagnosed with an STD or with any of the various types of hepatitis. Very low proportions reported having a positive STD diagnosis – 2% of Year 12 students and 1% of Year 10 students. The most common diagnoses were thrush, genital warts and pubic lice (Lindsay et al. 1997:49).
- Even lower proportions of students had ever had a positive diagnosis for any of the forms of hepatitis – 1% or lower in most cases.

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