YOUNG AUSTRALIANS AND
Sexual Health

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Young people’s sexual health (or ill-health) and behaviour patterns emerge from a complex interplay between the individual and more ‘upstream’ forces that shape social contexts.


Image credit: Martin Boulanger
A number of sexually transmitted infections (STIs) are becoming more prevalent in Australia, and young people are among those at highest risk. Sexual health education and social marketing programs can increase knowledge of STIs, but knowledge alone does not always translate into safer sexual practice.

In a globalised world in which some STIs remain incurable and others are developing drug resistance (see below), the sensitivity and effectiveness with which Australian parents, teachers, youth workers, governments, communities and peers help young people maintain their sexual health will have long-term individual, social and economic impacts.

This briefing offers an overview of current knowledge about rates and transmission of human immunodeficiency virus (HIV), gonorrhoea, chlamydia and human papilloma virus (HPV) among Australians aged 12 to 24 and considers the role of education and social marketing in reducing the prevalence of STIs. In so doing, it acknowledges, and is mindful of, the interrelationship between physical, mental and social wellbeing fundamental to the World Health Organization’s definition of sexual health (see boxed text).

Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It 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.¹

Mental health and social factors are as relevant to reducing STIs as they are to issues associated with teen pregnancy, gender identity and sexual orientation. As this briefing concludes, multifaceted and integrated sexual health education with a strong emphasis on healthy and respectful relationships is critical to addressing some of the underlying misconceptions among young people, and the adults they come in contact with, which are contributing to unsafe sexual practices.
Sexually transmitted infections and young Australians

What are HIV, gonorrhoea, chlamydia and HPV?

HIV
This incurable STI can be transmitted through unprotected anal, vaginal and oral sex, by sharing needles with an infected person, and from an infected mother to her baby during pregnancy, birth or breastfeeding. If untreated, it can progress to acquired immunodeficiency syndrome (AIDS), which can result in death from opportunistic infections. Although in affluent countries such as Australia HIV can now be effectively managed with medication, these drugs may have side effects for some people, and life expectancy may be shorter for some HIV-infected individuals than for the general population.

Gonorrhoea
Transmitted through vaginal, anal and oral sex, gonorrhoea causes a discharge in men but often has no obvious early symptoms in women. Untreated, it can lead to infertility and, in rare cases, damage to joints, the heart or the brain. Treatment with suitable antibiotics is effective. However, in recent years some strains of the infection have developed drug resistance. In September 2013, the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC) described drug-resistant gonorrhoea as ‘an immediate public health threat that requires urgent and aggressive action’. As of August 2013, no extensively drug-resistant strain had been reported in Australia, but this situation could change in the future.

Incidence of HIV and STIs in young people

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<td><strong>FEMALES 20 – 24</strong></td>
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| **Gonorrhoea**       |      |      |      |      |      |
| **MALES 15 – 19**    |      |      |      |      |      |
|                      | 747  | 796  | 928  | 1027 | 1039 |
| **FEMALES 15 – 19**  |      |      |      |      |      |
|                      | 843  | 838  | 1055 | 1283 | 1225 |
| **MALES 20 – 24**    |      |      |      |      |      |
|                      | 1144 | 1304 | 1625 | 1815 | 2120 |
| **FEMALES 20 – 24**  |      |      |      |      |      |
|                      | 663  | 803  | 929  | 1022 | 1106 |

| **Chlamydia**        |      |      |      |      |      |
| **MALES 15 – 19**    |      |      |      |      |      |
|                      | 3701 | 4092 | 5306 | 5492 | 5383 |
| **FEMALES 15 – 19**  |      |      |      |      |      |
|                      | 11228| 12148| 14614| 16168| 15511|
| **MALES 20 – 24**    |      |      |      |      |      |
|                      | 8197 | 9384 | 10897| 12157| 12220|
| **FEMALES 20 – 24**  |      |      |      |      |      |
|                      | 12964| 13715| 15956| 17584| 18108|

SOURCE: MIDDLETON, M., TAPIA, M., WILSON, D. & MCDONALD, A. 2013, HIV, VIRAL HEPATITIS AND SEXUALLY TRANSMISSIBLE INFECTIONS IN AUSTRALIA ANNUAL SURVEILLANCE REPORT 2013, KIRBY INSTITUTE, UNIVERSITY OF NEW SOUTH WALES, SYDNEY
Chlamydia

This common STI can be transmitted through vaginal, anal and oral sex. It has few early symptoms but left untreated can lead to pelvic inflammatory disease, ectopic pregnancy and/or infertility in women, and swelling of the prostate gland and/or testicles, and sometimes infertility in men. It can be effectively treated with antibiotics.

HPV

HPV is a common sexually transmitted virus affecting men and women that often does not have easily recognisable early symptoms. Some people suffer genital warts, which can be unpleasant but do not cause cancer. According to 2013 Australian Government information:

- The more harmful types of HPV can cause abnormal cells that lead to a range of cancers and disease. HPV can cause penile, anal, cervical, vulval and vaginal cancers … HPV infection can be prevented by vaccination. The vaccination is most effective when given before a person becomes sexually active.

Reasons for concern

The most recent report on the incidence of HIV and other STIs among Australians, published by the Kirby Institute for Infection and Immunity in Society at the University of New South Wales in late 2013, makes troubling reading:

- New diagnoses of HIV in Australia were 10 per cent higher in 2012 than in 2011; more than 1,250 new cases were diagnosed in 2012, and transmission continues to be primarily through sexual contact between men; between 2011 and 2012 notifications rose for young people aged 13 to 19, and 20 to 24, and 25 to 29. According to the Institute’s Associate Professor David Wilson, the total number of diagnoses in 2012 is the largest increase since the epidemic began in the 1980s, and the increase among young men is particularly alarming. The Institute’s report states that for males aged 20 to 24, and 25 to 29, notifications also rose in 2011; newly acquired HIV infection among men younger than 25 who have sex with men and are seen by sexual health clinics rose sharply from 2011 to 2012, and much more sharply than for older men having sex with men.

- Following stable rates of gonorrhoea notifications from 2003 to 2007, overall notifications increased each year from 2009 to 2012 inclusive, for those aged 20 to 24; notifications for children aged five to 14 increased in 2010, 2011 and 2012.

- Reported diagnoses of chlamydia more than doubled between 2003 and 2012; more than 82,700 people were diagnosed in 2012, and of these, 80 per cent were aged 15 to 29; from 2009 to 2012, inclusive, notifications rose each year for those aged five to 14, and 20 to 24. In a separate study by Yeung and colleagues of more than 4,000 sexually experienced people aged 16 to 29 visiting 134 general practice clinics in 54 rural and regional towns in four Australian states and nine metropolitan clinics, 4.6 per cent of people tested positive; 73.4 per cent of diagnoses were in asymptomatic patients attending for reasons other than sexual health concerns, and the prevalence was slightly higher among rural and regional patients. Researchers in that study concluded that ‘[t]esting only those with genital symptoms or a partner with an STI would have missed three-quarters of cases’.

Rates of HIV are similar for Indigenous and non-Indigenous populations, but a higher proportion of Indigenous notifications are attributable to injecting drug use than in the non-Indigenous population. Rates of gonorrhoea and chlamydia, by contrast, are substantially higher for Indigenous populations than for non-Indigenous Australians.

The Kirby Institute report, however, does show some positive signs in relation to young people’s sexual health that should not be overlooked. Although notifications of chlamydia rose for women and men aged 15 to 19 each year from 2009 to 2011 inclusive, they declined in 2012. And, after rising each year from 2009 to 2011 inclusive, total notifications of gonorrhoea for the same age group also declined in 2012. Following the introduction of a vaccination program for HPV, rates of genital warts among Australian-born women aged 21 or younger decreased from 11.5 per cent in 2007 to 1.1 per cent in 2012, and the vaccination program has been extended to include male school students.
Sexual activity among young people

In Australia, a large proportion of students in the final three years of high school have had sexual intercourse, but in Years 10 and 11 a larger proportion have not. Results of a 2013 national survey of high school students conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University (to be published in early 2014) indicate that approximately one-quarter of Year 10, a third of Year 11 and half of Year 12 students had ever had sexual intercourse (Mitchell, A., personal correspondence, 26 January 2014). Of people aged 16 to 29 years, at least 70 per cent will be sexually active.\(^{17,18}\)

It is also clear that some young people have sexual intercourse before they turn 16. In an earlier 2008 ARCSHS survey, 43 per cent of Year 10 boys reporting on their last sexual encounter said it had been with someone aged younger than 16.\(^{19}\) A recent Burnet Institute study of chlamydia test results of people aged under 25 from 15 laboratories around Australia found the highest percentage of positive tests of young women and girls to be among those aged 12 to 15,\(^{20}\) indicating sexual activity among people of that age. Although most in this age group returning positive tests were 14 or 15, approximately a dozen were 12 years old.

In an article published in 2010, Associate Professor Juliette Goldman of Griffith University observed that the age range within which first sexual intercourse is likely to occur has not altered appreciably for some time, falling between 15 and 19 years in most parts of the world. Australian research published in 2003 found 16 years to be the median age of first sexual intercourse for men and women who were aged 16 to 19 in 2001–2002, compared to 18 years for men and 19 years for women who were aged 50 to 59 years.\(^{21}\) More recent Australian data were not discovered during the research for this briefing, although a French study published in 2010 found the median age of first sexual intercourse for women to be 17.6 years, and for men, 17.2 years.\(^{22}\)

More relevant than the age of first sexual intercourse may be the fact that many young people today spend much longer than earlier generations being sexually active outside of committed or long-term relationships.\(^{23}\) By comparing data from two surveys, the French study cited above found that French women in 2006 had, on average, 4.4 sexual partners in their lifetime, whereas French women in 1970 averaged 1.8.\(^{24}\) In the most recent ARCSHS survey of Australian school students in Years 10, 11 and 12, nearly 40 per cent of sexually active participants reported having intercourse with more than one person in the past year, and 23 per cent reported having intercourse with three or more people in the same period (Mitchell, A., personal correspondence, 26 January 2014).
Barriers to safe sexual practice

Background

For the majority of sexually active people, condoms offer the most effective protection against vaginally, anally and orally transmitted STIs. Despite provision of sex education in schools, and government social marketing campaigns aimed specifically at young people, too many of those who use condoms only do so intermittently, leaving themselves highly vulnerable to infection. As the American Academy of Pediatrics’ policy on contraception and adolescents notes, ‘an adolescent’s level of knowledge about how to use contraception effectively does not necessarily correlate with consistent use’.

In 2003, Boyle and colleagues reported that 70 per cent of those aged 18 to 29 years in 1999–2000 reported using a condom the first time they had sex. However, the 2013 ARCSHS survey of high school students in Years 10, 11 and 12 found only 43.4 per cent of sexually active respondents reported always using a condom when they had sex the previous year, whereas 39 per cent reported using condoms sometimes, and 13 per cent reported never using them. In this survey, sexually active young women were less likely than sexually active young men to have used a condom the previous year.

A survey of people aged 16 to 29 years conducted for the Australian Government in 2008 by Stancombe Research and Planning found that almost half of those who were sexually active had not used a condom the last time they had intercourse. Women were less likely than men to report having used a condom the last time they had intercourse.

In terms of HIV, those currently most at risk are men who have sex with men, and young men in this cohort are particularly vulnerable. Seventy per cent of people testing positive for HIV are men who have sex with men, and the age of notification is declining, suggesting that many young men who have sex with men are failing to use condoms consistently and/or effectively.

Although among young people as a whole, knowledge of STIs appears to increase with age, some studies here and overseas have found condom use declining for those in early adulthood. The Stancombe survey conducted for the Australian Government in 2008 found a progressive decrease in condom use at last sexual intercourse as age increased. Rates of condom use in this survey were much higher for single respondents than for those in long-term relationships. Nevertheless, the decline in use as age increased was evident for single as well as partnered respondents.

Some studies have also found that consistent condom use has declined or stabilised in recent years, rather than continued to increase. ARCSHS research reports that the number of sexually active Australian Year 10 and 12 students always using a condom declined between 2002 and 2008, while the number using them only sometimes increased. In the USA, condom use by sexually active students in Years 9 to 12 increased significantly from 1991 to 2003 but then declined slightly from 2003 to 2011. A study of the sexual...
health of Australian same-sex-attracted and gender-questioning (SSAGQ) young people aged 14 to 21 years by the ARCSHS found condom use at last experience of penetrative sex declined from 65 per cent to 51 per cent in this cohort between 2004 and 2010.38

Recent research has found that young Indigenous people do not engage in more-risky sexual behaviour than non-Indigenous young people and that the rates of those who always use condoms with a casual partner are similar for the two groups.39 The number of partners and age of sexual initiation are similar for young Indigenous and non-Indigenous people, while condom use is greater in the youngest Indigenous groups.40 This suggests that higher levels of chlamydia and gonorrhoea among young Indigenous people may be attributable to higher background levels of STIs in their communities.41

The following sections about specific barriers to safe sexual practice are not intended to be alarmist. Many sexually active young people are well informed and responsible, and generally pleased with their sexual encounters.42 However, so long as such large proportions of Australia’s sexually active young people continue to use condoms only intermittently or avoid their use altogether, STIs will remain a high risk for them and the wider community. It is important to understand why young people are failing to protect themselves adequately against STIs before considering how they might be helped to make better decisions about their own sexual health and the sexual health of their partners.

**Assumptions, miscommunications and embarrassment**

Young people may understand the risks of STIs in the abstract but still have difficulty applying that knowledge to their own situation. Young people (just like adults) may believe STIs have symptoms they would recognise in themselves,44 and they may use unreliable indicators such as social position, appearance and familiarity to assess the likelihood that a potential partner will have an STI.45 In view of this highly subjective approach to disease risk assessment, it is perhaps not surprising that the converse is often also true: many young people associate requests for condom use with a lack of trust.46 The 2008 Stancombe focus group research found that “[y]oung people were often concerned that to suggest condom use may imply a perception that the other person is in some sense “dirty”, “slutty” or of poor moral character – that is, a likely carrier of STIs’.47 In view of this, young people attempting to avoid offence may employ such ambiguous language when discussing condom preference that miscommunication occurs.48

**Lack of preparation**

Young single people often do not carry condoms.49 For some this may be a result of carelessness, but for others it may be associated with a concern that to carry them would indicate promiscuity or presumptions about the sexual availability of potential partners (see previous section). The American Academy of Pediatrics advocates making condoms available in schools etc. and notes that ‘data from condom availability programs demonstrate no increases in sexual activity, with modest increases in condom use after introduction of the programs into school-based settings’.50

**Unwanted sex**

If sex is unwanted, it is very unlikely that a young person will have prepared for it by carrying condoms or will be in any position to negotiate condom use. In the 2013 ARCSHS survey of students in Years 10, 11 and 12 (Mitchell, A., personal correspondence, 26 January 2014), 28 per cent of sexually active young women and 20 per cent of sexually active young men reported having had sex at some time when they did not want to. Of those who reported having unwanted sex, 49 per cent cited being too drunk as a reason, more than 50 per cent reported being influenced by their partners, and nearly 30 per cent reported being frightened.

**Contraception often a higher priority for heterosexual young people**

According to Stancombe focus group research conducted in 2008, many heterosexual young people associate the term ‘safe sex’ with the avoidance of pregnancy. If the female member of a heterosexual couple is taking the pill, condoms may not be discussed:

Amongst heterosexuals, avoidance of unwanted pregnancy is highly motivating and oral contraception is viewed as the most important (sometimes the only) form of safe sex. A condom is only ever likely to be used (if available and thought about in the moment) in cases where the woman is not using oral contraceptive and when having sex with a total stranger.43
Much higher proportions of young women than young men reported being influenced by a partner or being frightened, and a much higher proportion of young men than young women reported being influenced by their peers.\textsuperscript{51}

\section*{Lack of information for same-sex-attracted young people}

According to Wilson,\textsuperscript{52} a factor contributing to the decline in consistent condom use by men who have sex with men may be that people in their twenties today are too young to remember when high numbers of men were dying of AIDS:

The problem is they are not using condoms as much as what they were in the past, and it’s very simple, we know condoms work ... It’s a new generation. Twenty or 30 years ago people were dropping dead all around us, we didn’t know what this disease was, then we learned it was [a] virus, we didn’t know how to contain it. We now know that we’ve got effective treatments and these treatments keep people alive. They can almost have a full life expectancy. So it’s a very different disease than what it was 20 or 30 years ago. So for that reason the young gay men who enter the scene don’t have the same fear, but they don’t realise that it’s still a very serious condition.\textsuperscript{53}

However, there is also evidence that sexual health classes in schools often ignore the needs of SSAGQ young people:

From these findings it is clear that quite conservative messages emphasizing heterosexual sex and danger are the norm in most Australian schools with a far smaller number providing critical messages inclusive of SSAGQ youth.\textsuperscript{54}

\section*{Multiple partners}

An ARCSHS survey in 2008 found that young people who had three or more partners were less likely to report always using a condom,\textsuperscript{55} while the 2008 Stancombe survey found ‘those with the most sexual partners are also less likely than those with fewer partners to identify behaviours such as sex without a condom … as high-risk’.\textsuperscript{56}

\section*{Failure to be tested for STIs}

A large proportion of people under 30 have never been tested for STIs. The 2008 Stancombe survey of young people aged 16 to 29 years found that more than 60 per cent had never been tested for an STI.\textsuperscript{57}

Men who have sex with men are most likely to be tested, and women are more likely to be tested than men.\textsuperscript{58} There are also ‘encouraging signs that those with multiple partners and higher sexual activity report a higher incidence of testing for STIs’,\textsuperscript{59} although this seems at odds with findings that those with the most sexual partners are less likely than those with fewer partners to identify sex without a condom as risky (see previous section).

Many people decide not to be tested because they perceive themselves to be in a committed relationship, but even more say they have not been tested because they do not have any apparent symptoms:

Only one-in-three non-testers quoted regular condom use as a reason to forego testing. More often, a committed relationship (44%) and, more concerning, a lack of symptoms (46%) were provided as justification. Lack of symptoms was more often mentioned by males (49%, compared to 43% of female non-testers).\textsuperscript{60}

This is of major concern, because, as Yeung and colleagues have concluded, as many as 70 per cent of cases of chlamydia among young people would be missed if only those presenting with a sexual health concern were tested (see ‘Reasons for concern’ in ‘Sexually transmitted infections and young Australians’ earlier in this briefing).\textsuperscript{61}

There is also evidence that some young people feel there is social stigma associated with having an STI test. This may lead young people and people living in small communities, including remote Indigenous communities, to avoid discussing the subject with family doctors or staff at local health clinics.\textsuperscript{62} However, if a GP suggests that a test might be warranted, a patient is likely to comply.\textsuperscript{63}

Some people report that they avoid being tested because of the expense of a doctor’s appointment and their fear that there will be costs involved, while homeless or otherwise mobile people may not have reliable contact details by which to learn of their test results.\textsuperscript{64}
Problems with condoms

The Bill and Melinda Gates Foundation recently offered a million dollars to encourage the development of a new generation of condoms. The rationale was that people around the world would be more likely to use condoms if they preserved or enhanced pleasure and were easier to apply.

Some people do not like the feel of sex with a condom. For others the mechanics of applying condoms can be tricky, while a few men cannot maintain an erection with a condom in place. Even men well into their twenties can have ‘low self-efficacy for correct condom use’ that correlates with erection loss. The following quotes summarise some of the issues:

Existing research on condom use has demonstrated several ongoing problems reported by both college-aged [i.e. university-aged] individuals and adults. Among these problems most commonly reported are breakage and slippage, erection loss, problems with ‘fit’ or ‘feel’, sensation loss and decreased sexual pleasure.

Fifty articles representing 14 countries [were reviewed]. The most common errors included not using condoms throughout sex, not leaving space at the tip, not squeezing air from the tip, putting the condom on upside down, not using water-based lubricants and incorrect withdrawal. Frequent problems included breakage, slippage, leakage, condom-associated erection problems, and difficulties with fit and feel … Conclusion: Condom use errors and problems are common worldwide, occurring across a wide spectrum of populations. Although breakage and slippage were most commonly investigated, the prevalence of other condom use errors and problems found in this review were substantially higher.

However, there is evidence that condoms are less likely to be associated with erectile dysfunction or interfere with sexual pleasure in long-term and ongoing relationships than in casual encounters. The following quote indicates that interpersonal considerations may sometimes have physical outcomes in regard to condom use:

In general, the [US university student] participants who reported having a monogamous sexual relationship over the past 6 months were significantly more likely to view condoms as less interruptive to foreplay or sexual arousal; more likely to view condoms as erotic or enhancing sexual pleasure, and less likely to view condoms as negative compared with participants who were in non-monogamous sexual relationships over the past 6 months including casual monogamy, non-monogamy and casual sexual relationships. These findings suggest that college-aged [that is, university-aged] individuals’ attitudes about condoms are not only likely to be influenced by sex, but also the type of sexual relationship the individual is engaging in. Similar to other social perceptions and attitudes, condom attitudes are likely to be fluid and variable, and based on multiple factors.

In terms of the difficulty associated with using condoms, ‘data demonstrate that effectiveness increases with experience, leaving those adolescents with the least experience at greatest risk for improper use’. This suggests that young people need to be given the practical skills necessary to use condoms effectively.

Data demonstrates that effectiveness increases with experience, leaving those adolescents with the least experience at greatest risk for improper use.

SOURCE: AMERICAN ACADEMY OF PEDIATRICS
Making a difference

Background

The Australian Government’s national strategy on sexually transmitted diseases is being reviewed. However, its 2010–2013 iteration acknowledged the importance of high-quality school-based sexual health education, peer education and social marketing:

- Ongoing and enhanced sex education within schools as an integral part of the school curriculum is strongly recommended. A holistic approach places risk-taking behaviours within the social context of young people’s lives. It will require a committed and strong partnership between health and education departments, with a clear enunciation of roles and responsibilities and supportive evidence. This approach is supported by the health reform agenda. Other approaches, such as youth peer education and social marketing, are recognised as effective tools to engage with young people about STIs, including HIV.

There is extensive evidence that only integrated approaches to changing young people’s risky sexual behaviour will have any real success. A systematic analysis by Cicely Marston and Eleanor King of 268 qualitative studies that were published between 1990 and 2004 found strong evidence that social and contextual influences help explain why information campaigns and condom distribution programs alone are unlikely to change young people’s risky sexual behaviour. Although the studies reviewed by Marston and King are now dated and range across many communities, including those in developing countries, the themes they identified were evident to some extent in all cultures and countries studied.

As noted by the Youth Affairs Council of Western Australia in relation to its survey of relevant literature published in 2011:

Young people’s need for context-relevant sexual health education (Sorenson & Brown, 2007) is supported by a clear consensus in the literature that young people’s sexual health (or ill-health) and behaviour patterns emerge from a complex interplay between the individual and more ‘upstream’ forces that shape social contexts. These include sociocultural norms, community, family, peers, economic status and opportunities, access to and quality of institutions such as schools and health services, religion, policy, historical period, and media ...

Below are some of the individual components of an integrated approach to reducing risky sexual behaviour among young people.

Education in the home

Parents are important to the wellbeing of their children and their knowledge of risk, although they tend to overestimate the extent to which their offspring will come to them with their concerns. A large study of risk-taking behaviour among young people conducted in Tasmania and published in 2008 found that students who relied on their parents or ‘a combination of parents, peers and other family members’ for advice and support had a lower risk profile than those who relied entirely on their peer group. In the opinion of the researchers, ‘[t]his underlines the importance of broad social support resources and of parents establishing a close and trusting relationship with their children, in which all problems can be openly discussed and shared’. In its 2008 survey, ARCSHS found that more than half of Year 10 and 12 students were confident to very confident about discussing STIs with their parents, and that there had been a substantial increase in this confidence since 2002.
A comprehensive resource to help parents talk to their children about sex, reproduction, sexuality and relationships is Talk Soon. Talk Often, by the ARCISH's Jenny Walsh, which was commissioned by the Western Australian Department of Health. The booklet was produced following consultations conducted in 2008 to determine what kind of support parents felt they needed. In particular, parents wanted to know what was normal, how they could share their values with their children, how to keep the communication going, and how to deal with the vast array of sexual information encountered by young people on television, on the internet, in the community and in schools. As the title Talk Soon. Talk Often suggests, the booklet advises mothers, fathers and carers to have many small conversations with their children about sexuality, and provides information to help them do so:

You might be relieved to know that helping your child towards a happy, healthy sexuality does not come from any One Big Talk that you have to get perfectly scripted ... Life presents lots of opportunities to chat, make a comment, ask a question about the kids’ school, so you can always go back to what you were trying to say the first time. By the time you’ve done that a few times, your child will have learned the most important message: They can talk about this subject with you.  

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### Education in schools

There is strong evidence that good-quality sex education in schools is the most effective way to promote safer sexual behaviour among school-aged young people. As noted by Goldman, it is also important because it counterbalances ‘the inevitable sexual boasting, banter and bullying of the school playground’. A 2013 Australian rapid review of academic literature about programs aimed at reducing STIs in young people found that ‘comprehensive, well-supported school-based sexual health programs, supported within a broader school community’, had the strongest success in ‘increasing protective behaviours’. Specifically, they can increase condom use, delay sexual initiation and reduce the frequency of sexual activity among the young; conversely, these kinds of programs very rarely have the opposite effect. Fears in some quarters that such programs promote sexual activity among adolescents simply do not appear to be borne out by the literature. The same cannot be said, however, for programs that promote abstinence alone: according to Brown and colleagues, there is ‘strong evidence that programs focused on abstinence only, in any setting, were ineffective in reducing risk or delaying sexual behaviour and indicative evidence that they may increase risk’.  

Sexual health education that promotes respectful relationships (see ‘Respectful relationships’ section later in this briefing) is an important way of improving the ability of young people to negotiate safe sex. In late 2013, Professor Peter Aggleton of the Centre for Social Research in Health at the University of New South Wales gave a public lecture about sexual health education. In common with many modern-day researchers in the field of sexual health, his concern was for the creation of ‘a fairer and more respectful world for all young people regardless of gender or sexual orientation’, as well as preventing STIs. Here, and in an associated article, he argued that ‘[i]n Australian schools sex education is patchy and inconsistent, with many education departments leaving it to individual schools to decide what, if anything, to teach’.  

More positively, Aggleton described some of the components he believes should be part of good school sex education:  

- **Sex education should begin, in appropriate forms, at an early age.** Experts in human sexuality and learning and teaching should be involved in curriculum development. Sexual health programs in schools should have clear and focused health goals – alongside a concern for values such as dignity and respect. Students should feel safe and comfortable in classes. Skilled and motivated teachers are essential ...  

There are examples, such as Juliet Goldman’s, of favourable studies of sexual health education programs in Australian schools. However, Goldman has expressed concern ‘that school-based devolution of decision-making in some curriculum areas means that school communities will “self-censor” and opt out of sexuality education if even just a few parents object’. In her view:  

... without specific, detailed and compulsory guidelines for Sexual and Reproductive Health Education, most primary school teachers and their principals, who have discretionary authority over curricula implementation, are very likely to take the default position of avoidance of sexuality education. In recent years, a number of studies have been conducted to ascertain the views of students, parents and teachers. Below are some key findings of these important pieces of research.
What students say

ARCSHS research indicates that young people consider sexual education programs in schools and the teachers of these programs to be important sources of trusted information. Consultations with young people conducted in 2006 by the Youth Affairs Council of WA for the Western Australian Department of Health found that young people want sexual health education that is ‘relevant, trustworthy, confidential and safe, non-judgemental, and in the context of young people’s lives’. The Australian Youth Affairs Coalition (AYAC) and Youth Empowerment Against HIV/AIDS (YEAH) believe governments should consult with young people when developing sexual health policies and programs for them. Their national survey of people aged 15 to 29 found ‘strong evidence from young people wanting teachers to engage external agencies to support and complement the delivery of sexual health education in the classroom, with an emphasis on peer education’.

Young people are witness to advertising, education, relationships, media and popular culture that brings sexual health into their reality whether they are developmentally ready or not. Educators and health professionals are continually challenged to create learning environments where young people can safely and openly learn about the complexity of sexual health in relation to their physical bodies and the social reality they live in.

The AYAC and YEAH survey found that the majority of young people would prefer to be taught sexual health by trained peers and community sexual health educators a little older (but not considerably older) than themselves rather than by physical education teachers.

As noted earlier, the ARCSHS study of SSAGQ students published in 2010 found many sexual health education programs overlooked the needs of SSAGQ students. Although there were reports of good-quality inclusive sexual health education in a number of schools, several young people described the classes as promoting homophobia, or as presenting perspectives in which homosexuality is framed as evil or dangerous. When respondents were asked what they wanted from their school, ‘the strongest theme (appearing in 40% of responses) was that they wanted the Sexuality Education delivered by their school to be changed so that it was more inclusive of same sex attraction and gender diversity.’

What parents say

Focus group research conducted with metropolitan and regional Western Australian parents of children and young people aged up to 22 years found strong support for school sex education with the following provisos:

- Parents want their children to be well informed about sex, sexual health and relationships; however, they want to be kept informed about school programs.
- Parents want to be assured that the educators who will be teaching their children about sexual health have the skills and qualifications to do their job well, and remain sensitive to the diversity of values among their students and their families.
- Parents believe schools need to take an active role in providing written communication about what will be covered in sexuality education programs and be open to meet with parents who have concerns.

What teachers say

A national survey of sex education teachers conducted in 2010 revealed that the majority believed programs were effective in passing on knowledge but less successful in reducing risk-taking behaviour; however, at the time of the survey almost no sexual health education was provided to Year 11 and 12 students. This may have changed in the intervening years, or there may be alternatives. For example, New South Wales state schools offer a 25-hour compulsory Crossroads personal development course in relationships and drug issues delivered to Year 11 and 12 students.

The national survey of sexual health teachers found there was ‘a critical question … around the degree to which teachers and schools remain unsupported and untrained in the delivery of comprehensive, sequential and age appropriate sexual health education programs’. It recommended that ‘national standards and detailed unambiguous guidelines for the delivery of sexuality education from primary through to secondary school Year 12’ be developed ‘based on reviews of age appropriate sexuality education’.

Respectful relationships

As noted in the Overview, this briefing is concerned with ways in which young people can be encouraged to protect themselves against STIs, but there is overlap between this and addressing other sexual health concerns such as sexual violence, homophobia, and issues associated with ‘sexting’ (that is, young people sharing explicit images of themselves via social media). Research into all these aspects of sexual health can...
contribute to knowledge of how best to promote the kinds of respectful relationships among young people likely to be associated with safer sexual practices.

For example, in 2006 Professor Moira Carmody of the University of Western Sydney developed the sex and ethics violence protection program for people aged 16 to 25:

The Program offers structured activities using real life scenarios which prompt participants to think beyond popular discourses surrounding sex, gender and sexuality … Through a series of carefully constructed critical questions and individual and group reflection, young people are also invited to consider alternative possibilities for how people may relate in intimate situations.

The program can be adapted to the needs of SSAGQ people and people from different cultural backgrounds, and can be conducted in single gender or mixed gender groups. Topics covered include:

- different cultural perspectives on sexual intimacy
- the sexual ethics framework and how to decide what is right for you and the impact on others
- how to handle pressures to be sexual
- non-verbal communication skills
- alcohol and drugs and the impact on sexual decision-making
- skills in ethical consent and the law, ethical use of social media and technology
- negotiating conflicting desires and needs in casual and ongoing relationships
- recognising the signs of abusive relationships
- breaking up and
- being an ethical bystander and standing up to sexual violence and other gender-based abuse in your community.

Peer education encompasses both formal and informal educational activities:

Peer education typically involves the use of members of a group to effect change among other members of the same group. In terms of youth, peer education has been defined as the process by where motivated, well-trained young people undertake informal or organised educational activities with their peers, that is those similar in age, background, or interests who identify with the peer educators …

A two-year Youth Educating Peers Project conducted in 2009–2010 in association with six Western Australian youth sector agencies and funded by the Western Australian Department of Health determined that peer education has considerable potential as an adjunct to youth sector and sexual health initiatives targeting disadvantaged, marginalised and/or disengaged youth.

Particularly when youth peer education is embedded in programs that support disadvantaged youth, participants may require extensive personal development before they can progress to delivering formal sexual health programs to their peers. For this reason two types of youth peer education are discussed: peer development and peer delivery. In peer development, young people develop self-esteem, knowledge and skills through formal workshops delivered by ‘a well-trained and trusted person, such as a youth worker or older peer’. Depending on the level of disadvantage experienced by these participants, they may or may not progress to becoming formal peer educators themselves, but even if they do not, it is expected that their new sexual-health knowledge will be circulated through participants’ naturally occurring conversations with their peers.

Although the Youth Educating Peers Project found that peer education programs have many important benefits for the peer educators themselves, it was not clear that these young people were then able to successfully deliver sexual health education to their peers. Nevertheless, Australian data suggest that many young people like to receive sexual health information from trained peer educators, and surveys conducted by YEAH have found that many young people gain new information about safe sex from talking to peer educators (see ‘Youth sector initiatives’ in the ‘Social marketing’ section below).

Internationally, a literature review by the Youth Peer Education Network in 2005 contained in a toolkit funded by the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS found very mixed research standards and results among
evaluations of peer-led education programs. However, it reported that the more-rigorous evaluations, though relatively few, identified a number of benefits, including increased reports of condom use to prevent HIV and increased intention to delay first sexual encounter. It is possible that peer education has particular value in specific contexts. For example, the 2010–2013 iteration of the Australian Government’s sexually transmitted diseases strategy noted that ‘peer-based responses to HIV’ have been clearly demonstrated to be effective in gay communities.

**Sexual health clinics and youth services**

There is evidence that good-quality counselling can be a cost-effective way to change behaviour:

There was strong evidence that one-to-one structured counselling interventions with sexually active young people can be effective in behaviour change and can also be cost-effective. However, evidence was also good that such programs are more likely to be effective when they target those identified as high risk, and when they emphasise motivation, self-efficacy, and factors that underlie risk-taking and are implemented as part of a broader STI prevention program.

A report for the Western Australian Department of Health on the sexual health education of young people published in 2007 found ‘[m]any young people identified youth centres and youth health services as preferred sources of health education outside of school, particularly those who felt isolated or marginalised from mainstream education’. The report recommended support for ‘the building of partnerships between schools and youth health services in the facilitation of sexual health education and building relationships between young people and the services available to them, in and out of school’. This is in line with international experience, which suggests that bringing community health services into the school rather than expecting young people to find their own way to them is an effective way forward.

As youth workers Marty Janssen and Jackie Davis suggest, youth workers who may themselves lack education in effective approaches can be reticent about providing sexual health education and may refer clients to sexual health clinics rather than addressing their concerns directly. However, Janssen and Davis also argue that because sexual health education is not just concerned with imparting technical and biological information but necessarily also encompasses ‘relationship issues, communication skills and peer pressure’, youth workers are ideally placed to make a contribution, particularly in the case of marginalised, disadvantaged and/or disengaged youth. Similarly, the Youth Educating Peers Project notes that youth workers’ ability to create safe, non-judgemental spaces and facilitate holistic, relevant [sexual health] peer education was considered unique to the role of the youth sector, as youth workers can have more flexibility than other professionals, for example teachers, to develop relationships with young people and address sensitive topics.

Computer-based sources of information and advice compare well to face-to-face provision according to academic evaluations. Confidentiality is extremely important to young people in many areas of sexual health, so it is significant that websites operated by sexual health clinics can now enable people with STIs to advise sexual partners anonymously that they are at risk, thereby making it likely that more people will be tested. For example, the Melbourne Sexual Health Centre’s Let them know website discusses the pros and cons of advising partners by talk, letter, email or SMS, and provides facilities for all three forms of written communication to be sent anonymously.

**Social marketing**

Social marketing likely to be most effective with young people seeks the involvement of youth, is well funded, has high exposure and uses appropriate messages that address ‘young people’s needs for independence and rebellion’.

In May 2009 the Australian Government launched an STI social marketing campaign aimed at people aged 15 to 29 and informed by the two reports by Stancombe referred to earlier in this briefing.

The key issues for all targets appear to be to raise perception of personal risk of contracting a STI (including HIV/AIDS) on all occasions with all types of people and to actively promote personal sexual responsibility and accountability for self and others. For most target groups, there appears to be a need to promote messages of personal susceptibility and educate people about the harm associated with STIs (including HIV/AIDS). Some additional issues for the heterosexual targets (especially amongst Aboriginal and Torres Strait Islander people) include increasing knowledge of STIs and HIV, assisting people to assert themselves during negotiations around sexual relationships.
encounters, enabling and fostering negotiation and discussion around sex and use of condoms, beliefs about sex generally, and encouraging the carrying and using of condoms (i.e. normalise it). The campaign used a dedicated website containing factsheets, brochures, details of sexual health clinics etc. and advertisements in magazines and cinemas, online, on radio and outdoors to inform young people of the transmission, symptoms, treatment and prevention of STIs. Its work aimed to speak directly to young people, and particularly young women, explaining how and why condoms are necessary, attempting to undercut the stigma associated with carrying condoms and negotiating their use, encouraging testing, and providing answers people can use in response to common excuses for not using condoms.

The effectiveness of the campaign was tracked over four reviews. Condom use among those who had had sex in the past 12 months increased over the four review periods, but men remained significantly more likely than women to report using a condom: the increase for men from the first to the fourth review was eight per cent, whereas for women it was only two per cent. The authors of the report did not specifically indicate whether there had been increases in consistent condom use. The numbers of survey participants carrying condoms all the time remained low, though considerably more people said they kept them on hand at home or bought them as they needed them. There was no significant increase in STI testing over the four reviews. Men were less likely than females to perceive the campaign message that they needed to get tested for STIs.

Youth sector campaigns

The youth sector also runs social marketing campaigns designed to increase young people’s knowledge of sexual health. One example that may appeal to young people’s desire for independence and rebellion is YEAH’s sponsorship of the Groovin’ to the Moo music festivals in Canberra and regional towns in Victoria, New South Wales, Queensland and Western Australia. In addition to making peer educators available for consultation at these events, YEAH signposted its presence with two giant inflatable condom castles and two spinning wheels with sexual health questions. Volunteers distributed state and territory specific sexual health referral cards, condoms and condom tins, sexual health information flip books, safe-sex branded hats and visors, and ‘I Love Safe Sex’ branded slap bands. YEAH reported that 12,600 young people told them they learnt something new about sexual health because of YEAH’s presence at the festivals in 2013.

Projects targeting Indigenous youth

An evaluation of six demonstration projects aimed at improving the sexual health of Indigenous young people was published by the Australian Institute of Health and Welfare (AIHW) in 2013. It found five features of successful projects:

- appropriate consultation with a broad range of stakeholders, including community Elders, young people and health professionals
- engagement and developing partnerships with the community, organisations and services
- culturally appropriate project design and implementation
- project design, delivery and implementation that was flexible and adaptable
- staff who were respected by the community, accessible to young people, engaged well with young people, and were the same gender as the target group.

The Marie Stopes Australia project ‘Don’t Let Your Community Get Bitten, Ask for a SNAKE’ aimed at sexually active Aboriginal people aged 16 to 30 years was one of the projects evaluated. This was part of a larger Marie Stopes Australia SNAKE Condoms campaign that has a range of features, including a brand of condoms in the colours of the Aboriginal flag developed with input from Indigenous Australians, a culturally informed sexual health information website, health promotion days, highly targeted distribution of message cards designed specifically for Indigenous audiences, and humorous slogans. It is important to note, however, that what works in some Indigenous communities may be considered inappropriate for others. The AIHW evaluation referred specifically to the SNAKE slogan when explaining the need for projects to be sensitive to cultural variations between Aboriginal groups:

... the Marie Stopes SNAKE condoms were used by Durri [on the traditional lands of the Dungulati people in northern New South Wales] and were also considered for use by [Ngaanyatjarra Health Service in the Northern Territory]. However, the SNAKE campaign slogan was not considered appropriate in the Ngaanyatjarra communities participating in the project and so were not used. A similar example is from Congress where Red Boxes were renamed ‘Toolboxes’, as the term ‘Red Boxes’ was not appropriate for cultural reasons in some communities.
Media

The media is often critiqued for its role as a ‘super peer’ capable of shaping young people’s attitudes to sex and relationships in ways that may be stereotyped, image-focused and inequitable. Investigating these concerns is extremely important, but young people’s attraction to popular culture also makes television, radio, newspapers and magazines important conduits for delivering safe-sex messages (see previous section in regard to social marketing campaigns).

Professor Alan McKee, from the School of Media, Entertainment and Creative Arts at Queensland University of Technology, argues that media products that provide reliable and comprehensive sexual health information in a format and style of language that appeals to young people can complement school education programs that young people may find too ‘scientific’. McKee’s research led him to enter into a partnership with popular magazine *Girlfriend* to develop a product with a particular focus on sexual health education:

We ran focus groups with 14- to 16-year-olds to find out what they know about sex and how they know it. They consistently told us that sex ed in schools was ‘scientific’ and didn’t relate to their own lives. Many of the young women mentioned *Girlfriend* magazine as a resource that did relate to their everyday lives. For this reason we approached the editor of *Girlfriend* and proposed co-editing a special issue devoted to healthy sexual development. She jumped at the idea. I brought to the table a list of topics I wanted to see covered from a sexual health perspective – and she brought to the table a list of topics that 14-year-old girls want to see covered. These were very different and so we merged them to produce the final contents. I edited every article for accuracy; she edited every article to put it into the language and context of a 14-year-old reader.

One challenge for projects that seek to use popular media to circulate sexual health information to young people may be persuading readers that the information is reliable. Although many young people report that they derive information about safe sex from the media or the Internet, there is evidence that they may treat it with scepticism or trust it less than other sources, including schools and parents.

Getting the message right:

- The format and language of the information needs to appeal to young people.
- Information provided by schools may be ‘too scientific’.
- Programs and services should be sensitive to culture and gender.
- Those delivering sexual health education should be accepted by the community and accessible to young people.
- Teachers of sex education need to be skilled, motivated, well-resourced, supported and trustworthy.
Conclusions

Multifaceted and integrated sexual health education with a strong emphasis on healthy and respectful relationships is critical to addressing some of the underlying misconceptions among young people, and adults they come in contact with, which are contributing to unsafe sexual practices. The following conclusions are informed by the studies cited in this briefing.

1. It is important to ensure that young people’s knowledge of STIs continues to improve, but this alone will not necessarily result in safer sexual behaviour.

2. Gender stereotyping continues to hamper communication and negotiation about sex between young people.

3. Social marketing that assumes young people are sexually confident risks failing those of any sexual orientation whose inexperience, sensitivity or confusion makes it very difficult for them to raise the subject of condoms with prospective partners.

4. Social marketing needs to be accompanied by acceptable, free, easy access to male and female condoms and STI testing.

5. Promoting respectful relationships among young people and ensuring sexual health teachers are skilled, motivated, well-resourced, supported and trustworthy are central to improving sexual health.

6. The benefits of peer education in changing risky sexual behaviour are still uncertain but peer development and delivery can be valuable components of broader sexual health programs in schools and in the broader community.

7. Social marketing can achieve important results. However, rising rates of STIs among those aged 20 to 24 suggest that better school sexual health education is required to prepare young people for life after school, and that people in their early twenties need access to free STI testing and good-quality, non-judgemental, free sexual health education and advice in TAFE and higher-education campuses, youth centres and easily accessible health clinics.

8. High-quality school education intended to reduce the transmission of STIs should ensure – at the very least – that young people:
   - are encouraged to become more comfortable with their own sexuality
   - respect gender and sexual diversity
   - have the knowledge, confidence and self-esteem to resist social pressure or pressure from partners to engage in sexual activity before they are comfortable to so
   - have accurate information about HIV and other STI risks
   - have ready access to condoms, know how to access them, and know how to use them effectively
   - have the confidence, knowledge and skills to successfully negotiate condom use, and equate such negotiation with self-respect and respect for others rather than imputations of uncleanliness or promiscuity
   - understand the risks of combining sex and excessive consumption of alcohol and other substances
   - have easy access to free, confidential sexual health advice and HIV/STI testing, know how to access it, and understand the need for testing
   - are aware that there can be sexual health advantages to delaying the initiation of sexual activity and having fewer sexual partners
   - are aware of the health effects of living with HIV.
Gaps in knowledge

- More research is required to understand why young women consistently report lower condom use than young men.
- It is not clear why consistent condom use declines as people move from adolescence to adulthood, even when associated increases in long-term relationships are taken into account.
- What has led to a fall in chlamydia and gonorrhoea among those aged 16 to 19? Is it a result of effective social marketing or sexual health education?
- Why does consistent condom use appear to be declining among young gay men?

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More information

Australian Indigenous HealthInfoNet
http://www.healthinfonet.ecu.edu.au/other-health-conditions/sexual

Australian Research Centre in Sex, Health & Society, La Trobe University
http://www.latrobe.edu.au/arcshs/

Burnet Institute
http://www.burnet.edu.au/

Centre for Social Research in Health, University of New South Wales
https://csrh.arts.unsw.edu.au/

Get the facts, Western Australia Government

Kids Helpline
1800 55 1800

Kirby Institute for Infection and Immunity in Society, University of New South Wales
http://www.kirby.unsw.edu.au/

Let them know (for help telling sexual partners who may be at risk)

Melbourne Sexual Health Centre

Multicultural Health Communication, New South Wales Government

Queensland sexual health clinics, Queensland Government

Safe Sex. No Regrets, Northern Territory Government

Sexual Health and Family Planning Australia

Sexual Health Information, Networking and Education SA
http://www.shinesa.org.au/

Sexual Health Plus, New South Wales Government

SNAKE Condoms

STIs are spreading fast: Always use a condom, Australian Government

Talk Soon. Talk Often, Tasmanian Government

Talk Soon. Talk Often, Western Australian Government
http://www.public.health.wa.gov.au/2/1276/2/parentcarer.giver.pm

Tasmanian Council on AIDS, Hepatitis and Related Diseases
http://tascahrd.org.au/

Youth Empowerment Against HIV/AIDS (YEAH) & Red Aware
References


Albury, K., Crawford, K., Byron, P. & Mathews, B. 2013, *Young people and sexting in Australia: Ethics, representation and the law*, ARC Centre for Creative Industries and Innovation and Journalism & Media Research Centre, University of New South Wales, Sydney.


Notes

5. Ibid.
7. Ibid.
10. Ibid.
11. Ibid.
13. Ibid., p.170.
19. Ibid.


34. CDC 2012; Smith et al. 2009; Stancombe 2008; Yeung 2014.


36. Smith et al. 2009. At the time this briefing was published, comparisons of condom use could not be made between the 2008 and 2013 ARCSHS surveys, because the 2013 survey included Year 11 students for the first time and employed a different methodology.


43. ibid.


46. See Marston & King 2006.


51. ibid.

52. Hillier et al. 2010, p.83.


54. Stancombe 2009, p.iii.


56. ibid., p.46.


58. Yeung et al. 2014.


60. Stancombe 2008; Yeung 2014.


65. ibid., p.257.


72. ibid.

73. Marston & King 2006.


ibid. p.624.

ibid.


Brown, G., Croy, S., Johnston, K., Pitts, M. & Lewis, V. 2013, Rapid review: Reducing sexually transmissible diseases in young people, Australian Institute for Primary Care & Ageing (AIPC), & Australian Research Centre in Sex, Health & Society (ARCSHS), La Trobe University, Melbourne, p.3, retrieved from, <http://docs.health.vic.gov.au/docs/doc/4370ED-1C8ABBB896CA257C8-00631Ce8F2E9-4CD8-8B51-4266E1FAAB62%7D.PDF>.


Brown et al. 2013, p.4.


Aggleton 2013b.

Aggleton 2013b; see also:


Aggleton 2013b.

Goldman 2010, p.50.

ibid.


ibid., p.6.

ibid., p.7.

Giordano & Ross 2012; see also Sorenson & Brown 2007.

Hillier et al. 2010, p.xi.

ibid., p.85.

ibid., p.xi.


Smith et al. 2011.


Smith et al. 2011, p.51.

ibid., p.49.


See Hillier et al. 2010.

See Albury, K., Crawford, K., Byron, P & Mathews, B. 2013. Young people and sexting in Australia: Ethics, representation and the law, ARC Centre for Creative Industries and Innovation and Journalism & Media Research Centre, University of New South Wales, Sydney.

Carmody 2013.

ibid.

Sorenson & Brown 2007, p.46.


Walker 2011.

ibid., p.14.

Walker 2011.

ibid.

Giordano & Ross 2012.

126. ibid., p.51.
127. Aggleton 2013c.
130. See Brown et al. 2013.
140. AIHW 2013, p.52.
141. Walker 2011, p.11.
143. McKe, A., personal correspondence, 26 February 2014.
Face the Facts has been developed in response to the need for policy- and decision-makers to have information on emerging trends in the youth sector.

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