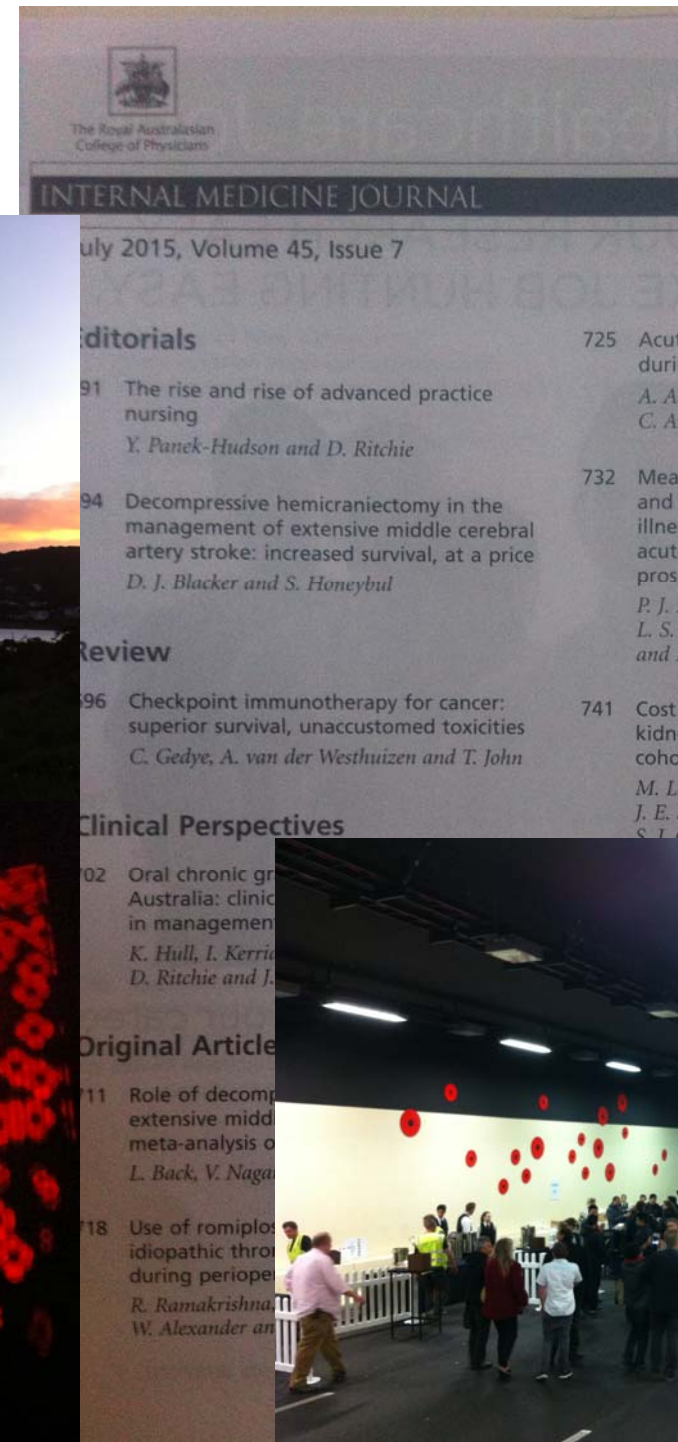
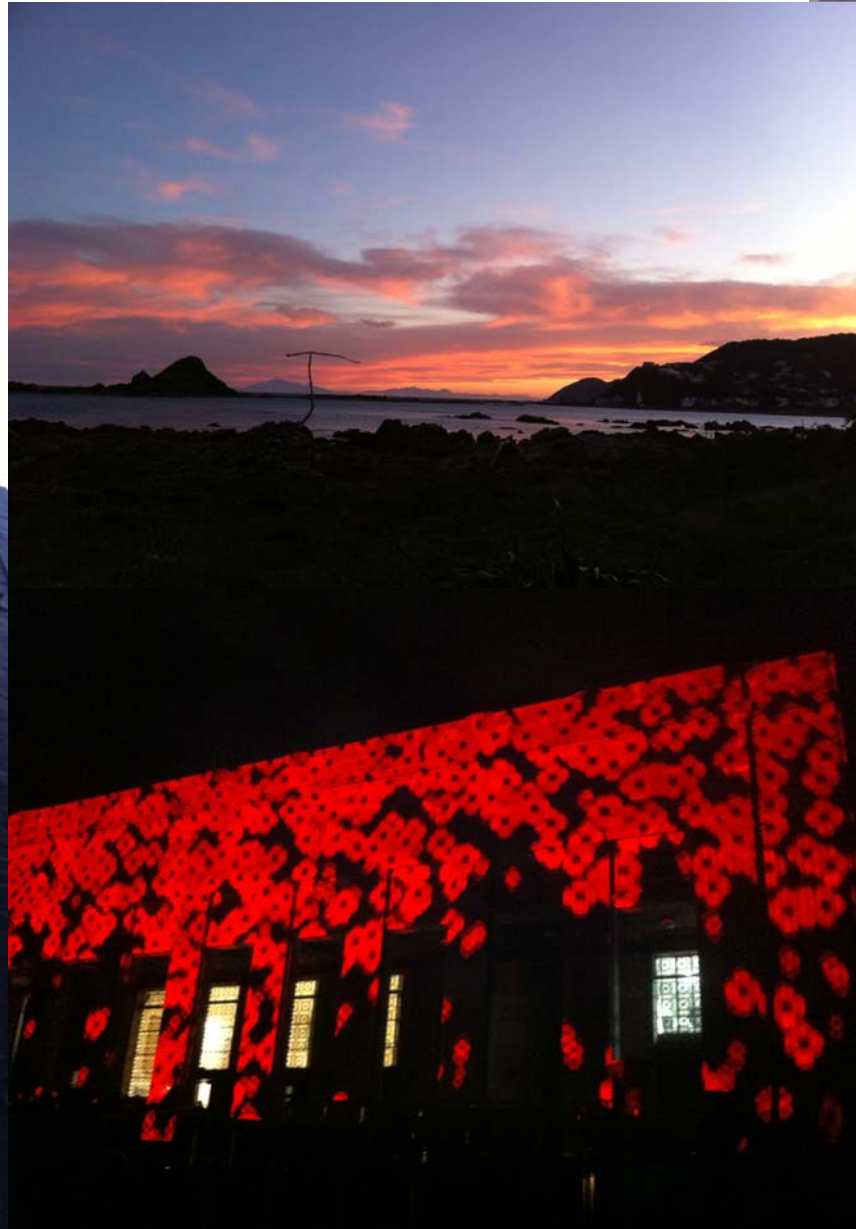
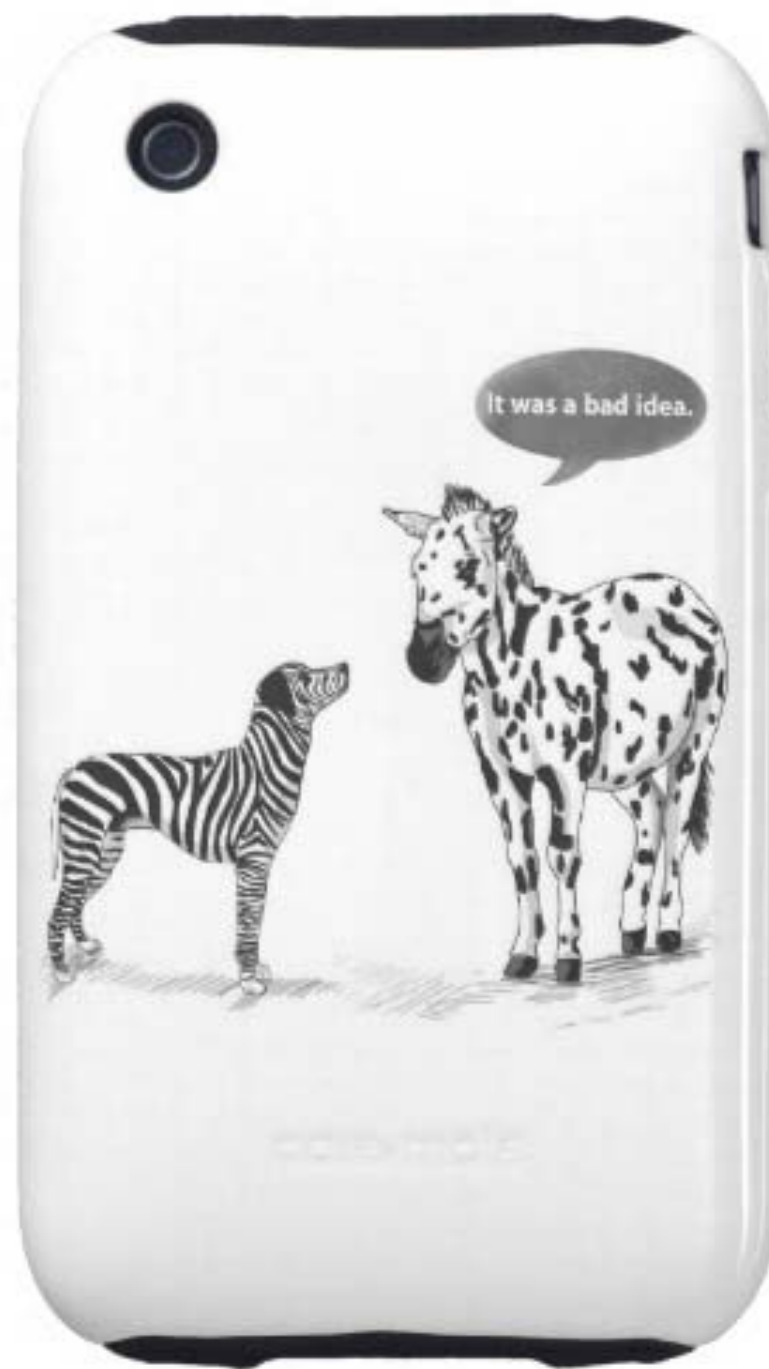


DR JENNY HAYWARD





Google



Introduction

The aim of this session is to provide an introduction for those not familiar with working in this area, and an update for those that are, to some areas of Sexual Health.

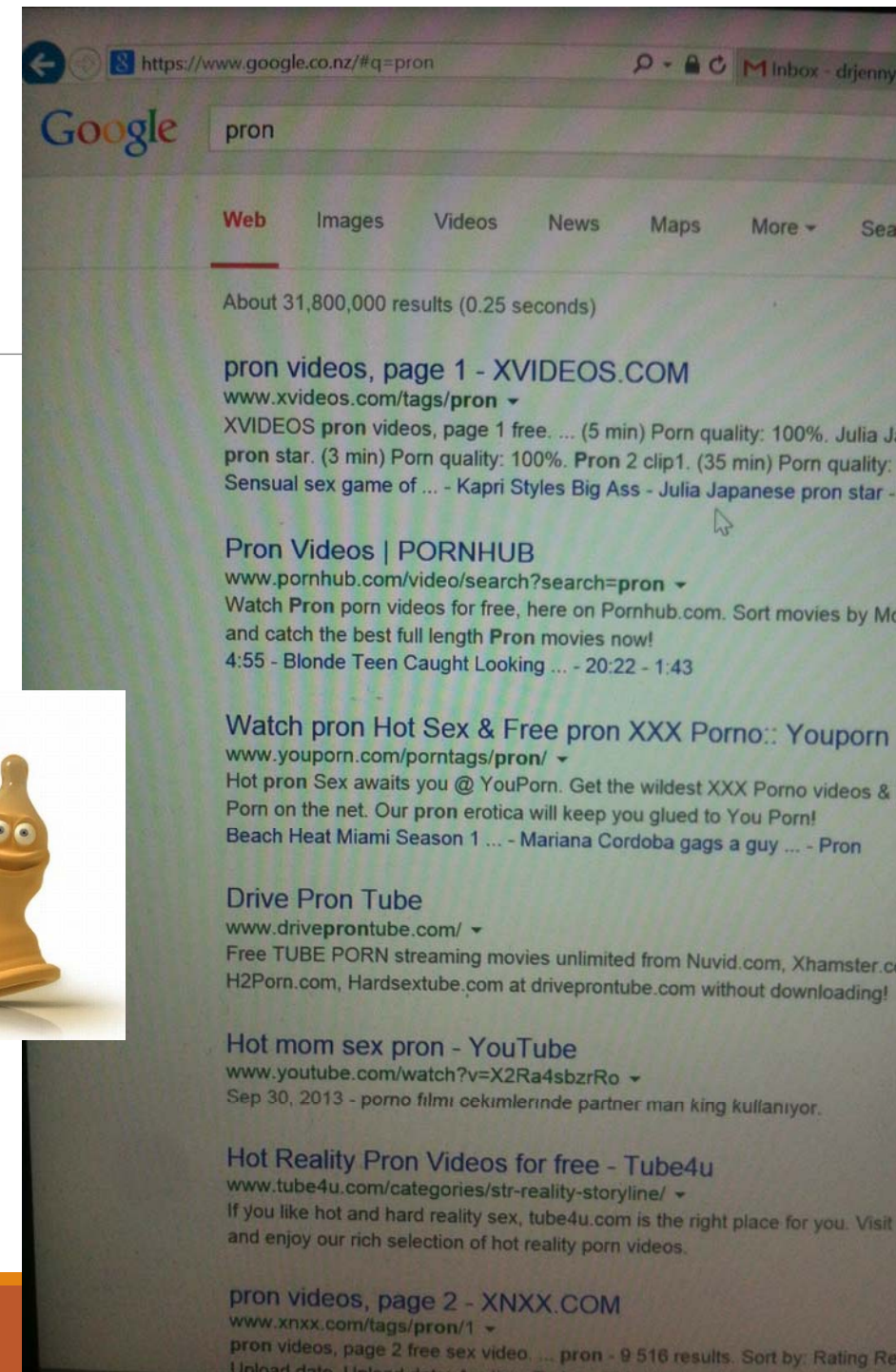
It will include guidance on where to find out more and some useful websites for example:

www.nzshs.org

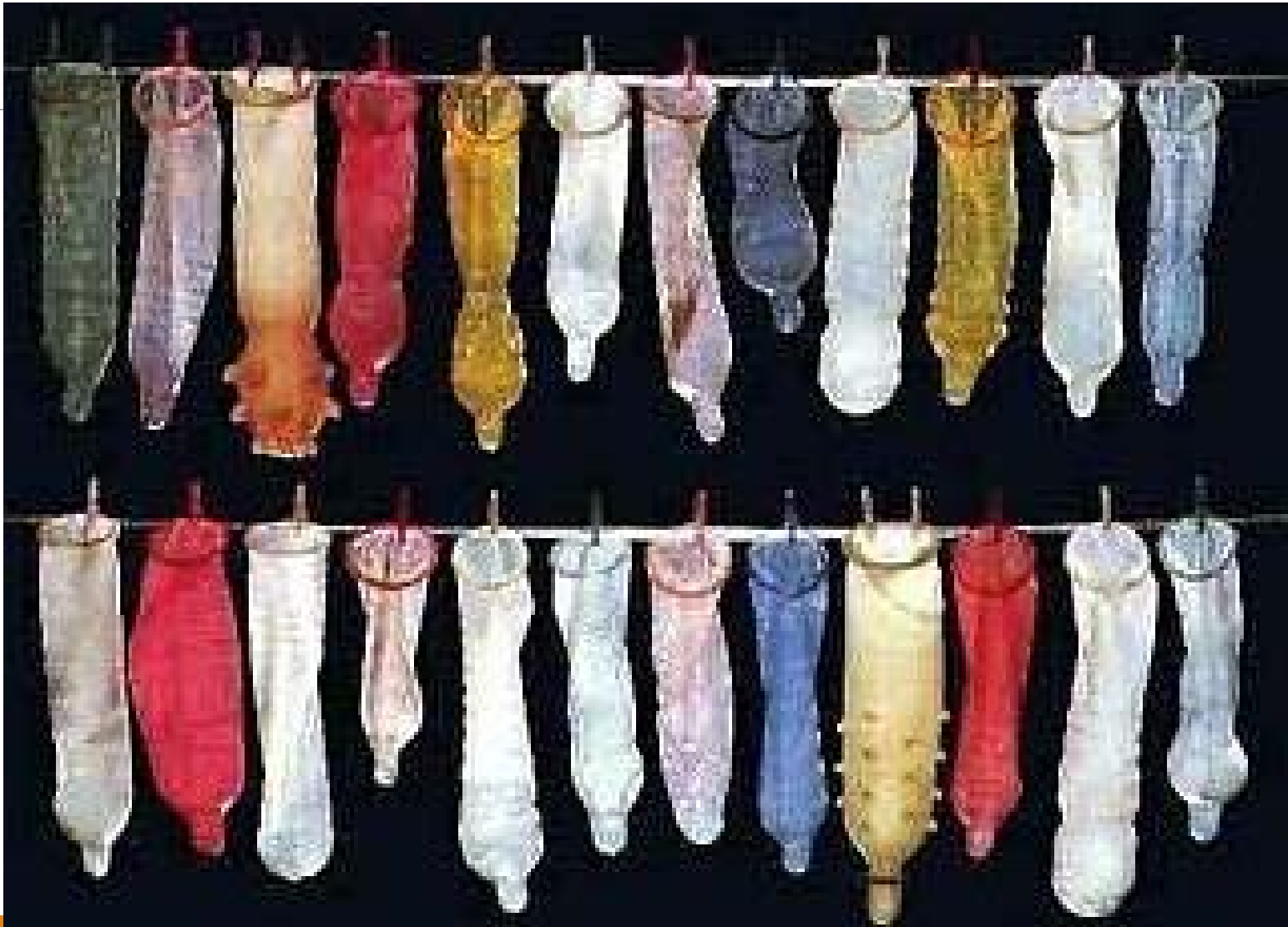
www.justthefacts.co.nz

www.familyplanning.org.nz

Look what is just one click away – even with typos..



What is Sexual Health?

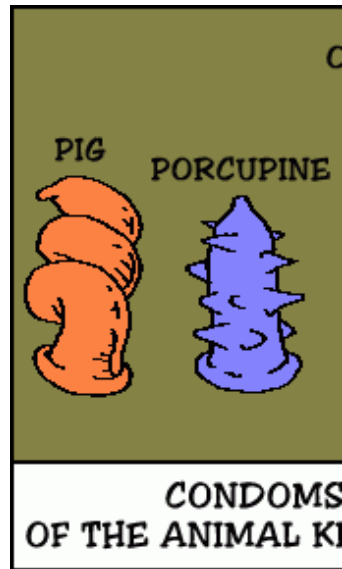


WHO's working definition of Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality. It is not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

To achieve sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.



What is Sexuality?





WHO's working definition of Sexuality

A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

While sexuality can include all of these dimensions, not all of them are always experienced or expressed.

Sexuality is influenced by the interaction of biological, psychological, social, economic, cultural, legal, historical, religious and spiritual factors.”

...fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled.”

the rights to equality and non-discrimination

the right to be free from torture or to cruel, inhumane or degrading treatment or punishment

the right to privacy

the rights to the highest attainable standard of health (including sexual health) and social security

the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage

the right to decide the number and spacing of one's children

the rights to information, as well as education

the rights to freedom of opinion and expression

the right to an effective remedy for violations of fundamental rights.



Statistics Chlamydia



Chlamydia was the **most commonly reported STI in 2013**, in both laboratory and clinic settings.

A national chlamydia rate (based on all DHBs) of 633 per 100 000 population was calculated from laboratory surveillance data.

Sixty-eight percent of cases reported through laboratory surveillance data in 2013 were aged between **15 and 24 years**.

There were 84 cases of chlamydia in infants.

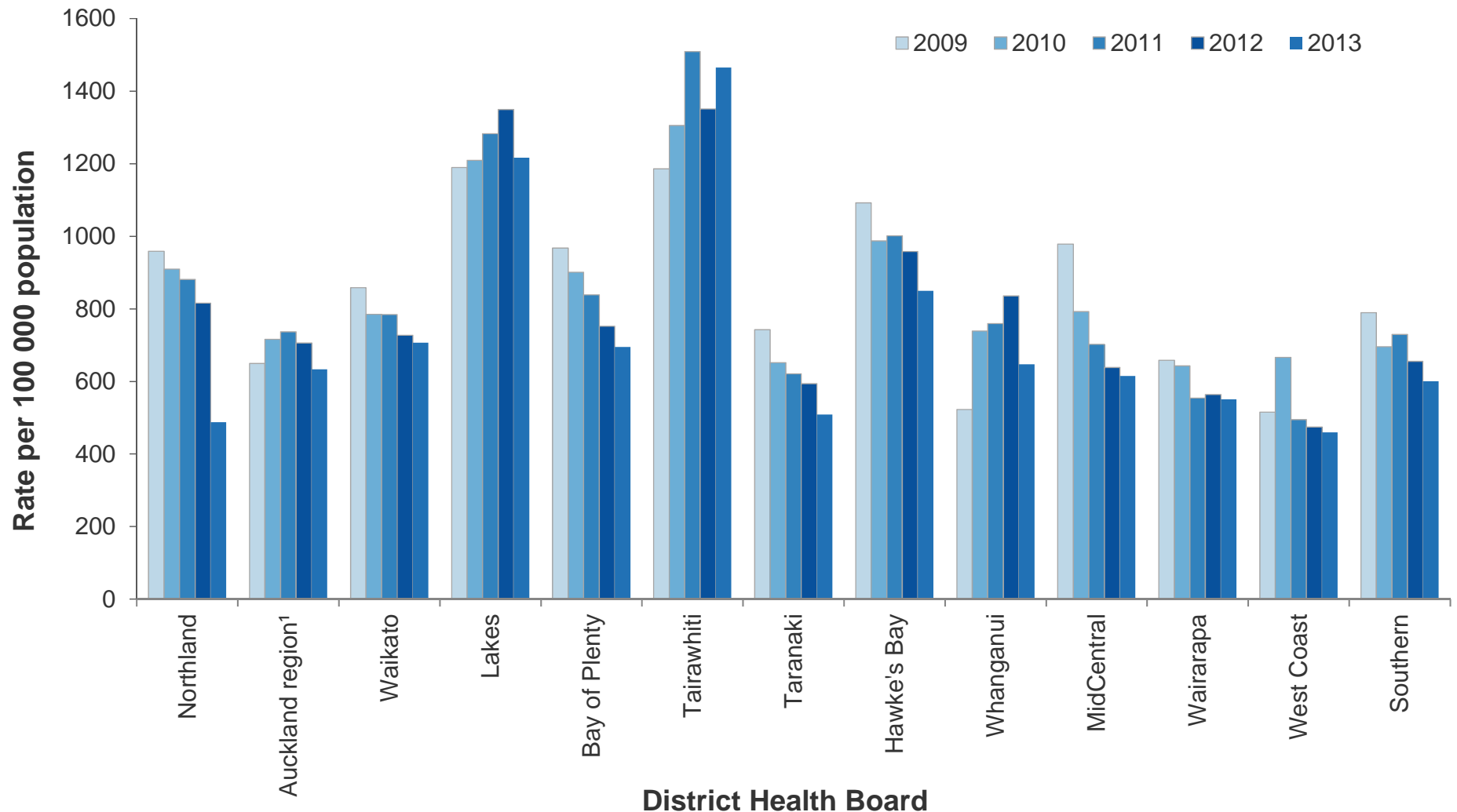
In data derived from SHCs, over 50% of cases were from non-European ethnic groups (Māori, Pacific Peoples and Other).

In data from laboratories, Tairāwhiti, Lakes and Hawke's Bay DHBs reported the highest chlamydia rates.

Laboratory surveillance data showed the estimated national rate of chlamydia (based on all DHBs where data was available) was stable between 2009 and 2011 but has decreased since 2012.



Chlamydia rates by DHB, 2009–2013



¹ Waitemata, Auckland and Counties Manukau DHBs

Note: New data processing methods introduced in 2013 allow for exclusion of repeat tests within a defined period

Source: Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2013, available from: www.surv.esr.cri.nz

Statistics Gonorrhoea



In 2013, a national gonorrhoea rate (based on 19 DHBs) of 78 per 100 000 population was estimated from laboratory surveillance data.

Over **50% of cases** reported by laboratories were aged between **15 and 24 years**

Two cases of gonorrhoea in infants were reported.

In SHCs, over 60% of cases were from non-European ethnic groups (Māori, Pacific Peoples and Other ethnic groups).

Of the 19 DHBs meeting the laboratory selection criteria for analysis in 2013, Tairāwhiti DHB reported the highest gonorrhoea rate, over five times the estimated national rate.

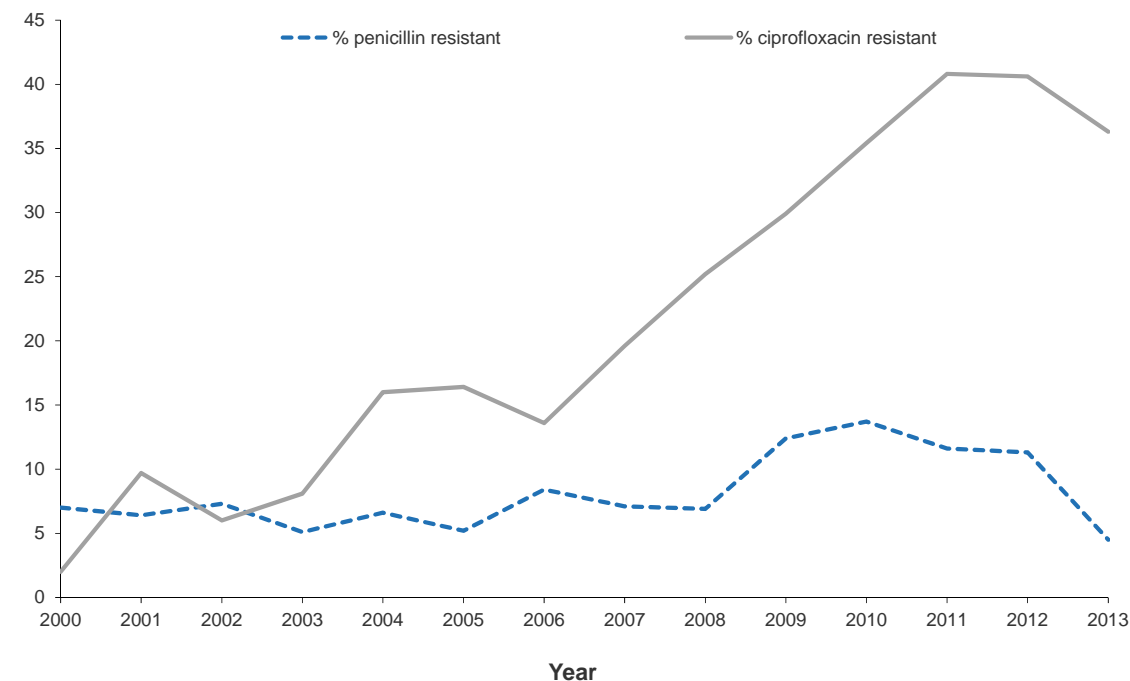
The introduction of testing via nucleic acid amplification tests (NAAT) for gonorrhoea since 2011 may have impacted on gonorrhoea case numbers.

[Zealand Guideline for the Management of Gonorrhoea, 2014, and Response to the Threat of Antimicrobial Resistance](#)

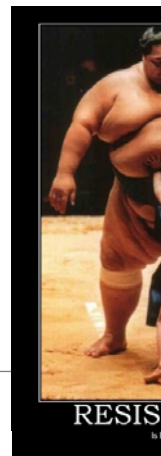
<http://www.nzshs.org/guidelines>

spread antibiotic resistance in NZ to penicillin, tetracyclines and ciprofloxacin
recommended treatment **Ceftriaxone 500mg imi PLUS azithromycin 1g stat**

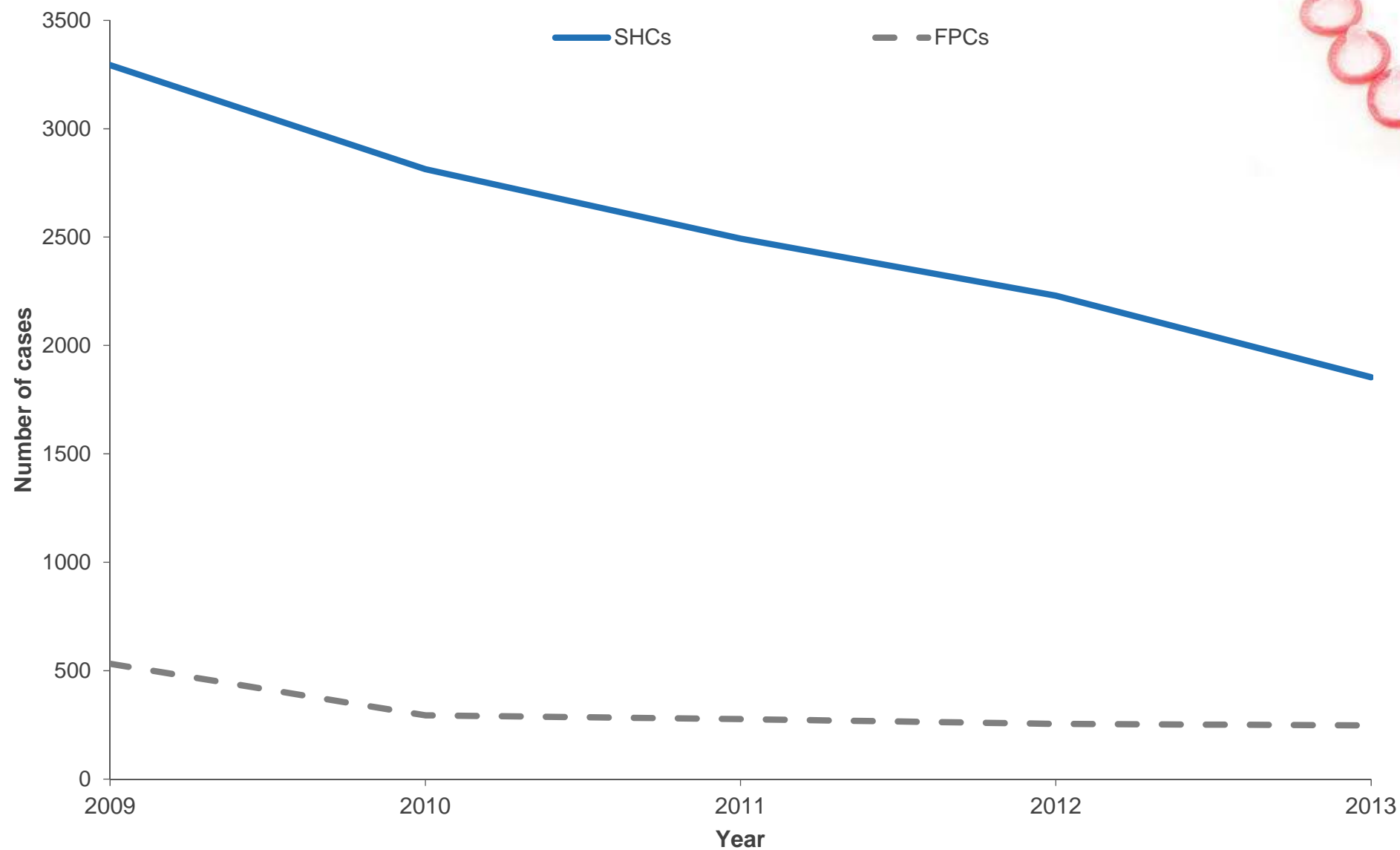
Prevalance of penicillin and ciprofloxacin resistance among *N. gonorrhoeae* isolates, 2000–2013



www.inhousepharmacy.biz



Genital warts (first presentation) cases by clinic types, 2009–2013



Source: Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2013, available from www.surv.esr.cri.nz

Statistics Syphilis



ESR 2013

The number of cases of syphilis reported by SHCs remained stable between 2012 and 2013 (80 cases).

Three cases were reported by FPCs.

The SHC cases were predominantly male (92.5%) and occurred most commonly in the 40 years and over age group.

Sixty percent of the cases were from the European ethnic group, 20.5% from the Other ethnic group, 11.0% from the Pacific Peoples ethnic group and 8.2% from the Māori ethnic group.

Syphilis cases were predominantly reported from clinics in the Auckland region and Canterbury DHB.

Health alert: Syphilis, gonorrhoea and HIV on the rise in Auckland

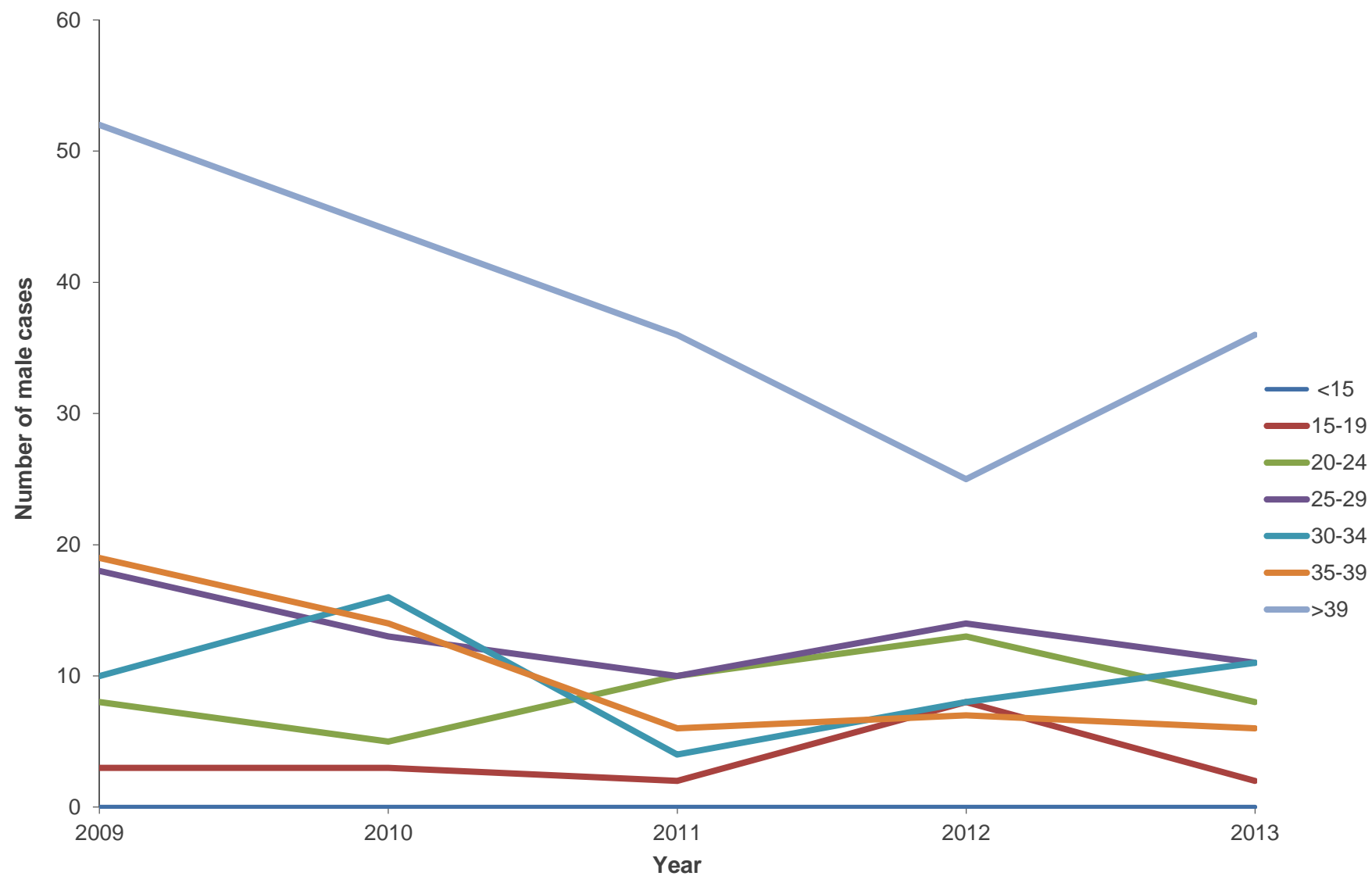
NZAF 25 June, 2015

An increase in cases of syphilis, gonorrhoea and HIV is being reported among gay and bisexual men in the Auckland region. Gay and bisexual men are encouraged to use condoms and lube for anal sex and to get tested.

The increase of rectal gonorrhoea infections indicates that the rising infections are most likely a result of anal sex without condoms which carries the highest risk of HIV and STI transmission.

Average monthly syphilis cases have increased 120% over the last 18 months and average monthly gonorrhoea cases by 170% in the last six months. In addition, recent data from University of Otago shows that HIV is on the rise among gay and bisexual men across New Zealand.

Number of infectious syphilis cases in SHCs in males by age group, 2009–2013



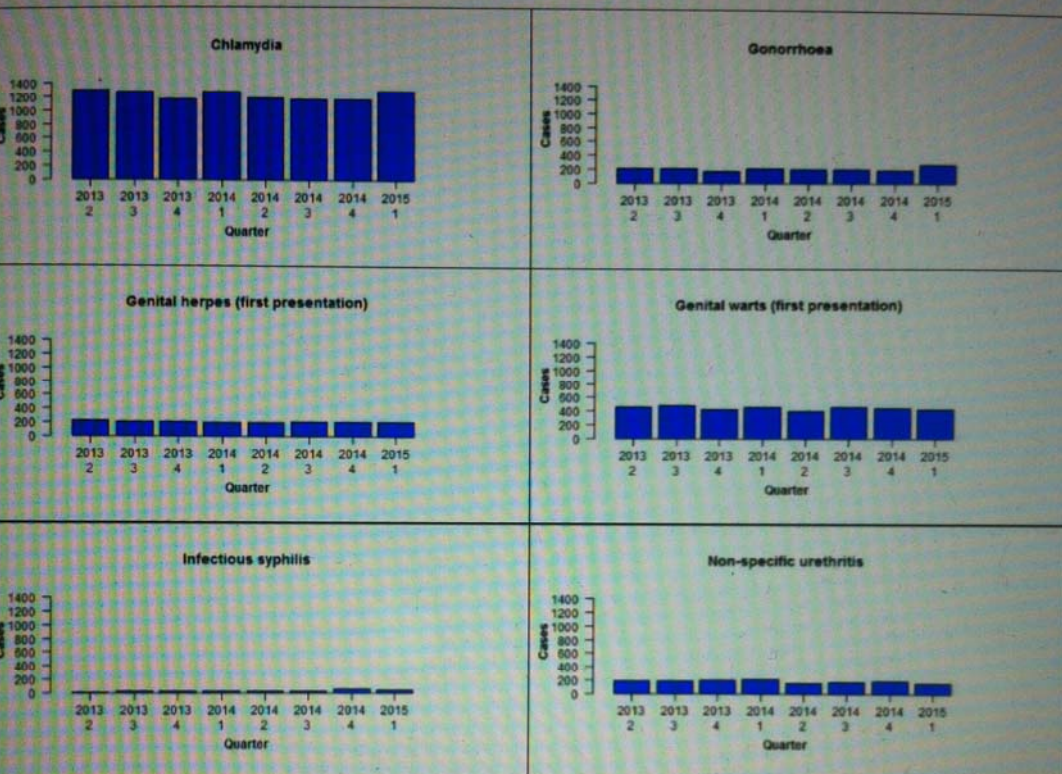
Source: Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2013, available from www.surv.esr.cri.nz



NEW ZEALAND

Sexual health clinic (SHC) surveillance of STIs: January-March 2015

Quarterly case counts in participating SHCs by disease, April 2013 to March 2015



No cases of chancroid, granuloma inguinale or lymphogranuloma venereum were reported during the last quarter

Note: Data was not received from the Ashburton SHC for January 2014. This clinic sees only a small number of STI cases each month.

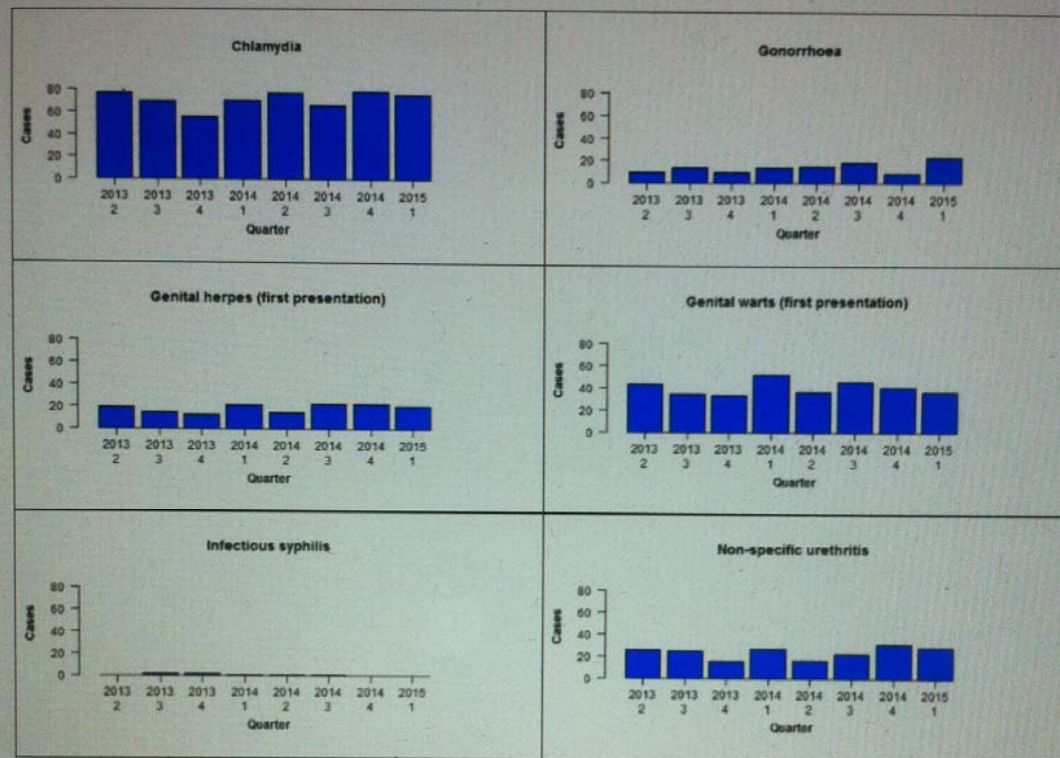
Quarterly case counts in participating SHCs by disease, April 2013 to March 2015

	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015
Chlamydia	1292	1276	1163	1273	1190	1174	1164	1281
Gonorrhoea	224	211	170	214	196	201	183	272
Genital herpes (first presentation)	228	212	212	204	200	214	214	213
Genital warts (first presentation)	463	488	432	456	411	469	441	434
Infectious syphilis	14	27	23	31	29	30	53	39
Non-specific urethritis	186	182	202	210	158	172	194	163

CAPITAL AND COAST DHB

Sexual health clinic (SHC) surveillance of STIs: January-March 2015

Quarterly case counts in participating SHCs by disease, April 2013 to March 2015

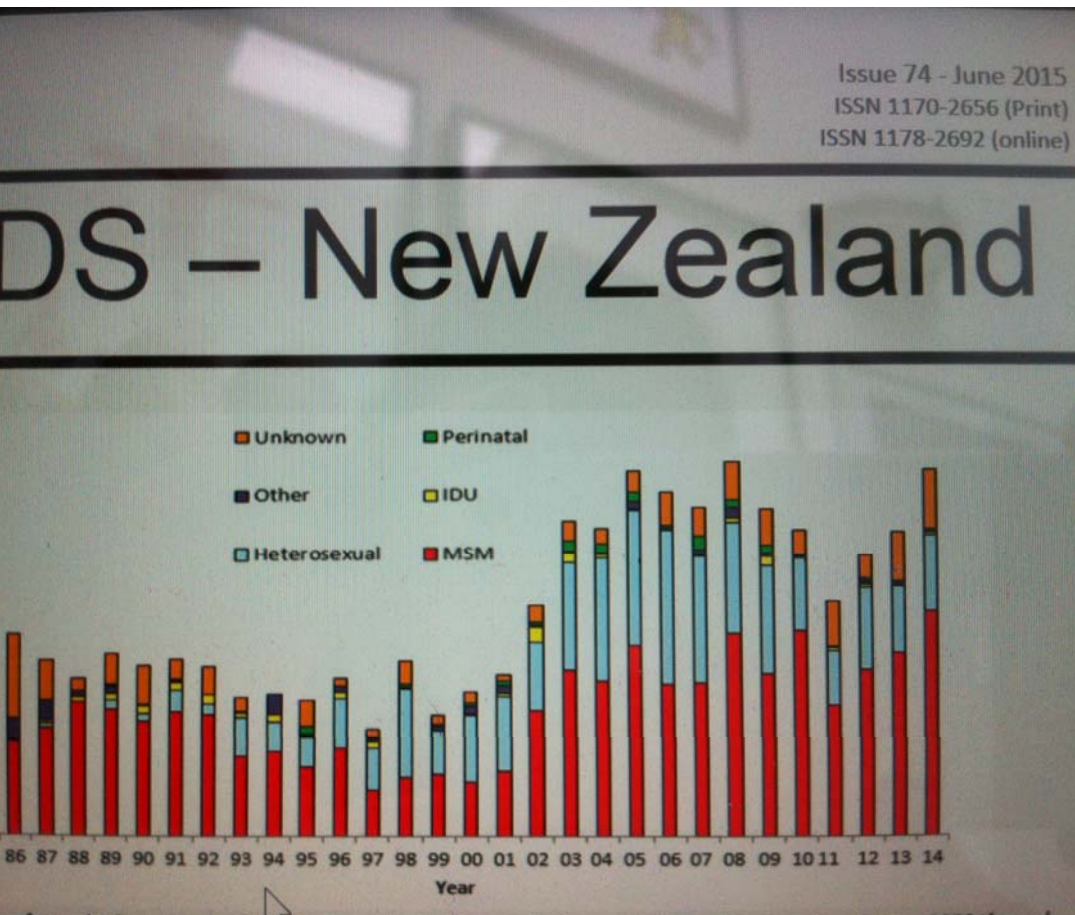


No cases of chancroid, granuloma inguinale or lymphogranuloma venereum were reported during the last quarter

Quarterly case counts in participating SHCs by disease, April 2013 to March 2015

	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015
Chlamydia	77	70	56	71	77	66	78	76
Gonorrhoea	10	14	10	14	15	18	9	23
Genital herpes (first presentation)	19	15	13	22	15	23	23	21
Genital warts (first presentation)	44	35	34	52	37	46	41	37
Infectious syphilis	0	2	2	1	1	1	0	0
Non-specific urethritis	26	25	16	27	17	23	31	16

2014 HIV stats



217 first known to be infected in NZ

136 MSM (114 in 2013)

45 heterosexual

2 by IDU

1 pregnant women diagnosed (6 2011-2014)

2013 180 people dx

NUMBER DIAGNOSED NOT SAME AS NUMBER INFECTED ?true rise, ? more testing

1998-2014, 128 births women known HIV infected prior to delivery in New Zealand, none infected

ESTIMATE total number of people in New Zealand approximately 2900, prevalence of around 64 per 100,000 total population.

Sexual Health Consultation

Primum non nocere - First do no harm

ng tests not aware taking and so then having to inform people of positive results (or going on leave and leaving colleagues)

ical Smears – people may assume that have had a smear whenever have a speculum – tell people what testing what NOT testing

ning how give results – check have correct contact details, see in person

onse to what told:

closure sexual abuse

ivities

mbers of partners

x work

nder diversity

e tests when not indicated - False positive tests





Sexual Health Consultation

<http://www.nzshs.org/guidelines>

Why here?
What went
Where
With whom
Who else
When (contact tracing)
What test
With what



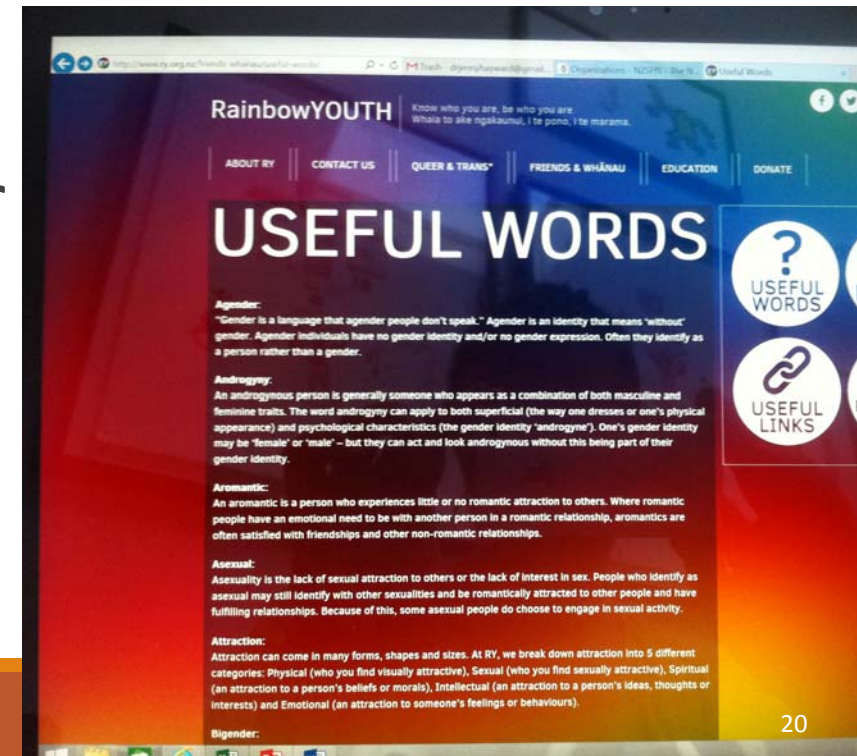
PERSONAL / PUBLIC HEALTH





Barriers to a good sexual history

- Embarrassment
 - Patient
 - Practitioner
- Feeling judged – give wide range options
- Confidentiality issues
- Reasons for questions not made clear
- Language not understood
 - Patient
 - Practitioner



Exercise



Examination

People who have a vulva and vagina

<http://www.nzshs.org/guidelines>

If symptomatic (vaginal discharge, abnormal bleeding, pelvic pain) or if a contact of gonorrhoea a speculum examination is required for proper clinical assessment:

Take a vulvovaginal swab for chlamydia and gonorrhoea testing by NAAT* (e.g. PCR or SDA) prior to speculum insertion

An endocervical swab for gonorrhoea culture

A high vaginal culture swab for bacterial vaginosis, candida, and trichomoniasis.

If asymptomatic, or declines a genital examination

A self-collected vulvovaginal swab for chlamydia and gonorrhoea testing by NAAT* should be taken

Instruct the person to remove the swab from the container, wipe the swab around the vaginal entrance, then insert the swab 4cm (thumb's length) into her vagina, count slowly to 5 and replace in the swab container.

Rectal swab as appropriate

Serology as appropriate for hepatitis A,B,C, syphilis, and HIV.

How to take your Vaginal Swab

Wash and dry your hands first.

The pack contains a swab stick and a plastic container.

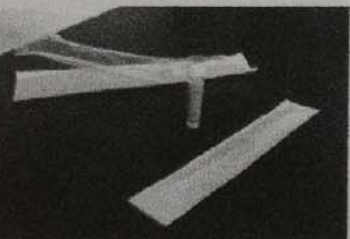
Do not place the swab stick directly on any surface.

Do not touch the cotton wool tip of the swab.

Get a new kit if you drop the swab or touch the tip or spill any of the liquid in the container.

2. Getting ready:

Peel open the pack. Take out the container, carefully unscrew the top and place it on a flat surface.



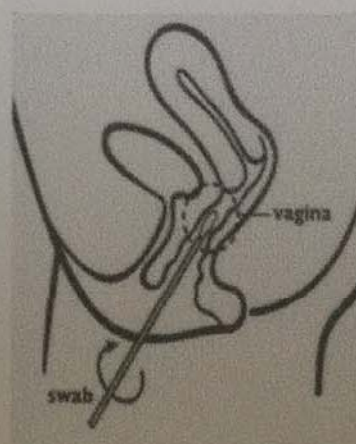
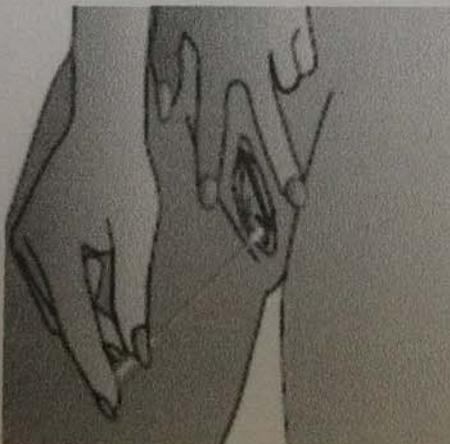
How to hold the swab:

Take the swab stick out of its packet and hold the plastic shaft in the middle.



3. Taking the sample:

- With your legs apart, spread the opening of your vagina.
- Rub the cotton bud around the upper part of the entrance to the vagina (where the red arrow is) a couple of times.
- Then insert it 1-2 inches into your vagina. Your fingers on the middle of the shaft will stop you going in too far.
- Rotate the swab around your vagina, making sure it touches the inside wall of your vagina for 5 seconds (count to 5 slowly).
- Carefully pull the swab out.



Leeds Centre for
Sexual Health

4. To finish off:

Put the swab in the container. Make sure you do not spill any of the liquid.



Snap the stick off at the black line.



Screw the lid back on tightly.



Reproduced with permission from Leeds Teaching Hospitals NHS Trust, Leeds, U.K.

Examination people who have a penis

<http://www.nzshs.org/guidelines>

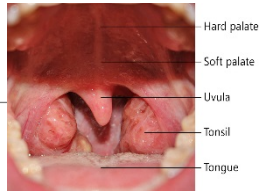
A routine check should ideally be performed when the patient has not passed urine for at least 1 hour and consists of:

- Physical examination of the genital and perianal skin, inguinal lymph nodes, penis, scrotum, and testes
- If symptomatic (urethral discharge or dysuria) or a contact of gonorrhoea:
 - Take a urethral swab for gonorrhoea culture, using the smallest possible bacterial culture swab (per-nasal swab inserted approximately 1cm into the urethral canal) followed by
 - A first void urine (first 30ml stream) for chlamydia and gonorrhoea testing by NAAT*
- If asymptomatic:
 - A first void urine for chlamydia and gonorrhoea testing by NAAT *. Note: Early morning urine not required.
- Serology as appropriate for hepatitis A,B,C, syphilis, and HIV.

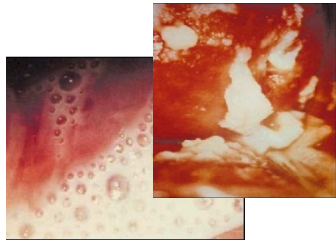
Anorectal swab as appropriate

Testing

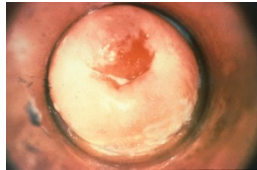
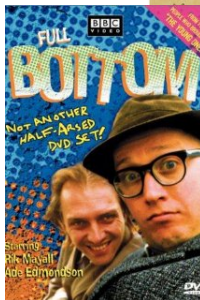
Pharynx



Vagina



Blood

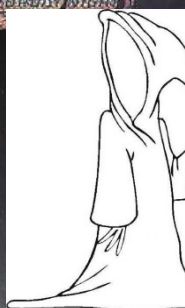
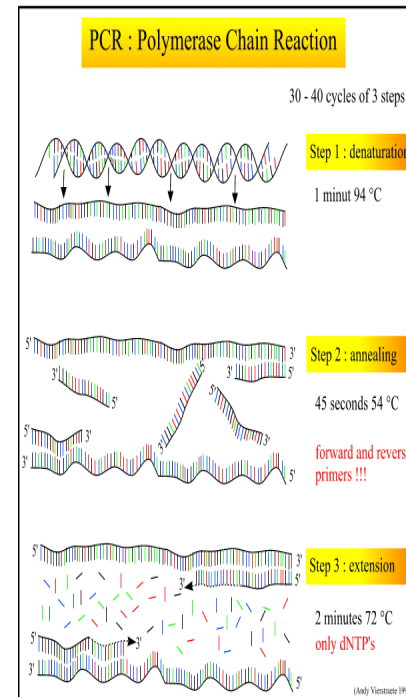


Cervix

Rectal

Other

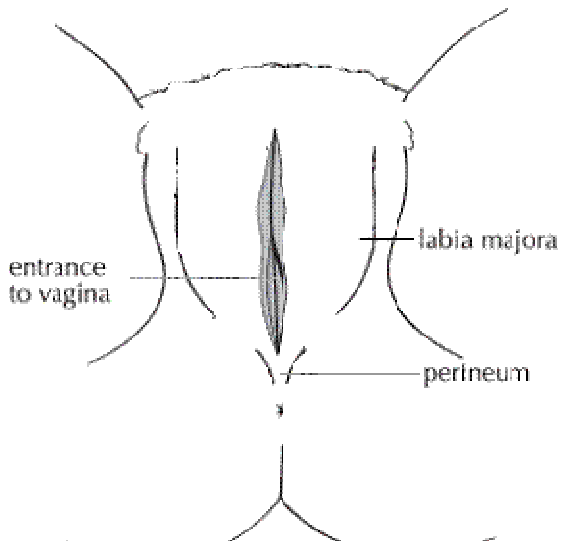
Molecular and Culture



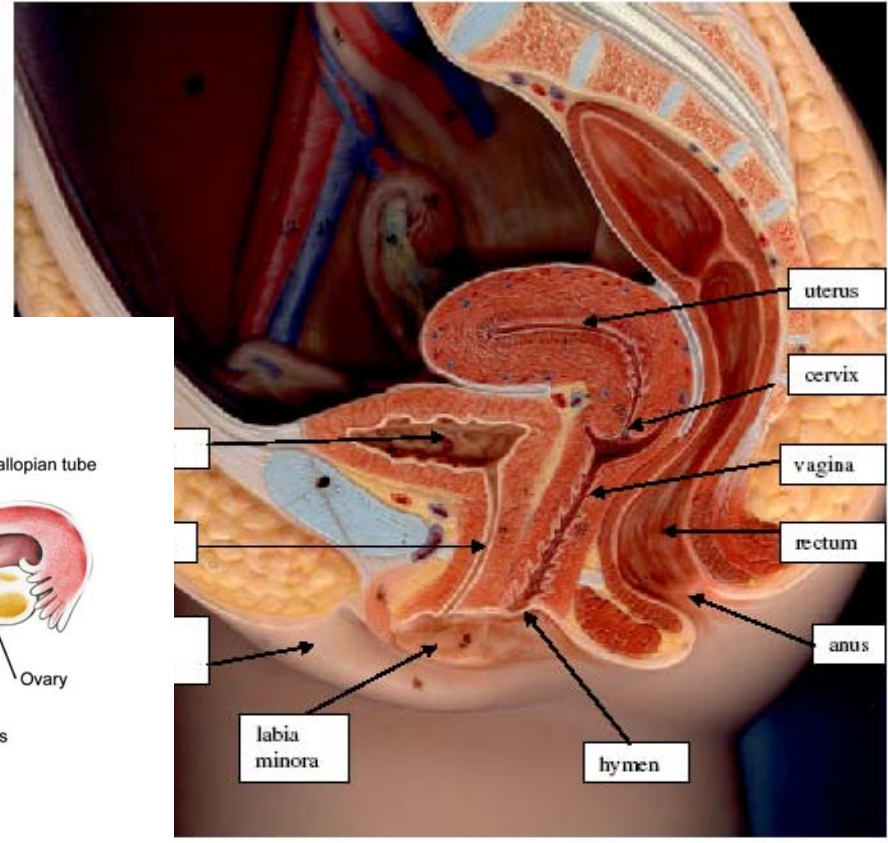
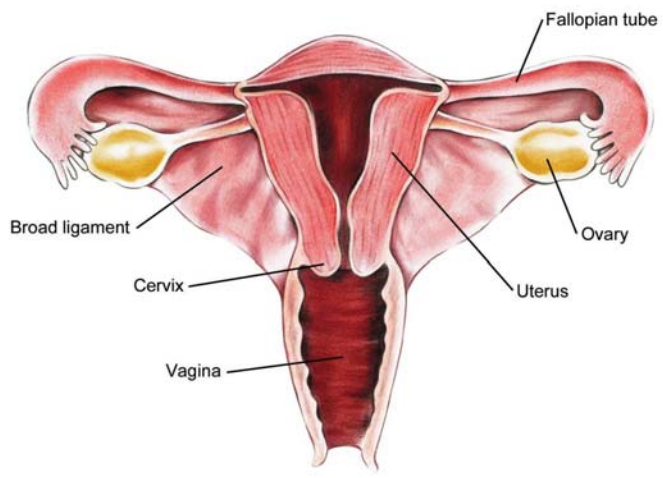
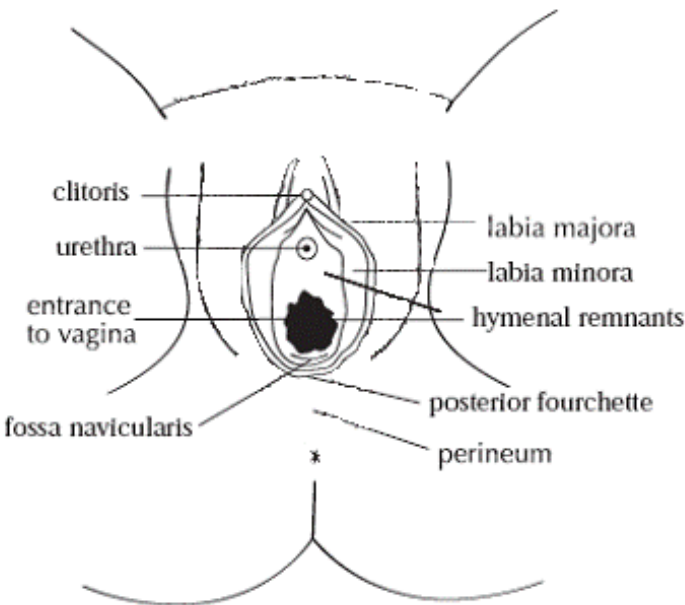
Consent

Remember to ask before examine

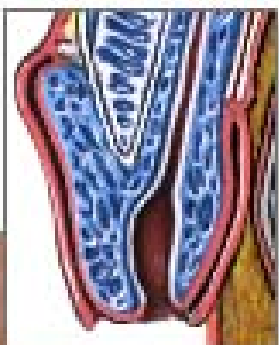




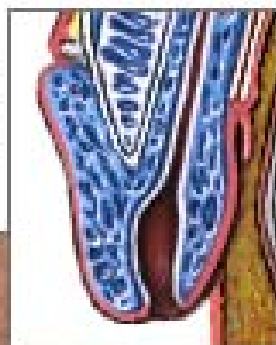
t / Sexually active external genitalia



Circumcised penis



Circumcised penis



Shaft of penis

um

Foreskin

Testicles

Foreskin

Glans

Rim of glans

Urethral meatus



Urinary bladder

Vas deferens

Pubic bone

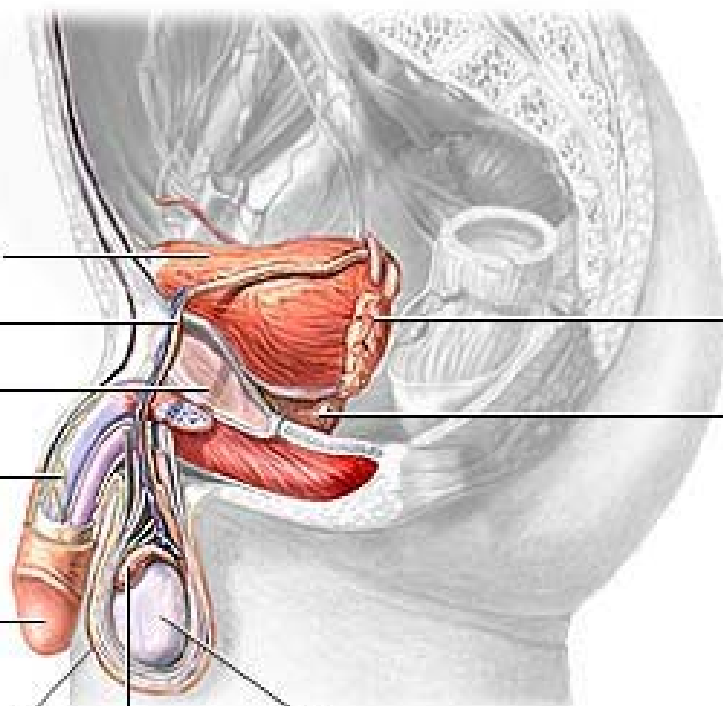
Penis

Glans penis

Scrotum

Epididymis

Testicle





Normal anatomical variants





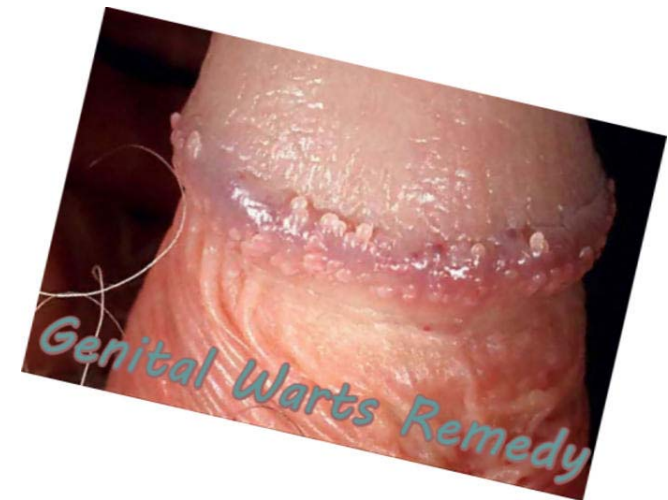
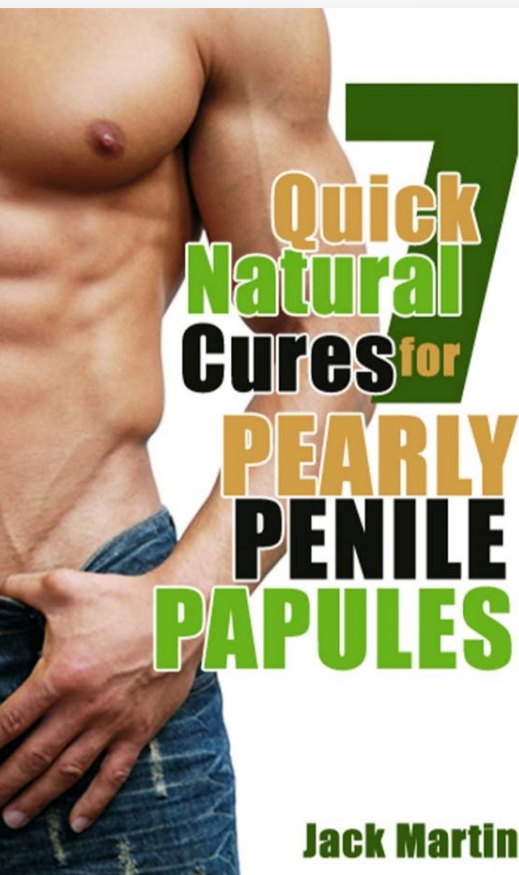
PEARLY PENILE

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Jack Martin



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Struggle to REMOVE your PEARLY PENILE PAPULES?

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WARNING



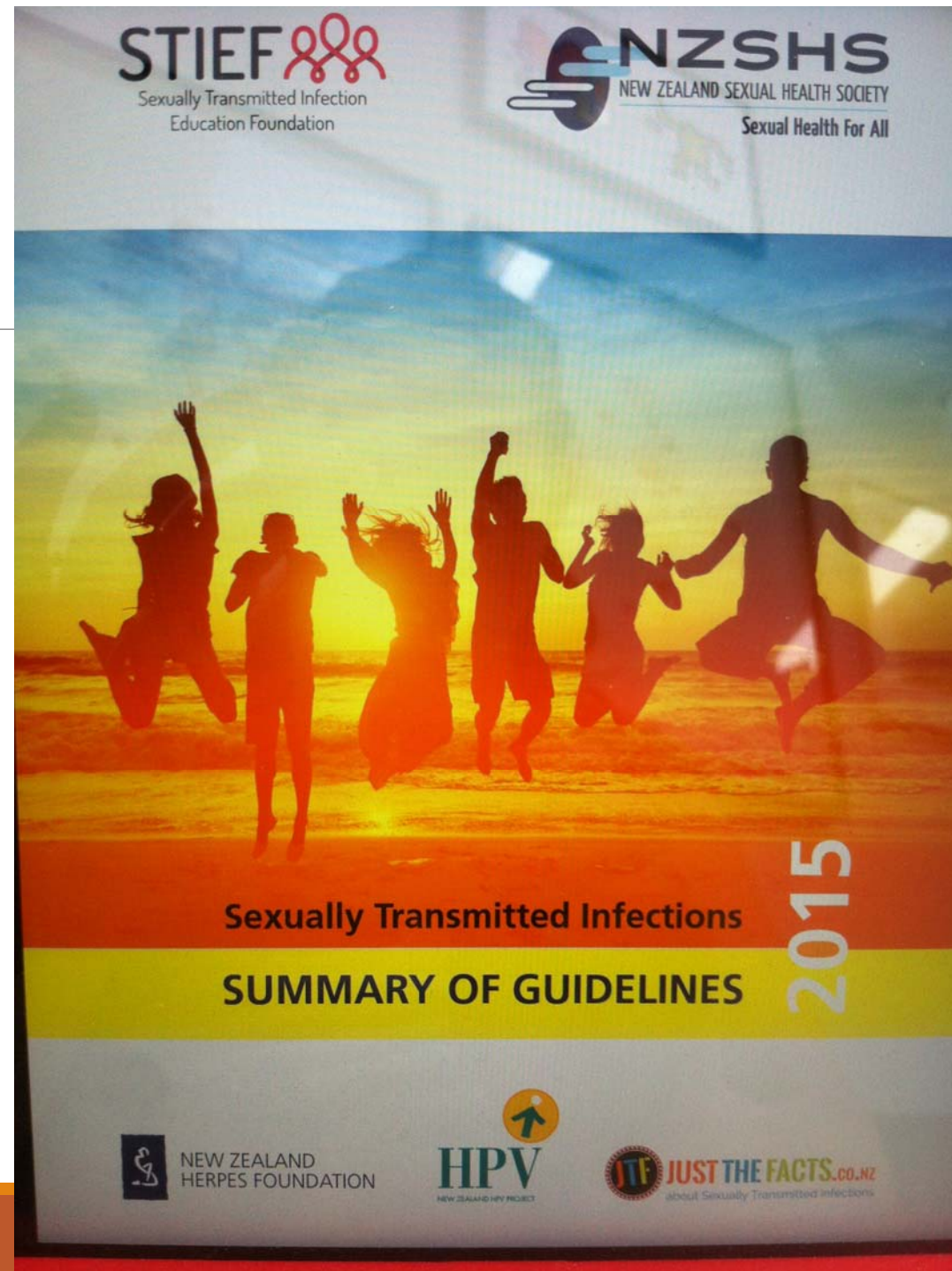
STIs

www.nzshs.org

www.dermnetnz.org

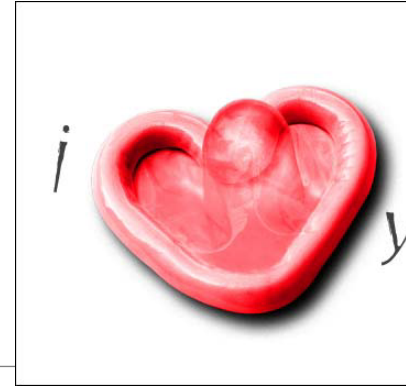
www.hpv.org.nz

www.herpes.org.nz




GARDA
Human Papillomavirus
Types 6, 11, 16,





HSV - what's still important

People with genital herpes require enough information and medication (when indicated) to self-manage their condition.

Treatment of first episode genital herpes

Oral aciclovir 400mg 3 times daily (8 hourly) for 7 days.

Treatment of recurrent genital herpes

Periodic treatment

Oral aciclovir 800mg (2 x 400mg) 3 times daily for 2 days. Prescribe 48 x 400mg tablets for patients to be able to self-initiate treatment at onset of symptoms.

Suppressive therapy

Oral aciclovir 400mg twice daily.

Valaciclovir (Valtrex™) 500mg daily is listed for suppressive treatment of recurrent genital herpes, subject to a Special Authority restriction, in the pharmaceutical schedule. – Initial application: From any practitioner. Approvals valid for 12 months where the patient has genital herpes with two or more breakthrough episodes in any 6 month period while treated with aciclovir 400mg twice daily. – Renewal: From any practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment



New Zealand Herpes Foundation

Tollfree 0508 11 12 13

www.herples.org.nz

Summary of Guidelines 2015 at www.nzshs.org/guidelines.html

Key Information to provide patients on diagnosis – available on www.herples.org.nz - 3 minute PowerPoint tool home page

- Up to one in three people have genital herpes, but only 20% of them experience symptoms. (This includes genital herpes caused by both HSV-1 and HSV-2.)
- Most people (80%) who become infected with genital herpes will not have any symptoms, or have such mild symptoms that they will not be recognised or diagnosed as genital herpes. 75% of herpes is acquired from partners unaware they have it.
- For most people who experience symptoms, genital herpes is a sometimes-recurring 'cold sore' on the genitals. It does not affect your overall health or longevity of life.
- A small percentage of people who get genital herpes may experience problematic recurrences. If this happens there is effective treatment available.
- People who experience a first episode of genital herpes will get better, lesions will heal and there will be no evidence of the initial lesions left.
- Most people who experience a first episode of HSV-2 will have recurrences, but they are generally milder than the first episode. HSV-1 tends to cause fewer recurrences than HSV-2.
- Getting genital herpes in a long-term relationship does not mean that the other partner has been unfaithful. However, a full sexual health screen may be reassuring.
- Where both partners in a long-term relationship have the virus, use of condoms is not necessary as they cannot reinfect each other. However, it is advisable to avoid skin-to-skin contact when lesions are present, as friction may prolong the healing.
- Oral to genital transmission of HSV-1 is very common through oral sex. This can happen when 'cold sores' are not causing symptoms.
- Genital herpes does not affect your fertility or stop you having children. Vaginal delivery is usual for most women with a history of genital herpes.
- Genital herpes does not stop you having sex.
- Anybody with genital herpes, whether they get symptoms or have never had symptoms, may shed the virus from time to time with no symptoms present.
- There is no evidence that genital herpes causes cancer of the cervix.
- Condoms reduce the risk of transmission. The use of condoms in a long-term relationship should be a matter of discussion between the individuals. It is advisable to avoid genital-to-genital contact, even with a condom, until any lesions are completely healed.
- Even if the virus is passed on, the most likely outcome is that the person will never experience symptoms.
- Ensure patients have access to the NZHF patient pamphlets and/or **TOLL FREE 0508 11 12 13** or visit www.herples.org.nz



V - What's new – changes since the 2013 Guideline

Quimod 2% Special Authority is no longer required from February 1, 2015.

Anal cancer The incidence of anal cancer is increasing and the burden of disease is highest in men who have sex with men (MSM) and HIV-positive MSM.

Oropharyngeal cancer The incidence of HPV-related oropharyngeal cancers is increasing in the general population and particularly in men.

9-valent vaccine A 9-valent vaccine (Merck) received FDA approval in the US in December 2014. This provides protection against five additional hrHPV Types. The 9-valent vaccine is expected to be registered and available in NZ. The timeline for this will be clarified once the registration process commences later this year.

New patient information leaflets Two new patient information leaflets are available from the HPV website – HPV and Throat Cancer (www.hpv.org.nz/patient-information/hpv-and-throat-cancer) and HPV and Men (www.hpv.org.nz/patient-information/hpv-and-men).

Two-dose vaccine The WHO states that vaccination can be given in two doses, 6 months apart, to girls aged 9–13 years, as an alternative to the three-dose schedule. The three-dose schedule is required for girls older than 13 years. The current New Zealand immunisation schedule is for three doses.



The New Zealand HPV Project

11 12 1

www.hpv.org.nz

Key Information for Patients

While it is helpful to normalise a diagnosis of a viral STI, it is important not to unintentionally be dismissive of the potential for psychological morbidity. The way to do this is to proactively provide information and education and address key concerns. The following information may be helpful:

- HPV is a very common sexually transmitted infection that can infect the genital areas of men and women. It can also infect the mouth and throat. Most sexually active people get HPV at some time in their lives, although most never know it.
- Most persons who acquire HPV do not develop health problems from it. In most cases, the body's natural defences control HPV before it can cause any health problems.
- When the body does not control HPV infection, genital warts can develop.
- Genital warts can develop months or years after getting HPV. Genital warts can be passed on to another person even when there are no visible signs of warts.

HPV and cancer

- HPV can also cause cervical cancer and other cancers, including cancers of the anus, penis, vulva, vagina, and head and neck. Most HPV clears and does not lead to cancer.
- The types of HPV that cause genital warts are different from the types that can cause cancer.
- There is no evidence that cancer (rather than HPV) can be transmitted to a partner through sexual activity.

Treatment

- There are treatments for the conditions caused by HPV, but not for the virus itself.
- Women with genital warts do not need cervical smears more often than other women.
- Routine STI screening does not include testing for either HPV or HSV. There is no sure way to know when HPV was acquired or from whom.

HPV and partners

- Partners who have been together tend to share HPV. Having HPV does not mean that a person or his/her partner is having sex outside the relationship.
- There is no need to alter sexual activity with a stable partner, as sharing of HPV would have occurred long before the abnormal smear result or clinical appearance of the lesion.
- There is no reliable HPV test to check HPV status. This means there is no test that can help answer the questions "Do I have HPV?", "Does my partner have HPV?", "Has my HPV gone?", "Can I have the vaccine?".
- It is not clear if there is any health benefit to informing (future) partners about a past diagnosis of genital warts. This is because it is not known how long the virus remains after warts are gone.
- HPV does not affect fertility.
- People with HPV can have normal sex.

Prevention

- Condoms have some use in the reduction of transmission of genital HPV.
- HPV vaccine (Gardasil) immunises against four types of genital HPV: Types 16 and 18 which cause 70% of cervical cancers and types 6 and 11 which cause 90% of genital warts.
- Cervical cancer can be prevented by HPV vaccination and having regular smears.

For more information about cervical screening and HPV testing please go to the New Zealand Cervical Screening Programme, www.nsu.govt.nz/files/NCSP/HPV_and HPV_testing_fact_sheet_for_women.pdf.

Partner Notification

<http://www.nzshs.org/guidelines>

Patient delivered partner therapy (PDPT)

Patient-delivered partner therapy, also known as expedited partner therapy, is the process whereby the patient delivers antibiotics to their sexual contacts without the contact attending a consultation with a health professional.

This practice is not legal under current New Zealand prescribing law (Section 39 of the Medicines Regulations 1984).

There is no strong evidence that this practice improves outcomes over standard patient referral.



Sexual Assault

Know who is there to help and how to contact



- Paeds/adolescents/adults
- Acute or historic

Have resources to hand and think in practice how would deal with presentation

- Specialist support agencies
- Counselling
- Medical
- Police
- CYF
- ACC

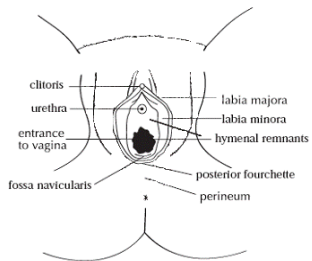
Self care

www.rpe.org.nz

www.dsac.org.nz

ACC Sensitive Claims Helpline 0800 735 566





Documentation

Document history need to guide examination

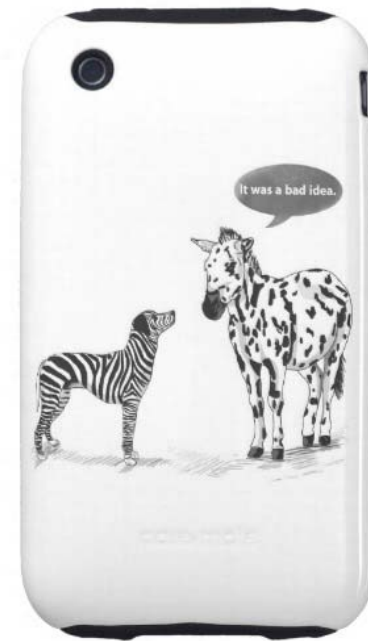
‘alleged events’

Note who told you what

Any limitations examination

Describe what you see – **some terms indication mechanism of injury**

Use diagrams



Normal to be normal - Absence of genital injury does not mean it did not happen.

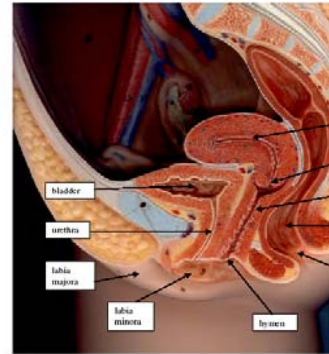
- 1/3 cases injury
- higher in anal, multiple assailants and post-menopausal

NO injury:

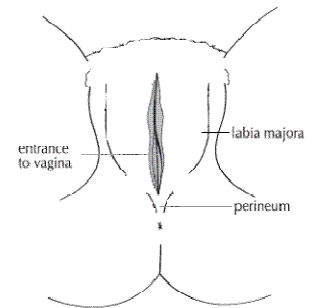
- Stretchy tissues
- Nature of the contact
- Injuries healed by time of exam
- No assault

Explain to

- Person
- Friends/family
- Police
- Court

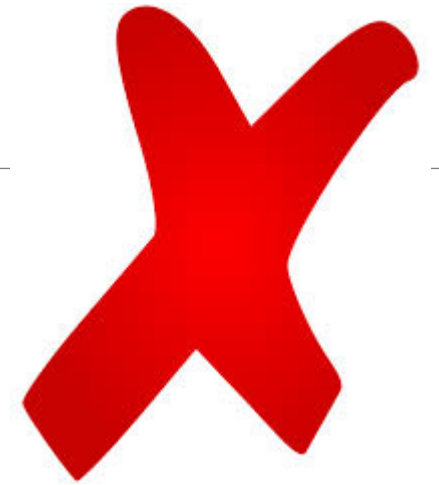


Adult



Issue of CONSENT

Some genital injuries indicate penetration
but not consent



Genital injury can occur after consensual intercourse.

Rape is a legal definition not a medical diagnosis



Sex work

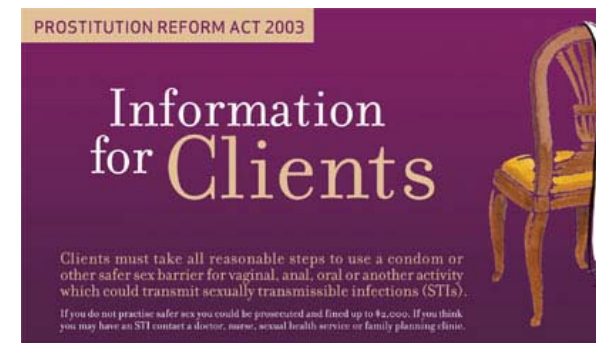
New Zealand Prostitutes Collective

info@nzpc.org.nz

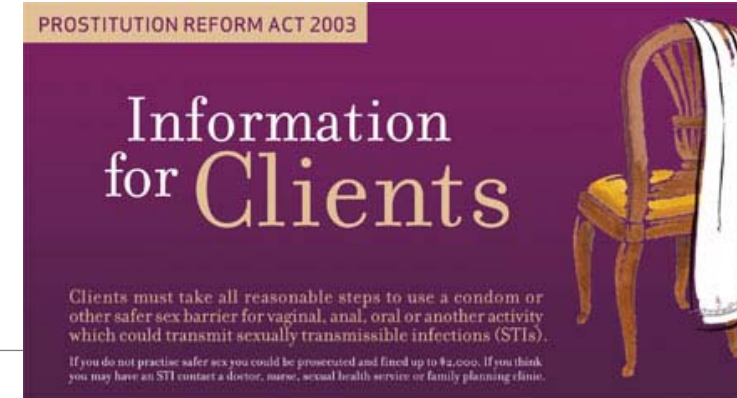


OSH – Sex Workers <http://www.business.govt.nz/healthandsafetygroup/information-guidance/all-guidance-items/sex-industry-a-guide-to-occupational-health-and-safety-in-the-new-zealand/sexindustry.pdf>

- STI checks - Frequency of assessment is a matter for determination by the individual sex worker in consultation with her/his clinician and must be voluntary.



'Certificates of Attendance'



Employers.....they may request that employees present a certificate which indicates attendance for regular sexual health assessment but which does not disclose results of this assessment.

These certificates are the property of the employee and must not be displayed anywhere in the sex industry establishment.

Differences for NZ and Australia

<http://www.business.govt.nz/healthandsafetygroup/information-guidance/all-guidance-ms/sex-industry-a-guide-to-occupational-health-and-safety-in-the-new-land/sexindustry.pdf>

You are staying until it's done

Alli Kirkham

<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



You said I could have it once

Alli Kirkham

<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



You said you liked it

Alli Kirkham

<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



You are my wife and it's your duty

Alli Kirkham

<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



You owe me

Alli Kirkham

<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



You are asking for it

Alli Kirkham

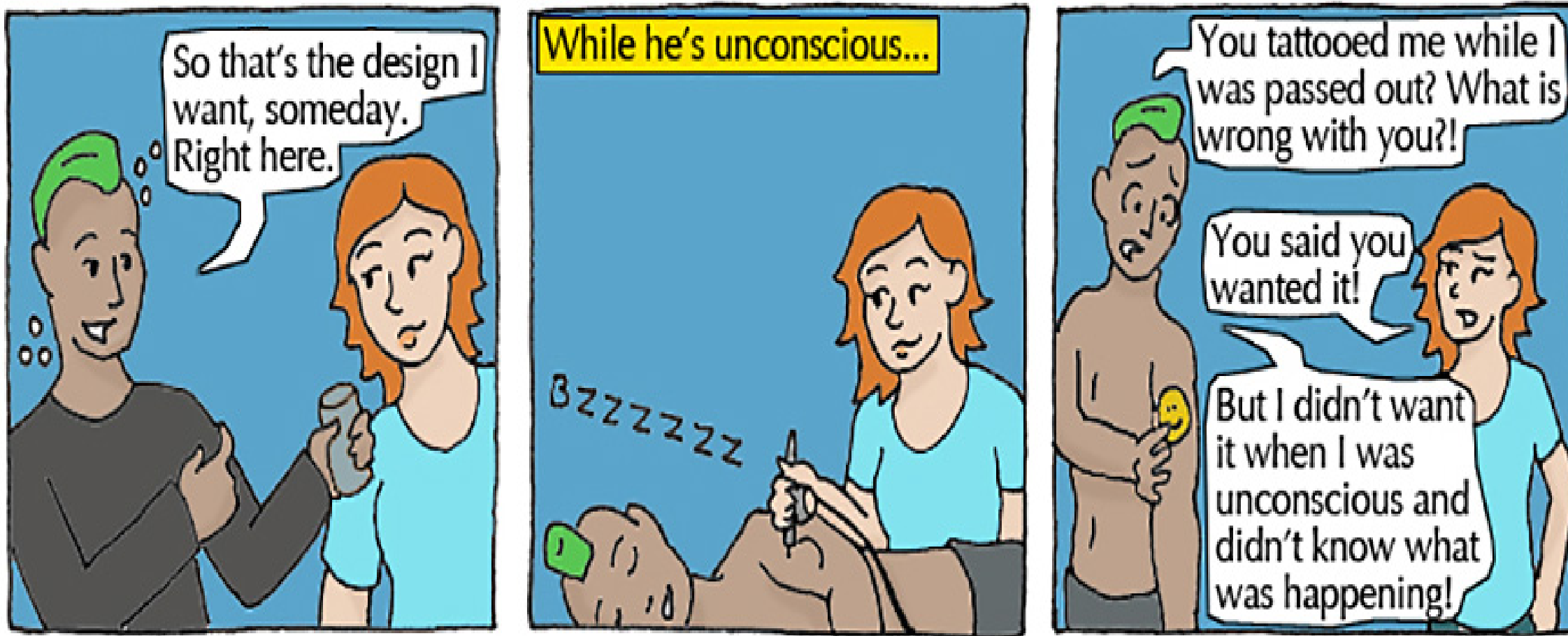
<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



You said you wanted it

Alli Kirkham

<http://everydayfeminism.com/2015/06/how-society-treats-consent/>



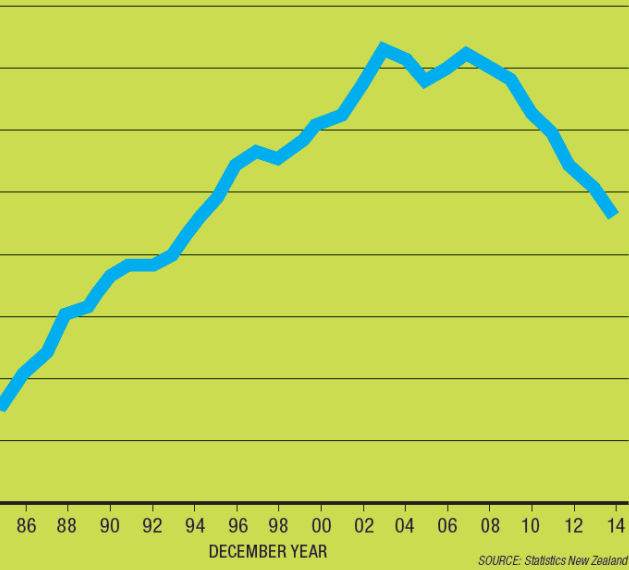
July 2015

Abortion statistics

– downward trend continues



Number of abortions
1980-2014



Numbers lowest since 1994

There were 13,137 abortions in New Zealand in the year to December 2014, the lowest number since 1994.

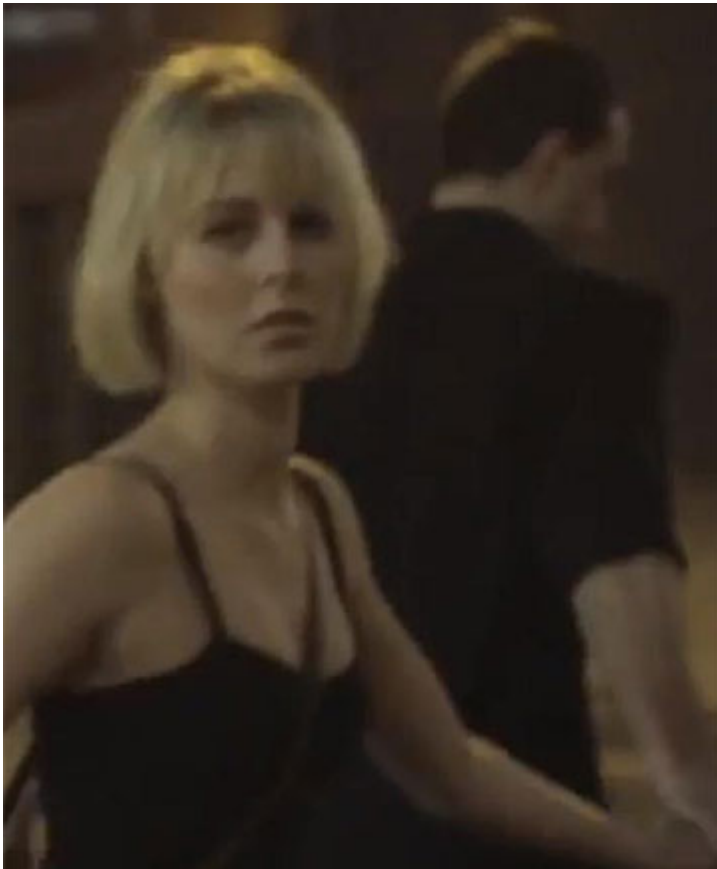
Statistics New Zealand released the 2014 data in mid-June and the general abortion rate was 14.4 abortions per 1,000 women aged 15-44 years, down from 15.6 in 2013.

The general abortion rate in New Zealand has fallen from a peak of 20.8 per 1,000 women in 2003 trending downwards since that time.

The abortion rate is dropping globally – driven, we believe, in large part by the increased availability of long acting reversible contraception and more extensive comprehensive sexuality education programmes.



Who are you?



Are you the ethical by-stander that will intervene?

www.whoareyou.co.nz



practical session

AVERT.ORG

HOW TO USE A CONDOM

NEED TO USE A NEW CONDOM EVERY TIME HAVE SEX, FOR ALL SEXUAL CONTACT.

NEVER USE THE SAME CONDOM TWICE.

PUT ON A CONDOM ONCE THERE IS A PARTIAL OR FULL ERECTION.

- 1** BE CAREFUL NOT TO TEAR THE CONDOM WHEN YOU OPEN IT. CHECK ITS CONDITION AND EXPIRY DATE.
- 2** PLACE THE ROLLED CONDOM OVER THE TIP OF THE HARD PENIS. PINCH THE TIP AND UNROLL IT.
- 3** ROLL THE CONDOM ALL THE WAY DOWN TO THE BASE OF THE PENIS, AND SMOOTH OUT ANY AIR BUBBLES, WHICH CAN CAUSE A CONDOM TO BREAK.

This graphic is taken from AVERT's Educator Booklet featured on avert.org