Discussing Sexual Health

Edited by Justin Healey
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INTRODUCTION

Discussing Sexual Health is Volume 386 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC
According to the latest National Survey of Australian Secondary Students and Sexual Health, teenagers claim sex education in schools is inadequate and focuses too much on biology instead of issues such as the emotional challenges of relationships, sexuality diversity, pleasure and consent.

This book presents the latest information on sexual and reproductive health for young people, and includes key survey findings and advice on a range of safe sex behaviours relating to teenage relationships, sexual pressures and consent, contraception choices, teen pregnancy and sexually transmitted infections.

The book sensitively explores the most effective approaches to sexuality education for parents, teachers and students. How can teenagers be encouraged to learn positive sex education in the digital age?

SOURCES OF INFORMATION
Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:
- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

CRITICAL EVALUATION
As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES
The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH
This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
Chapter 1: Young people and safe sex behaviours

Sexual and Reproductive Health of Young People

Fact Sheet Advice from Women’s and Children’s Health Network

Pregnancy, child birth and sexually transmitted infections are major health concerns for young people. In Australia, pregnancy termination (abortion) is the second most common hospital procedure for girls and young women aged 12 to 24 years. Contraception and sexual health problems are the most common issues for which young women see their family doctors. Young men seek help less frequently, but they also have concerns about sexual health, contraception and sexually transmitted infections.

Sexual behaviour of teenagers

- Teenagers tend to take risks because of their stage of development. Some take many more risks than others, but all may take risks with their health.
- Teenagers often take risks because they believe that they will not be harmed – they tend to think of themselves as immortal or invincible. They also like experimenting and want the approval of their friends.
- Teenagers generally do not understand how easy it is to become pregnant or to catch a sexually transmitted infection.
- Teenagers often have short-term relationships – if they are sexually active, the risk of problems arising is greater with a greater number of sexual contacts.
- They often do not follow safer sex guidelines, even when they know what to do, and why.

Contraception

- On average, teenagers do not seek information from a doctor about contraception until at least 12 months after they have started sexual activities.
- About 45% of sexually active teenagers in Australia do not use condoms most of the time (condoms can prevent the spread of many sexually transmitted infections, as well as prevent pregnancy).
- About 30% use only condoms, which can be less effective than some other forms of contraception.
- Half of adolescent pregnancies happen in the first six months of sexual activity.
- Teenagers are the most frequent users of emergency contraception.

Sexually transmitted infections

- Chlamydia infections are common in young people, and seem to be increasingly common.
  - Most infections with chlamydia do not cause symptoms, but the infection can cause pelvic inflammatory disease in women (PID), and go on to cause infertility (inability to have babies), chronic pelvic pain and ectopic pregnancy (where the baby develops outside of the uterus – a potentially life-threatening situation for the mother).
  - Chlamydia infections in males often do not cause
any symptoms, and can be passed on to women without the male knowing it.

- Gonorrhea is another sexually transmitted infection that is occurring more often.

**Teenage pregnancy**

- In South Australia in 2008, 885 teenage women gave birth and 864 teenage women had a termination of pregnancy (abortion).
- Young women who become pregnant in their teenage years are more likely to be single, smokers, to be living in areas that are socially disadvantaged, and to be using illicit drugs or alcohol – however, many pregnant young women do not fit this ‘stereotype’. Young aboriginal women are also more likely to get pregnant during their teenage years.
- Babies who are born to teenage mothers are more likely to be born early, have a low birth weight and have major health problems at birth.

**Prevention of high-risk sexual behaviour**

- Countries that have in-depth sexual health education programs (such as the Netherlands and some other European countries) have a lower rate of teenage pregnancy, terminations and sexually transmitted infections.
- Countries such as Australia, USA and Britain, where there is less comprehensive education about sexual health, have significantly higher rates of teenage sexually transmitted infections, teenage pregnancies and terminations.
- Many people strongly believe that teaching young people about contraception and safe sex promotes earlier sexual activity, but research evidence does not support this belief.
- Programs that also look at other risk behaviours, and that help young people to make safe choices and resist social pressures, seem most effective.
- Having easy access to contraceptive products is also seen as important.

**Going to a doctor or health clinic**

- Many young people find it difficult to talk about their sexual health needs, especially if they are not sure that the doctor will keep the visit confidential.
- There are youth health services in many areas, and sexual health is a very frequent reason for visits. At these clinics, confidentiality is very important.
- There are also clinics that specialise in sexually transmitted infections. They provide expertise and a very confidential service.
- In some regions (e.g. in South Australia), parental consent is needed for treatment of young people under 16 years of age.

**REFERENCES**

- Clinic 275 (Sexually Transmitted Diseases Clinic)  
- Department of Health, *Pregnancy outcomes in South Australia*.

This information should not be used as an alternative to professional care. If you have a particular problem, see a doctor, or ring a parent helpline.

This topic may use ‘he’ and ‘she’ in turn – please change to suit your child’s sex.

Women’s and Children’s Health Network.  
*Sexual and reproductive health of young people*.  
About Sexual Health

If you’re sexually active, it’s important to keep an eye on your sexual health. Get the facts on sexual health and why doctors’ visits are important. Find out what a sexual health check-up involves, including what to do if a check-up is making you uncomfortable. This fact sheet is courtesy of ReachOut.com

This may help if …

• You’re sexually active
• You’re worried you might have an STI
• You want info on visiting doctors for sex-related health issues.

What is sexual health?

When people think about sexual health, they mostly assume sexual health is about sexually transmitted infections or sexual dysfunction. They are definitely part of sexual health, but there’s more to it than that. Sexual health is about three things – safety, pleasure and respect. In other words, it’s about caring for yourself in sexual relationships.

Factors which are important to your sexual health:

• Good communication. It’s important that you feel comfortable discussing your sex life with your partner. Get tips on how to communicate effectively.

• Enjoyment. Both you and your partner should be working together to ensure that your sexual relationship is fulfilling.

• Respect. It’s important that sexual relationships are based on respect for each other’s needs, desires and value as a person.

• Consent. The person you’re with needs to be happy and comfortable with the sexual relationship you have. Non-consensual sexual activity is a crime, so make sure you understand the laws around consent.

• Minimising risk of pregnancy and STIs. Make sure you understand the risks of pregnancy and STIs in sexual relationships, and learn how to practise safer sex.

Sexual health checks

If you are sexually active, it’s important you visit a doctor regularly to have sexual health checks, even if you feel nervous about it. Remember that you’re not alone in feeling this way. At the check-ups, you’ll be able to discuss your sexual and reproductive health and rights issues.

Sexual health is about three things – safety, pleasure and respect. In other words, it’s about caring for yourself in sexual relationships.

Sexual health checks can involve:

• Tests – e.g. for sexually transmitted infections, pap smears (for women), or sexual dysfunction
• Discussing contraception – including long-term contraception options
• Reproductive issues
• Discussing your rights in sexual relationships.

Anyone who is sexually active should have sexual health check-ups, but how often and when depends on your lifestyle and sexual activity.

A sexual health check is really recommended if the following circumstances apply to you:

• If you think you might have an STI
• If you’ve had unsafe sex, including vaginal, oral and anal sex
• If a condom broke or fell off during sex
• If you or your partner have more than one sexual partner
• If you’ve shared injecting equipment
• If you’re at the start of a new sexual relationship.

Getting a sexual health check

Sexual health checks can be intimidating and scary. It can be hard to talk about sex with other people, and it can be even harder when you’re young.
Questions you could be asked

During a sexual health check you will probably be asked a number of detailed questions about your sexual history.

They might include:
- How many sexual partners you’ve had
- About the type of sexual activity you engage in
- Who you have sex with (men, women, or both)
- Whether you have any symptoms that could indicate a sexual health or reproductive problem.

As uncomfortable as it is sharing this kind of information with someone you don’t know very well, it’s important to answer any questions honestly; as it could impact on the types of tests or advice you’re given. Untreated STIs can lead to long-term health problems like infertility, organ damage or blindness.

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Tests that could be performed

With your permission, a health practitioner may also:
- Examine your external genital area for signs of STIs
- Take swabs of fluid or discharge on a cotton bud for examination under a microscope
- Ask you to provide a urine sample or blood test
- For women, perform a vaginal examination, such as a pap smear (a swab on the cervix inside your vagina to test for signs of cervical cancer).

Asking questions

It’s a great idea to ask any questions you have, including about any tests you have, confidentiality or about the impact any health issues may have on your life.

If a sexual health check is making you uncomfortable

Sexual health checks can be uncomfortable, awkward and embarrassing. It might not put all your concerns at ease, but it’s worth remembering that for a doctor or qualified health practitioner, sexual health checks are a normal part of their job. However, make sure you stay in tune with how you’re feeling. If you’re really uncomfortable with the practitioner, or you think they aren’t comfortable with the situation, you might like to see someone else.

WHAT CAN I DO NOW?

- Book an appointment with your doctor or local family planning clinic.
- Find out info about your healthcare rights.
- Get info on sexually transmitted infections (STIs) and what symptoms to look out for.

Early teenage relationships often involve exploring physical intimacy and sexual feelings. You might not feel ready for this, but you have an important role in guiding and supporting your child through this important developmental stage. A guide for parents from the Raising Children Network

About teenage relationships
Romantic relationships are a major developmental milestone. They come with all the other changes going on during adolescence – physical, social and emotional. And they’re linked to your child’s growing interest in body image and looks, independence and privacy.

Romantic relationships can bring lots of emotional ups and downs for your child – and sometimes for the whole family. The idea that your child might have these kinds of feelings can sometimes be a bit confronting for you. But these feelings are leading your child towards a deeper capacity to care, share and develop intimate relationships.

When teenage relationships start
There isn’t a ‘right age’ to start having relationships – every child is different, and every family will feel differently about this issue. But here are some averages:

- From 9-11 years, your child might start to show more independence from the family and more interest in friends.
- From 10-14 years, your child might want to spend more time in mixed gender groups, which might eventually end up in a romantic relationship.
- From 15-19 years, romantic relationships can become central to social life. Friendships might become deeper and more stable.

Many teenagers spend a lot of time thinking and talking about being in a relationship. In these years, teenage relationships might last only a few weeks or months. It’s also normal for children to have no interest in romantic relationships until their late teens. Some choose to focus on schoolwork, sport or other interests.

First crushes
Before your child starts having relationships, he might have one or more crushes. An identity crush is when your child finds someone she admires and wants to be like. A romantic crush is the beginning of romantic feelings. It’s about your child imagining another person as perfect or ideal. This can tell you a lot about the things that your child finds attractive in people. Romantic crushes tend not to last very long because ideas of perfection often break down when your child gets to know the other person better. But your child’s intense feelings are real, so it’s best to take crushes seriously and not make fun of them.

Talking about relationships with your child
Your family plays a big part in the way your child thinks about teenage relationships.

When you encourage conversations about feelings, friendships and family relationships, it can help your child feel confident to talk about teenage relationships in general. If your child knows what respectful relationships look like in general, she can relate this directly to romantic relationships.

These conversations might mean that your child will feel more comfortable sharing his feelings with you as he starts to get romantically interested in others. And the conversations can also bring up other important topics, such as treating other people kindly, breaking up kindly and respecting other people’s boundaries.

Having conversations with your child about sex and relationships from a young age might mean your child feels more comfortable to ask you questions as she moves through the early teenage period.
Discussing Sexual Health Issues in Society

attraction to someone else, the number of young people might develop bisexual attraction. This will mean realising they have same-sex attraction. A larger percentage of young people, the start of puberty will include same-sex attraction and experiencing this is a good first step. A big part of this is being clear about your own feelings about same-sex attraction. If you think you might have trouble being calm and positive, there might be another adult who can also find more information in our articles on tricky conversations and problem-solving with teenagers.

Sex and teenage relationships

If your child is in a relationship, it can bring up questions about sex and intimacy.

Not all teenage relationships include sex, but most teenagers will experiment with sexual behaviour at some stage. This is why your child needs clear information on contraception, safe sex and sexually transmitted diseases (STIs).

This could also be your chance to talk together about dealing with unwanted sexual and peer pressure. If you keep the lines of communication open and let your child know that you’re there to listen, he’ll be more likely to come to you with questions and concerns.

Talking with your child about sex and relationships won’t encourage her to start having sex before she’s ready. In fact, the opposite is true – comfortable, open discussions about sex can actually delay the start of sexual activity and lead to your child having safer sexual activity when she does start. You might like to read more in our article on sexuality and wellbeing in adolescence.

Sexuality develops and often changes over time. What happens in adolescence isn’t set in stone for the rest of your child’s life. She doesn’t have to label herself as ‘gay’, ‘straight’ or anything else. Exploration and experimentation with sexuality is normal and common – the most important thing is to be safe.

Dealing with break-ups in teenage relationships

Break-ups and broken hearts are part of teenage relationships. To make things worse, teenage break-ups might be played out in public – maybe at school, or online on social networking websites.

You might expect your child to be sad and emotional if his relationship ends. It might not seem this way at the time, but this is part of learning how to cope with difficult decisions and disappointments. Your child might need time and space, a shoulder to cry on, and a willing ear to listen. He might also need some distraction.

Active listening can help you pick up on your child’s needs. But if your child seems sad or even depressed for more than a few weeks after a break-up, it might be worth getting some advice from a health professional, such as your GP.

Extra help with teenage relationships

Many people and services can help you with support and information – in person, online or on the phone.

You could try:
• Your family doctor
• The school counsellor
• Your local community health centre
• Parentline – phone 132 289
• Sexual Health and Family Planning Australia – find the branch for your state or territory
• Relationships Australia.

Teenage relationships for children with special needs

A child with special needs has the same interest in – and need for information about – sex and relationships as other teenagers. Rates of sexual activity for young people with disability are the same as those for teenagers without disability.

Make sure your child has developmentally appropriate sex education at home and at school. Your health professional, local community resources and relevant support groups should be able to give you help or advice.

This article was developed in collaboration with the Centre for Adolescent Health, Royal Children’s Hospital, Melbourne.

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You have probably been in a situation where you have felt pressure to do something that you didn’t want to – maybe speak in front of a big crowd, or try something you didn’t want to try, like drugs and alcohol.

Having sex is also something that other people can try to pressure us into when we don’t want to. It is important to not be ‘bullied’ into anything that you are not comfortable with. This article will talk about pressure to have sex, and help you to manage difficult situations!

Important: If anyone forces you to participate in any sexual activity without your consent then it is an offence called rape. Tell someone who you can trust (counsellor, friend, relative, neighbour, teacher, parent) about what happened as soon as possible.

BEING INTIMATE WITH SOMEONE

Intimacy is not just about sex and genitals. You can be intimate with someone in many other ways, such as by talking and sharing personal information about yourself, like your feelings.

Being sexually intimate with someone should be an enjoyable and comfortable experience that makes you feel pleasure and happiness. It is a way of expressing your feelings in a physical way.

If you feel good about sexual intimacy in your mind and emotionally, then your body will feel better also.

Being sexually intimate is not just about sexual intercourse, it can mean being close/sexual at many levels. Having a physical relationship or being sexually intimate can make you feel much closer to someone. There are many ways that you can become close with someone other than sex, like talking honestly about your feelings.

Some sexual/physical intimate behaviour may include:

- Kissing
- Touching
- Stroking
- Hugging
- Massaging.

If you want to be sexually intimate with someone it is important that you think about what it is you are comfortable doing. You should only do what you want to do and feel ‘right’ about; you do not have to commit to anything. If you say you want to have sexual intercourse (or participate in any other sexual activity) and then decide that you don’t want to, you are allowed to change your mind – at any time, and that should be respected.

Being silent does not legally mean that you are consenting to sex – people can often become quiet or feel silenced when they feel anxious or scared. This is not the same as consent. It is an offence if someone forces you to have sex (or to participate in any sexual activity) against your will or without your consent.

It is against the law in South Australia to have sexual intercourse with someone under 17 years of age, even if both young people are under 17.

VIRGINITY

Depending on where you live and your culture, males and females can feel some pressure about whether they are a virgin or not. Virgin refers to someone who has not had sexual intercourse. In many cultures it is...
seen as a bad thing by some groups if a guy has not ‘lost’ his virginity because it is seen as ‘unmanly’ or not masculine. For women it is the opposite, with young girls being pressured to not ‘lose’ their virginity until they are married or at least in a serious relationship. These expectations are often pushed on young people by society and may influence your decision making about your sexual behaviour.

Your decision about having sex (or being sexually intimate with someone) should be about how safe and comfortable you feel, whether it is safe sex, how in control you feel over your actions and whether your partner is respectful of your needs/wishes.

**DOING WHAT YOU WANT TO DO**

You may have heard your friends talk about their sexual experiences and what sexually intimate things they have done – it does not mean that you have to do the same. You may not even be sure that they are telling the truth because many young people exaggerate this. Plus everybody is different and we all have different comfort levels. You may want to keep some things private and that is okay.

If you are with someone (in a sexually intimate way) and they ask you to do something you don’t understand – say no! Either just say no or ask them what they mean (if you feel comfortable to do this).

If you say no, you can then go and find out about it. It is a lot safer than saying yes to something that you don’t understand – you may not like it at all and it may not be safe.

Just because you are attracted to someone and want to be sexually intimate with them, does not mean that you have to want to do ‘everything’ with them (sexually). What you do with someone is not a sign of how much you like/love him or her, despite what some people might say! In fact, it is a sign of their ‘love’ for you that they respect your wishes.

**PRESSURE TO HAVE SEX**

If someone wants to be intimate/sexual with you and wants you to do things that you are not comfortable doing, they may try to pressure you into it.

There are many ways that a person could try and pressure you; some of them include the following:

- Telling you that if you really loved them, then you would do it.
- Telling you that they will ‘break up’ with you if you won’t do what they want.
- Blaming you for getting them aroused, and saying that they have to continue or they will get ‘blue balls’.
- Still doing what you have said you don’t want to do, by gradually easing into it.
- Trying to get you drunk or under the influence of drugs so that you do not have the ability to say no.
- Telling you that it is what other couples are doing and that you are not normal.
- Threatening to spread rumours that you are not “good in bed” or that you are frigid, or that you did it with them anyway.
- Offering a relationship to you if you will have sex with them.
- Saying that they won’t enjoy sex if they are ‘made’ to wear a condom.
- Saying “you have had sex with me before, what is the problem now?”
• By undressing themselves and undressing you anyway.
• Making you touch them when you don’t want to.
• Saying that other forms of sexual activity are not ‘real sex’ anyway so they don’t matter.

All of these are ways to try and manipulate you and they are not correct or healthy ways to relate.

Being aroused but not having sexual intercourse DOES NOT do any damage to the body.

HOW TO ASSERT YOURSELF
It is important to know how to handle these situations so that you do not get pressured into doing what you do not want to do. You will need to be assertive … here are some tips for what you could say.

What to say when he/she says …

“**You would do it if you really loved me.**”
• “If you really loved me you wouldn’t try to make me do anything that I don’t want to.”
• “I guess we have different ideas about love.”
• “Good point, I guess I don’t really love you.”

“I will break up with you if you don’t do that with me.”
• “You can’t make me do something by using threats.”
• “I guess we just broke up.”
• “I’ve just realised that I do want to break up with you.”
• “You don’t make me feel special and I am.”

“You’ve just got me aroused and now you won’t do it. You’ve given me blue balls – I need to have sex.”
• “You can’t force me by making me feel bad. I still don’t want to do it.”
• “There is nothing wrong with having blue balls, it can’t hurt you. I will feel worse if I do something that I don’t want to.”
• “It is not true that men have stronger sexual urges than women. That is just an excuse.”

“**Other couples do it. It is normal. Aren’t you normal?**”
• “There is no such thing as normal, and we are not other couples.”
• “How do you know other couples are doing it … do you believe everything you hear?”
• “No I am not normal, and neither are you.”
• “Happy couples don’t pressure each other into sex.”

“I’ll tell other people that you are no good in bed and that you are frigid.”
• “It was a good try attempting to pressure me into it, but it just won’t work.”
• “That is very immature. Anyone can spread stories.”
• “It’s unfair and uncaring and illegal to try to threaten me.”

“We can have a relationship if you have sex with me.”
• “No thanks, I am not that desperate for a relationship.”
• “That is not usually the way I like to be asked out. I think of myself as more than just a sexual being.”
• “You cannot force me to have sex with you by offering me things.”
• “No thank you, I am leaving now.”

“It won’t feel any good if you make me wear a condom.”
• “I am not going to make you wear a condom. We just won’t be having sex.”
• “It won’t feel any good if I get pregnant or if either of us gets a sexually transmitted disease like HIV/AIDS.”
• “Wearing a condom is not my responsibility. It is both of ours.”
• “I don’t want to have sex with you if this is your attitude.”

Some people may also try to get you drunk or under the influence of drugs so that you do not have as much control over what you are doing and saying. Be aware of what you are drinking. Try to have a trustworthy friend nearby looking out for you. Never leave your drink unattended, and pour your own from a can/bottle. Don’t let anyone mix your drinks for you. Have a look at the topic ‘Drink spiking’.

SEXUAL RIGHTS
You have sexual rights, which means you have the right to be in control of your body and to reject sexual exploitation. This means that you decide what happens with your body, not someone else! You have the right to change your mind at anytime!

General resources

> **Youth Say No**
A website from Western Australia that looks at date violence, www.youthsayno.wa.gov.au

> **The Sex-Fu challenge** is a fun game brought to you by the sexualityandu.ca website from Canada. Learn all about reproductive systems, safer sex and STIs. Are you skilled enough to take the challenge? www.sexualityandu.ca/en/games-and-apps/sex-fu-challenge

This information should not be used as an alternative to professional care. If you have a particular problem, see a doctor, or ring a youth healthline.

Women’s and Children’s Health Network.
MAKING CHOICES ABOUT SEX

Whatever choices you make about sex, it is important that you feel that they are the right choices for you, cautions the NSW Ministry of Health.

Making choices about sex is not always an easy or straightforward process. People have sex for all sorts of different reasons including:
• Are ‘horny’
• Are ‘in love’
• Want to lose their virginity
• Want to experiment
• Feel lonely
• Want to feel physical intimacy
• Fancy someone
• Want to feel emotional intimacy
• Were drunk or ‘out of it’
• Enjoy sex
• Like the person
• Feel pressure to have sex.

Sex should be a positive and enjoyable experience, yet sometimes sex can end up having a negative impact on your life and health. Be honest with yourself about what you want and the choices you make.

Sometimes sex and the choices we make aren’t always rational decisions. Lots of people say ‘sex just happened’. Often people talk about making choices in the ‘heat of the moment’. While we all learn from our experiences, thinking ahead may enable you to be more in control.

When you think about sex and making decisions about sex there are many things to consider.
• How do you feel about having sex?
• How does your partner feel about sex?
• What do your friends and parents think?
• Are you having sex with someone you feel safe with?
• How will you feel after sex?
• What contraception will you use?
• How will you prevent STIs?
• Do you need to talk to your partner about sex?
• What sort of sex are you prepared to have (oral, vaginal, anal, etc)?
• Why do you want sex?

You need to do what feels right for you. To feel better about the choices you make you can:
• Communicate with your partner. In any relationship between two people, communication is important. Communication can allow us to clarify our needs, feelings and wants and to also hear about those of our sexual partner. You can check if you are wanting the same things, and if your wants are different whether that is acceptable to you.

• Talk to friends and family. Friends and family may be able to provide good advice and support. Sometimes talking can help clarify how you are feeling. Make sure you talk to people who will respect your confidentiality and privacy.
• Be clear and honest about your own wants and desires.
• Seek out information. Have the facts about sex, STIs, condoms and contraception at hand so you can make well informed choices.
• Talk to a health care worker. There are many services specifically set up to help with sexual health issues.
• Be prepared. If you are planning to have sex make sure you have condoms and water-based lubricant available.

HAVING SEX FOR THE FIRST TIME

If you are just starting to become sexually active, remember staying in control can be tough but keep in mind that:
• Kissing or groping does not mean that you have to have sex
• Just because you have a boyfriend/girlfriend does not mean you have to have sex with them
• At any time during sex you can choose to stop if you no longer wish to continue
• Sex against your will is a crime, even if it is with somebody you know, and
• Sex has to be your choice – don’t let yourself be pressured or bullied.

Are you ready for sex? Your first sexual experience should be positive and safe, but how can you know if you’re ready for sex?
Here’s a checklist from the World Health Organisation of life skills that you need to keep yourself safe. Can you honestly say yes to each one?

• Can you make good decisions about relationships and sex and stand up for those decisions?
• Can you deal with the pressures for unwanted sex?
• Can you recognise a situation that might turn risky or violent?
• Do you know how and where to ask for help and support?
• Do you know what safe sex is and could you insist on condoms?

If you don’t feel sure about these things, you might not be ready to have sex. Delaying sex until you feel confident and comfortable will help you to make sure your first sexual experiences are safe and positive.

**ALCOHOL AND OTHER DRUGS**

Alcohol and other drugs can affect the decisions you make about sex and practising safe sex.

People like using alcohol and other drugs when out socialising. The reasons for this are varied but can include:

• A socially acceptable practice
• Makes you more social and friendly
• Enjoyable
• More likely to chat to people you find sexually attractive
• Your friends are all doing it
• Feel more in control
• Removes your inhibitions, and
• Frequently socialise in pubs, clubs or other places where alcohol is served.

Alcohol or other drugs can have negative effects on your sex life, and health more generally. Research shows alcohol and other drugs do affect the decisions people make about safe sex. Research also shows that people often state that they had unsafe sex because they were ‘drunk’ or ‘out of it’.

Alcohol and other drugs can lead to you making decisions you wouldn’t otherwise make. For example you may choose to have sex with someone you wouldn’t have otherwise chosen, you might not use a condom whereas you normally would, you may regret having sex at all. During sex it’s not uncommon for men to lose their erection after heavy drinking or taking other drugs.

**STAYING SAFE**

If you are having a night out and think you might have sex with someone, it is important you make a decision beforehand about what you want to do. Once you have made that decision you need to stick to it.

If you think you might have unsafe sex once you have been drinking or taking drugs then you need to consider not drinking or taking drugs or reducing your intake so that you can stay more in control.

If you choose to inject drugs, don’t share any injecting equipment including needles, syringes, swabs, filters, spoons, tourniquets, the mix, etc. Sterile syringes are available from pharmacies and Needle and Syringe Program outlets. The program is an anonymous and confidential service.

**HOW DO I KNOW IF MY PARTNER HAS AN STI?**

If there are no obvious symptoms then it is not possible to tell if someone has an STI, unless that person decides to tell you.

People can have an STI and not even know they do. This is one of the reasons why practising safe sex and seeing a doctor for a regular sexual health check-up is important.

Some people believe you can tell if someone has an STI based on the number of sexual partners they have, who they have sex with, if they dress well, or if they look ‘clean’ and ‘healthy’. These beliefs are incorrect and often reflect the values and biases of the person making the statement.

Unless there are obvious symptoms, there is no way you can tell if somebody has an STI by judging the way they look, their sexual behaviour or hygiene.

There is no one type of person who catches STIs. Anyone who is sexually active can be at risk of catching an STI.

**HOW SHOULD I NEGOTIATE SAFE SEX?**

If you want to practise safe sex, then there is a range of things you can do to make sure you stick to that decision.

• Make sure that you have a supply of condoms always available
• Ensure you know how to use a condom correctly
• Be clear about the reasons why you want to use a condom – your partner may have all sorts of arguments about why they don’t want to use them
• Talk to your partner about safe sex – so they are clear about your expectations
• Put the condom on
• Hand the condom to your partner and ask them to put it on
• Avoid alcohol or drugs if it is likely to weaken your resolve
• Make it clear to your partner that you won’t have sex if a condom is not used
• Make sure you choose a brand of condom that fits comfortably
• If your partner won’t use a condom, then engage in sexual acts other than intercourse
• Don’t let putting a condom on disrupt the flow, make sure they are nearby and easily within reach.

Your partner needs to respect your decision regarding safe sex – if they don’t then you need to consider how much they value you and your beliefs.
WHAT IS SEXUAL CONSENT?

Non-consensual activity is actually against the law, so be sure you understand what sexual consent is, with the help of this advice courtesy of ReachOut.com

Knowing why consent is important is really worthwhile when starting a sexual relationship. There are verbal and physical cues as well as things you can say if you want things to slow down or stop. When alcohol and drugs are involved it can be very difficult to give genuine consent, so the bottom line is to have a conversation and not to pressure someone if they don’t feel ready.

This might help if you ...
• Want to know more about consent
• You’re not sure how to tell if someone is consenting
• You want to know how to slow down or stop sexual intercourse.

When you have sex, you need to make sure that your partner is just as enthusiastic about having sex. In other words, that they give their full consent.

Why is consent important?
It’s important that you are 100% sure that the person you’re with is happy and willing because non-consensual sexual activity (even kissing and touching) is actually against the law.

Not only is sex without consent a crime, but being pressured or forced into a sexual situation you’re not ready for can do lasting emotional damage. It’s not enough to just assume someone wants sex as much as you, you really have to ask.

How do you know if the person you’re with has given their consent?
The only way to know for sure if someone has given consent is if they tell you. Sometimes the person you’re with might look like they’re happy doing something but on the inside they’re not.

One of the best ways to determine if someone is uncomfortable with any situation, especially with a sexual one, is to simply ask.

Here are some examples of the questions you might ask:
• Are you happy with this?
• Do you want to stop?
• Do you want to go further?

The look on someone’s face and their body language is also a way of communicating and often has more meaning then the words that come out of their mouth.

Ways you can tell if a person is not feeling sure about sex include:
• Not responding to your touch
• Pushing you away
• Holding their arms tightly around their bodies
• Turning away from you or hiding their face
• Stiffening muscles.

If you get a negative or non-committal answer to any of these questions or if your partner’s body language is like any of the above examples then you should stop what you are doing and talk to them about it.

Slowing things down
Taking your time, making sure you are both comfortable and talking about how far you want to go will make the time you spend together a lot more satisfying and enjoyable for both of you.

Some things you can say to slow things down if you feel that things are going too quickly:
• I don’t want to go any further than kissing, hugging, touching
• Can we stay like this for while?
• Can we slow down?

Stopping
You always have the right to say ‘no’ and you always have the right to change your mind at any time regardless of how far things have gone.

Below are some things you can say or do if you want to stop:
• No
• Say ‘I want to stop’
• Say ‘I need to go to the toilet’
• In a situation where the other person isn’t listening to you and you feel unsafe, you could pretend you are going to vomit (it’s...
amazing how quickly someone moves away from you if they think you are going to be sick).

When drugs or alcohol are involved
Drugs and alcohol can affect people’s ability to make decisions, including whether or not they want to be sexual with someone else. This means that if someone is really drunk or high, they cannot give consent. Being with them in a sexual way when they don’t know what’s going on is equal to rape, because they cannot give informed consent.

Drugs and alcohol can affect people’s ability to make decisions, including whether or not they want to be sexual with someone else.

The bottom line ...

The key to pleasurable sex for everyone involved is to know that you’re both as enthusiastic as each other. If you’re not sure, or it doesn’t feel right, don’t keep going. Don’t pressure someone if they don’t feel ready.

What can I do now?
• Always make sure that your partner is comfortable with what’s going on
• Make sure you talk to your partner before moving forward
• Don’t pressure someone if they don’t feel ready.

Legal age of consent in Australia

Why are there age of consent laws?
Age of consent laws are designed to protect children and young people from sexual exploitation and abuse. Such laws effectively determine that children and young people below the age of consent do not have the emotional maturity to consent to sexual activities.

In relation to sexual abuse charges in each state and territory, the key difference between child sexual assault and adult sexual assault is that adult sexual assault is based on the absence of sexual consent, whereas in child sexual assault, the issue of consent is superseded by age of consent laws (Eade, 2003). An important distinction should be made between ‘willingness’ and ‘consent’. A child may be willing to engage in sexual behaviour; however, as they do not have the psychological capacity to give consent according to law, all sexual interactions between an adult and a person under the age of consent are considered abusive (Barbaree & Marshall, 2006).

What is the legal age of consent in Australian state and territory jurisdictions?
The legal age for consensual sex varies across Australian state and territory jurisdictions. The age of consent is 16 years of age in the Australian Capital Territory, New South Wales, Northern Territory, Victoria and Western Australia. In Tasmania and South Australia the age of consent is 17 years of age. Queensland is the only state that makes a distinction between different forms of sexual activity and the age of consent. In Queensland, the age of consent for anal sex (referred to as sodomy in legislation) is 18 years of age, while the age of consent for all other sexual behaviour (described as carnal knowledge) is 16 years of age.

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SAFE SEX

BETTER HEALTH CHANNEL EXPLAINS
IN THIS FACT SHEET WHAT SAFE
SEX MEANS

Safe sex means having sexual contact while protecting yourself and your sexual partner against sexually transmissible infections (STIs) and unplanned pregnancy. Sexual contact that doesn’t involve the exchange of semen, vaginal fluids or blood between partners is considered to be safe sex.

Unsafe sex may put you or your partner at risk of STIs such as chlamydia, gonorrhoea, syphilis, HIV or hepatitis B, or may result in an unplanned pregnancy.

CONDOMS AND SAFE SEX

Condoms offer the best available protection against STIs by acting as a physical barrier to prevent the exchange of semen, vaginal fluids or blood between partners. Safe sex is also called ‘safer sex’ to highlight the fact that condoms and other barrier methods are not 100 per cent effective in preventing STIs. However, condoms do offer the best available protection when used correctly.

For vaginal, anal and oral sex, you should use condoms. Points to keep in mind include:

• The male condom is a fine, strong, latex-rubber sheath available in a variety of sizes and styles. Condoms made from polyurethane are available for people allergic to latex.
• The female condom resembles a regular condom made of polyurethane, but is designed to fit inside the vagina. The female condom is pre-lubricated and is ‘one size fits all’.
• You should use other barrier methods, for example, condoms on dildos and other penetrative sex toys, a latex glove for digital penetration of the vagina or anus, and a dental dam (a sheet of latex worn over the female genitals) during oral sex.
• Remember that a diaphragm (a cap worn high in the vagina to cover the cervix) offers good protection against pregnancy, but low protection against STIs.
• To be effective, condoms must be used from the start of sex to the very end.
• Always use a new, lubricated condom every time you have sex. Check the use-by date and open the packet, being careful not to tear the condom with fingernails, jewellery or teeth.
• If you need extra lubricant, use only water-based lubricants. Other lubricants can damage the condom.

EFFECTIVENESS OF CONDOMS

Condoms, even when used correctly, don’t guarantee 100 per cent protection against STIs or unplanned pregnancy.

Issues to consider include:

• Sex using a condom may still spread an infection if the condom does not fully cover the infected area. For example, some infections such as pubic lice, scabies, the genital wart virus and the herpes virus are spread by close skin-to-skin contact. Condoms provide some protection against these STIs, but not full protection.
• A condom may break, particularly if it has not been stored properly or the right lubricant has not been used. This is why you should always use water-based lubricant. Oil-based lubricants are associated with condom breakage and should not be used. Do not expose a condom to prolonged heat. Don’t use a condom that is past its use-by date. Don’t try to re-apply a used condom – they are designed for one use only.

OTHER TIPS FOR SAFER SEX

Safer sex is also about having sex when you and your partner are ready, and having sex that’s enjoyable, respectful and protected.

Ways that you can practise safer sex include:

• Having sex with only one partner, when neither of you has any STIs, is the safest way to have sex.
• Be STI-free by getting tested for common infections and having treatment if necessary, especially if you have a new partner. Avoid sexual contact until the doctor or nurse tells you that you are no longer infectious.
• Communicate with your sexual partner about what you want and enjoy sexually.
• Be aware that drugs and alcohol may affect your ability to make good decisions. Protect yourself from having sex that you might regret or were pressured into because you weren’t thinking properly.
• Use other types of contraception in addition to a condom to avoid unplanned pregnancy.

SAFE SEXUAL ACTIVITIES

Sexual contact that carries a low risk of STI transmission includes:

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Kissing, including open-mouthed kissing (also called deep or French kissing) if neither of you has a mouth sore and no blood is present
- Cuddling
- Massage
- Masturbation
- Mutual masturbation
- Ejaculating on unbroken skin
- Sexual intercourse using barrier contraception – such as a condom or female condom.

**HIGH-RISK OR UNSAFE SEXUAL ACTIVITIES**
Unsafe sex outside of a monogamous relationship increases your risk of getting a STI. Examples of unsafe sexual activities include:
- Having sex without a male or female condom
- Withdrawing the penis before ejaculation instead of using condoms (pre-ejaculatory fluid may be infectious and can also contain sperm resulting in pregnancy)
- Trying to re-use a condom or using a condom that is past its use-by date
- Using a condom incorrectly or continuing to have sex once the condom is broken
- Getting bodily fluids like menstrual blood, semen or vaginal fluids inside another person’s body (for example, mouth, vagina or anus).

**INCREASING THE RISK OF UNSAFE SEX**
Some of the factors that can make unsafe sex more likely include:
- Being drunk
- Using drugs
- Feeling pressured to have sex

- Alcohol consumption and drug use may increase risky behaviours such as unsafe sex and needle sharing.
- Sexually transmissible infections (STIs) were twice as prevalent among those who had used an illicit drug in the last 12 months or who reported having consumed more than 4 standard drinks on 1 occasion at least once a week (4% respectively compared with 2% of all 15-24 year olds).


**SAFE SEX MYTHS**
Some people believe, or may try to make you believe, all sort of myths about safe sex, including:
- Planning ahead for sex ruins the mood
- You can tell by the way someone looks that they do or don’t have an STI
- Practising safe sex implies that one of us has an STI
- Practising safe sex implies that one of us is an intravenous-drug user
- Lesbians don’t get STIs
- Taking the pill means I practise safe sex
- Condoms ruin the feel of sex
- Buying condoms is embarrassing.

**OVERCOMING BARRIERS TO SAFE SEX**
Safe sex doesn’t have to be a drag. Tips include:
- Be prepared for safe sex – it doesn’t have to be a passion-killer. Carry condoms in your wallet or purse and keep them handy at home, so that you don’t have to interrupt having sex to look for one.
If you find condoms reduce the pleasure that you or your partner experience, drop a bit of water-based lubricant in the tip of the condom for extra feeling and sensitivity.

Learn how to use condoms. They may take a little getting used to, but it’s better than catching an STI.

Involve condoms in foreplay – for example, apply a condom using your hands or mouth.

If you feel too embarrassed to buy condoms in a pharmacy or supermarket, buy them from vending machines in some public toilets, from mail-order sites or grab a handful from a community health centre or sexual health centre.

Hormonal contraceptives, such as the oral contraceptive pill, only provide protection against unplanned pregnancy. They provide no protection against STIs.

Prioritise your sexual health – it is important.

Don’t think you can tell if someone has an STI just by looking at them. Most STIs don’t have any obvious signs.

Educate yourself about STIs. Anyone who has sex is at risk.

Be mature about STIs and reassure yourself and your partner that an STI is not a moral judgement of character, but an infection like any other. Having an STI does not mean that you are ‘dirty’ or ‘cheap’.

Have STI tests if you are in a relationship and you want to have sex without a condom. Both partners should be tested. Think of STI testing as a sign of respect for each other.

WHAT TO DO IF YOU HAVE UNSAFE SEX
If you have had unsafe sex, you should:

Avoid vaginal or rectal ‘douching’ (washing out or irrigating these areas with water or other fluids) as the irritation to delicate tissues could increase the risk of infection

Make sure you are not at risk of pregnancy.

Consider taking the emergency contraceptive pill (within 72 hours is best, but it can be taken with 120 hours of unprotected sex or a broken condom if no other form of contraception was used)

See your doctor promptly for testing

Consider post-exposure prophylaxis (PEP) to prevent HIV, if you are a man who has had unprotected anal intercourse with another man. Call the PEP line to assess whether you require post-exposure prophylaxis.

WHERE TO GET HELP

Your doctor

Family Planning Victoria
Tel. (03) 9257 0100 or 1800 013 952

Family Planning Victoria Action Centre (for people under 25) Tel. 1800 013 952 or (03) 9660 4700

Melbourne Sexual Health Centre
Tel. (03) 9341 6200 or 1800 032 017 or TTY (03) 9347 8619

Women’s Health Information Centre (WHIC) Tel. (03) 8345 3045 or 1800 442 007

Connect Line – HIV and Sexual Health Line Tel. 1800 038 125

PEP Line 1800 889 887 (for advice on post-exposure prophylaxis (PEP) to prevent HIV).

THINGS TO REMEMBER

‘Safe sex’ is sexual contact that doesn’t involve the exchange of semen, vaginal fluids or blood between partners.

If used correctly, condoms can dramatically reduce the risk of most sexually transmissible infections (STIs) and unintended pregnancy.

Having regular STI screening and reducing the number of sexual partners also reduces the transmission risk of STIs.

This page has been produced in consultation with and approved by Melbourne Sexual Health Centre.

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CONTRACEPTION CHOICES
A GUIDE FROM SEXUAL HEALTH AND FAMILY PLANNING AUSTRALIA

What is contraception?

Contraception means prevention of pregnancy. There are a number of different methods and it is important to choose one that best meets your needs and circumstances.

Considerations when choosing contraception should include accurate information about:

- Effectiveness in pregnancy prevention
- Health issues which may limit some choices
- Ease of use
- Side effects including changes to usual periods
- Benefits other than contraception
- Cost and availability
- Reversibility
- Protection against sexually transmissible infections (STIs).

The most effective reversible methods are the “fit and forget” long-acting reversible contraceptives (LARCs) – intrauterine devices (IUDs) and contraceptive implants.

IUDs and implants:

- Are suitable for women of any age
- Can be used by most women, even if they have any significant health issues
- Can be removed easily at any time by a trained health professional and are immediately reversible on removal
- Involve an insertion and removal procedure by a doctor or nurse
- Provide no protection against STIs.

IUDs include a hormone releasing device or copper devices.

The copper intrauterine device (Cu-IUD) is a small device made from plastic and copper that is fitted inside the uterus. They stop sperm from reaching the egg and any fertilised egg from sticking to the wall of the uterus. They have no hormones and therefore have no effect on the normal female cycle but periods may become heavier when using a copper IUD. Cu-IUDs are 99.2% effective.

IUDs need to be replaced every 5-10 years depending on their type or can be removed easily at any time.

The contraceptive implant – Implanon NXT® is inserted directly under the skin, on the inner arm above the elbow, where it continuously releases a low dose of a progestogen hormone into the blood stream over a 3 year timeframe.

The implant works by preventing ovulation (egg release from the ovary). Devices need to be replaced every 3 years or can be removed earlier if required. Using an implant will change a woman’s usual bleeding pattern – for some women this will mean little or no bleeding at all but about 1 in 5 women have irregular or persistent bleeding. Implants are 99.9% effective.

Contraceptive injections – Depot medroxyprogesterone acetate (DMPA) is given by an injection into a muscle every 12 weeks. It prevents pregnancy by stopping ovulation. Periods may stop while using DMPA and there may be a short delay in return to usual fertility. DMPA is 94-99.8% effective.

Shorter acting hormonal methods include the contraceptive vaginal ring – NuvaRing®; the Combined oral contraceptive pill (The Pill) and the Progestogen-only contraceptive pill (mini pill).

A regular prescription is needed for hormonal methods of contraception. None of these methods provide protection against STIs. Some women can’t use the combined pill or ring because of health conditions or side effects.

All three methods are 91-99.7% effective.

The contraceptive vaginal ring – NuvaRing® is a soft plastic ring which slowly releases low doses of two hormones, oestrogen and a progestogen. These hormones are like those used in the combined oral contraceptive (‘the Pill’). The ring is self-inserted and remains in the vagina for three weeks and then removed and replaced with the next ring a week later.

Combined oral contraceptive pill (the COC Pill) commonly referred to as “The Pill”, is an oral contraceptive taken daily. It contains the hormones oestrogen and a progestogen. These hormones are similar to those naturally produced by the female body. The pill may help with acne or heavy periods. Pills rely on regular and consistent daily use to be effective.

Progestogen-only contraceptive pill (POP) sometimes referred to as ‘The Mini-Pill’ is an oral contraceptive taken daily. It contains a low dose of progestogen, similar to those naturally produced by the female body. The POP can be used by most women, even if they have any significant health issues. Pills
Condoms are the only method that offers protection from both unintended pregnancy and STIs.

The male condom is a sheath made of latex or polyurethane, which is rolled onto the erect penis before sex. The male condom is 82-98% effective for pregnancy prevention and consistent use is very important if they are the sole method of contraception. Condoms can be used in conjunction with other methods to increase contraceptive effectiveness.

The female condom is a polyurethane sheath, which is inserted into the vagina before sex. It has two flexible rings to keep it in place in the vagina. The female condom is 79-95% effective.

The diaphragm is a soft, dome-shaped silicone cap with a flexible rim, which is placed in the vagina before sex to cover the cervix and stop sperm getting into the uterus. A diaphragm should be fitted for the right size by a doctor or nurse and instructions provided on how to use it. The diaphragm is 88-94% effective.

Other methods include: Lactational amenorrhoea method (LAM), Fertility awareness-based methods (FABMs) and withdrawal. In typical use these are less effective than other methods.

LAM is the use of breastfeeding as a contraceptive method. Breastfeeding reduces the probability of ovulation (egg release) occurring, therefore reducing the chance of a pregnancy.

LAM is 98% effective when all 3 criteria are met:
- Menstrual periods have not returned
- Gave birth less than 6 months ago
- Fully breastfeeding (not feeding the baby with any food or milk supplements).

FABMs do not rely on the use of hormones or devices. FABMs include any method based on the identification of the fertile phase of the menstrual cycle to indicate when sexual intercourse should be avoided to prevent pregnancy. FABMs are 75-99.6% effective and require specific education from experts in this field.

Withdrawal is where the man takes his penis out (withdraws) from the woman's vagina before he ejaculates (comes). It is also known as coitus interruptus. Withdrawal is 78-97% effective and is not recommended as a reliable form of contraception.

Emergency contraception (EC) can reduce the risk of unintended pregnancy after unprotected sex.

EC is not a method of regular contraception. Using a reliable form of contraception is the best ongoing protection against unplanned pregnancy.

There are two types of EC – the emergency contraception pill (ECP), a pill containing a progestogen hormone and the Cu-IUD.

The ECP can be taken up to 5 days after unprotected sex but it is most effective if taken in the first 24 hours. When taken in the first 72 hours (3 days), it prevents about 85% of expected pregnancies.

A copper intrauterine contraceptive device (Cu-IUD) can also be used as EC. When inserted in the first 120 hours (5 days) after sex, it prevents about 99% of expected pregnancies. A Cu-IUD then provides immediate and ongoing contraception.

Permanent contraception (sterilisation) for men or women involves a small operation by a surgical doctor with general or local anaesthesia.

Sterilisation is permanent contraception which can't be reversed. Sterilisation methods are 99.5% effective.

Female sterilisation (tubal ligation) involves an operation blocking the Fallopian tubes to stop the passage of the ovum (egg). It is usually performed with a general anaesthetic.

Male sterilisation (vasectomy) involves an operation on the vas deferens to prevent sperm formed in the testes from joining the ejaculate fluid. It can be performed under local anaesthetic, often with light sedation.

This fact sheet gives an overview of the various methods available in Australia. Detailed information about all of these methods is available on the websites and at the clinics of the sexual health and family planning organisations in each state and territory.

**DISCLAIMER**

Sexual Health & Family Planning Australia has taken every care to ensure that the information contained in this publication is accurate and up-to-date at the time of being published. As information and knowledge is constantly changing, readers are strongly advised to confirm that the information complies with present research, legislation and policy guidelines. SHFPA accepts no responsibility for difficulties that may arise as a result of an individual acting on this information and any recommendations it contains. Version 1, May 2013.
SEXUALLY TRANSMITTED INFECTIONS

MYDR EXPLAINS THE MAJOR TYPES OF STI’S AND HOW TO AVOID THEM

WHO IS MOST AT RISK OF STIs?

Sexually transmitted infections (STIs) or sexually transmitted diseases (STDs), once called venereal diseases, are among the most common of the contagious diseases. As the name of this group implies, these infections can be contracted through vaginal, anal or oral sex. You may be at high risk of an STI if you have (or have had):

- Many sexual partners
- Sex with someone who has had many sexual partners, or
- Sex without a condom.

You are also at high risk for some of these diseases – notably HIV/AIDS and hepatitis B – if you share needles when injecting intravenous drugs.

DIFFERENT TYPES OF STIs

Bacterial STIs include:

- Chlamydia
- Gonorrhoea, and
- Syphilis.

Viral STIs include:

- HIV/AIDS
- Genital herpes
- Genital warts, and
- Hepatitis B (this is often not classed as an STI as sexual contact is not the main way hepatitis B is spread).

Other STIs include:

- Trichomoniasis – caused by a single-cell parasite.

HOW DO STIs SPREAD?

The microbes that cause most STIs are found in semen, blood, vaginal secretions and sometimes saliva. Most of the organisms are spread by vaginal, anal or oral sex, but in some cases, such as genital herpes and genital warts, they may be spread through skin-to-skin contact.

WHY IT’S IMPORTANT TO IDENTIFY STIs EARLY

Some common STIs can cause long-term complications affecting fertility and general health, and many STIs are easily passed on through sexual contact. It is therefore important to detect sexually transmitted infections in their early stages where possible, so that prompt treatment can begin and further spread can be prevented. The following is an indication of some of the symptoms of these diseases. Always contact your doctor if you suspect you have an STI.

SYMPTOMS OF SPECIFIC STIs

**HIV (human immunodeficiency virus) infection**

Soon after infection with HIV, the person may develop a flu-like illness with symptoms that can include headache, tiredness, fever, night sweats, sore throat, swollen lymph glands, diarrhea and rash. Doctors call this a ‘seroconversion illness’, and it can happen from a few days to 10 weeks after HIV infection.

Most people recover from the seroconversion illness within a few weeks and will be seemingly well for a varying length of time. However, during this period HIV progressively damages the immune system until it is depleted enough that the patient develops AIDS – acquired immunodeficiency syndrome. The period in which the person is infected with HIV but has not yet developed AIDS lasts an average of 10 years in adults but varies considerably.

In the months or years before someone with HIV develops AIDS, they may feel tired, lose weight, have stubborn yeast infections or skin rashes, lose their short term memory or have frequent fevers. When AIDS has developed, the person may develop a range of unusual, severe infections affecting a number of organs. Unusual cancers can also occur in people with AIDS.

**Chlamydia**

In women chlamydia can cause a white vaginal discharge, a burning sensation when urinating, itching, painful intercourse, or vaginal bleeding that happens after sex or is not related to menstruation. Men with chlamydia can develop a clear, watery discharge from the penis.

However, often chlamydia causes no symptoms. Even so, chlamydia infection can spread from the cervix to the uterus (womb) and fallopian tubes (these carry the egg from the ovary to the uterus) in women, resulting in pelvic inflammatory disease. Pelvic inflammatory disease can damage the fallopian tubes, leading to abdominal
pain, fertility problems or ectopic pregnancy (when the embryo lodges and grows in one of the fallopian tubes rather than in the uterus).

In men, chlamydia can spread from the penis to the prostate and the tubes that store and carry sperm – this can lead to fertility problems or long-term pain.

**Genital herpes**

Genital herpes causes itching, burning in the genital area, discomfort when urinating, a watery vaginal or urethral discharge and weeping, fluid-filled eruptions in the vagina or on the penis. However, many people with genital herpes do not notice symptoms at all.

**Genital warts**

People with genital warts may notice soft, cauliflower-like growths appearing either singly or in clusters in and around the vagina, anus, penis, and/or scrotal area. However, it is much more common to be infected with a genital wart virus (also called human papilloma virus or HPV) yet have no symptoms.

There is a close relationship between some types of genital warts and cervical cancer. The majority of women with a genital wart virus will not develop cervical cancer. Nevertheless, you should have regular Pap smears to make sure your cervix is healthy and talk to your doctor about whether you are eligible for vaccination that protects against the wart viruses most closely linked with cervical cancer.

**Gonorrhoea**

In women, gonorrhoea can cause frequent and painful urination, a cloudy vaginal discharge, vaginal itching, inflammation of the pelvic area, rectal discharge, or abnormal vaginal bleeding. Often, however, symptoms are absent or so mild that they are mistaken for those of a bladder infection.

In men, gonorrhoea can cause burning pain while urinating, painful or swollen testicles or a yellowish, white or green discharge from the penis. However, gonorrhoea may not cause any symptoms at all.

Untreated, gonorrhoea can lead to infertility in both men and women, and ectopic pregnancy in women.

**Pelvic inflammatory disease (PID)**

Pelvic inflammatory disease occurs when a woman’s uterus, fallopian tubes and ovaries become inflamed due to infection (usually with chlamydia or gonorrhoea, although pelvic inflammatory disease is not always due to a sexually transmitted infection). Symptoms of pelvic inflammatory disease include a yellow or green vaginal discharge that smells unpleasant, abnormal vaginal bleeding, fever, nausea and vomiting and lower abdominal pain. However, some women with pelvic inflammatory disease do not have any symptoms.

If pelvic inflammatory disease damages the fallopian tubes (these carry the egg from the ovary to the uterus), there can be complications such as infertility, ectopic pregnancy (when the embryo lodges and grows in the tube rather than in the uterus) and pelvic pain.

**Syphilis**

Syphilis usually first causes a painless sore on the genitals or anus, but sores are also possible in the mouth or inside the vagina or rectum, where they are not easily seen. There may also be swollen lymph nodes (lymph glands). This stage is called primary syphilis. Many people with a syphilis sore are unaware of it, increasing the risk of them unwittingly passing the infection on. (Syphilis is spread through direct contact with a sore.) Although the sore will heal by itself, without treatment the person may develop secondary syphilis up to 2 months later. Secondary syphilis can cause weight loss, fever, rash (often on the palms and soles), patchy hair loss, sore throat, headaches, muscle pains and tiredness.

The final stage of syphilis, tertiary syphilis, can occur many years after symptoms of secondary syphilis disappear. In this stage there can be blindness, dementia, problems coordinating movement, numbness and paralysis. Tertiary syphilis can be fatal.

**Trichomoniasis**

Trichomoniasis is caused by a single-cell parasite that is transmitted sexually. In women, trichomoniasis usually causes vaginal itching and pain with a foamy, greenish or yellow foul-smelling discharge.

Men with trichomoniasis may have a clear discharge from the penis, irritation of the urethra or a burning sensation after urinating or ejaculating, but most men with trichomoniasis do not have any symptoms.

**REFERENCES**


Sexual development is a normal part of young adulthood; however, not all young Australians practice safe sex (Smith et al. 2009). Sexually transmissible infections can cause significant long-term health problems and are a major public health concern (DoHA 2010).

In 2012, there were 57,119 notifications of chlamydia, gonorrhoea, syphilis and donovanosis among 15-24 year olds – a rate of 1,853 notifications per 100,000 young people (Department of Health 2013). More than half (around 57%) of all sexually transmissible infections notified in Australia were among 15-24 year olds. Chlamydia was the most commonly notified infection in this age group, accounting for about 90% of these notifications.

From 1991 to 2012, chlamydia notification rates increased over tenfold from 104 to 1,663 notifications per 100,000 young people. Increased testing may account for some of the increase (AIHW 2011b). Gonorrhoea notification rates also rose (from 38 to 178 per 100,000). In contrast, syphilis notification rates fell between 1991 and 2005 (from 25 to 11 per 100,000), and have remained relatively stable since (12 per 100,000 in 2012) (Figure 6.17).

In 2012, there were 154 HIV notifications for 15-24 year olds, a rate of 5 per 100,000 young people, higher than the 3 per 100,000 in 2001 (AIHW analysis of Australian HIV Public Access Dataset). One way of avoiding sexually transmitted infections is the use of condoms, which is also effective in preventing unwanted pregnancies. But in 2008, a survey reporting on sexually active students found only an estimated two-thirds of students reported using condoms at their last sexual encounter. Half of students reported using the contraceptive pill, 10% used the withdrawal method to avoid pregnancies, and 8% the ‘morning after’ pill (some students reporting using more than 1 form of contraceptive). In the same survey, only half (51%) of sexually active young people said they had always used a condom in the previous 12 months, and 43% said they sometimes used one (Smith et al. 2009).

Over the last 10 years rates of births to teenage girls have remained stable. In 2012, the rate of women aged 15-19 giving birth was 16 births per 1,000 women compared with 17 in 2002 (ABS 2013d). However, little is known nationally about the total number of pregnancies to teenage mothers as the number of pregnancy terminations is not known.
Teenage pregnancy is generally defined as a pregnancy in a woman who is 19 years of age or under. Teenage pregnancies in Australia have decreased considerably over the last four decades. This drop is due to increased availability of contraception, access to abortion and a change in educational and career opportunities for women. Internationally, Australia’s teenage fertility rate is substantially less than the United States of America and the United Kingdom but more than European countries like Switzerland and the Netherlands.

It is often assumed that all teenage pregnancies are accidental but this is not always the case. Some teenagers actively plan to become pregnant or don’t use contraception, knowing that pregnancy is a real possibility.

**Who is at risk of teenage pregnancy?**

There are a number of risk factors for teenage pregnancy.

- Family situations with regular conflict between members
- Violence and sexual abuse in childhood
- Unstable housing arrangements
- Poor school performance
- Poor school attendance
- Low socioeconomic background
- Family history of teenage pregnancies
- Low maternal education
- Father’s absence
- Low self-esteem
- In a relationship with an older partner
- Aboriginal or Torres Strait Islander
- Living in rural and remote areas

**Health implications for teenage mothers**

Teenagers have higher complication rates both during pregnancy and delivery. In teenagers under 15 years of age, these complications can be caused by biological immaturity. At this age girls have an underdeveloped pelvis which can cause difficulties during childbirth.

Teenager mothers often delay finding out if they are pregnant and, therefore, often do not receive adequate antenatal care. Poor antenatal care is a major contributing factor to pregnancy and birth complications. For example, during pregnancy women are screened for a number of conditions such as high blood pressure. Screening for these conditions means they can be addressed early, limiting their impact. If women are screened late in their pregnancy or not at all, it can lead to complications for both mother and baby.

Poor eating habits (skipping meals, dieting and eating more fast food) common in teenage girls can place them at risk of nutritional deficiencies due to the added dietary requirements during pregnancy.

Teenage mothers have a higher risk of postnatal depression than older women. This is most likely due to a number of factors including a lack of support, isolation from peers and/or family, financial pressures and societal attitudes.

**Socio-economic implications for teenage mothers**

One of the most important long-term implications for teenage mothers is not completing their education. This lack of education can result in long-term unemployment or job options that are poorly paid in confirming the pregnancy can impact on the type of termination available (i.e. medical abortion, where available, is only performed for pregnancies of less than 9 weeks).
and insecure. Being dependent on welfare or on a poorly paid job can place teenage mothers under greater financial pressure. In addition to the emotional stress that not having enough money brings, a low income often means living in poor housing and being unable to afford adequate health care or even basic necessities.

Teenage mothers may also experience alienation from their peers and family. In addition, a pregnancy can place a great deal of strain on young relationships. Consequently, 60% of young mothers do not have a male partner when their baby is born. Loneliness and financial dependence can make teenage mothers vulnerable to becoming involved in unhealthy relationships (e.g. domestic violence situation).

Unfortunately, there is also still a stigma in society attached to being a teenage mother. This stigma can affect the way a teenage mother feels about her parenting abilities, motherhood in general and even herself as a person. Negative attitudes towards young mothers can erode their self-esteem and feelings of self-worth.

**Implications for the baby**

As discussed above, inadequate antenatal care and/or exposure to tobacco smoke, alcohol and drugs can all impact on the unborn baby. Miscarriage, premature birth, low birth weight and birth defects can occur as a result.

Children born to teenage mothers are also more vulnerable to neglect. This is due to a range of factors including poverty, parenting experience, social isolation and being in an unhealthy relationship (e.g. domestic violence situation). They are also more likely to become teenage parents themselves.

**Support for teenage mothers and their babies**

Ensuring that young women receive adequate antenatal care is a very important step in improving the health of teenage girls and their babies. If they enter antenatal care in the early stages of their pregnancy they can be properly monitored and any health issues addressed.

Although educational policies aim to ensure that pregnant students and young parents are not disadvantaged, in reality many girls do not feel supported by the school environment and so stop attending. Some schools, however, have devised special programs that actively support teenage mothers to continue their education. In Queensland this includes Mabel Park State High School and Burnside High School and in New South Wales, Plumpton High School, which was also the subject of an ABC documentary.

There are also a range of community-based organisations that provide support to young mothers.

**Preventing teenage pregnancies**

Research suggests that knowledge about reproductive matters (i.e. sex education) and access to contraception, including emergency contraception are vital in preventing teenage pregnancies. Teenage girls often use contraception sporadically. While this can be due to a lack of understanding about the chances of pregnancy, it is also due to a lack of skills to successfully negotiate safe sex, particularly with a new and/or older partner.

As evidenced by the risk factors for teenage pregnancy (see ‘Who is at risk?’) it is clear, however, that much broader issues than just sex education and contraception are required to prevent teenage pregnancies. Protection from violence and abuse, family support, affordable housing, improved school retention, building self esteem and better educational and vocational opportunities are all required.

**REFERENCES**

5. Queensland Health. ibid.
7. Queensland Health. ibid.

**FURTHER INFORMATION**

- Australian Bureau of Statistics www.abs.gov.au Check for the latest publication of Births, Australia which provides statistics on births to teenagers.

This fact sheet was revised by Kirsten Braun and the Women’s Health Queensland Wide (Women’s Health) Editorial Committee in 2011.

Sex education – talking to young people

Research shows that talking to young people about sex does not encourage them to experiment sexually. This fact sheet advice is courtesy of the Better Health Channel.

Sex education in schools

In Victoria, sexuality education is a compulsory part of the school curriculum and parents are encouraged to contact their child’s school if they want more information about the school’s program. Parents may wish to enquire about whether or not the program is pro-choice and if it delivers sex-positive messages.

Research shows that school-based sexuality education improves the sexual health outcomes of young people. Sexuality education is a way of providing children and young people with the skills and knowledge to manage their sexual wellbeing, and can provide the fundamental tools so they can enjoy healthy, responsible and satisfying sexual lives.

How and when to start sex education

It is normal to feel awkward or unsure when talking with your child about sex. Most adults feel this way when they start having these conversations, but you will become more confident with time and practise.

The easiest way is to start from a young age by using the correct names for body parts. It is important to answer your child’s questions honestly and directly when they come up. You are not expected to have all the answers. If you cannot answer a question, you can suggest finding the information together.

Preparing yourself for talking about sex

The first step in talking to your child about sexuality is to prepare yourself. You are not alone if you feel unsure, as many adults have not had comprehensive sexuality education.

Ways to prepare yourself for talking with your child about sex include:

- Talking about the topic with your partner or other adults
- Deciding what values and messages you want to communicate
- Reading about current sexual issues
- Organising a parent information session for you and your friends through Family Planning Victoria
- Accepting that your child could have different views to your own
• Remembering that the aim is to talk openly and honestly about the topic
• Finding developmentally appropriate books to read with your child.

A positive approach to sexuality
The best sexuality education is ‘sex positive’. This involves:
• Acknowledging that young people choosing to be, or not to be, sexually active is a normal and healthy part of adolescence
• Recognising that adolescence is a time of sexual development and experimentation supporting the right of young people to develop healthy, respectful and consensual sexual relationships
• Talking about sexual preferences in a positive way.

Try to use everyday moments as opportunities to start talking about sex. Television shows, news stories and radio topics can all be great starting points. Try asking your child, ‘What do you think about that?’ or ‘Do you agree with what they said?’

How to talk about sex
Sexuality education is a lot more than the biology of reproduction. It also involves:
• How to have a good, respectful relationship
• Sexual feelings
• Sexual pleasure
• Personal values and beliefs about sexual relationships
• Gender roles
• STIs
• How to have safer sex
• Contraception, including emergency contraception (the ‘morning after pill’)
• Ways to be intimate without having sexual intercourse
• Sexual problems
• Sexual preferences
• How to say ‘no’ to unwanted sex and what to do if it happens
• What to do if you get pregnant.

Contraception
It is important to talk with your child about contraception and how to practise safer sex. The reasons some young people do not use contraception include:
• Lacking knowledge
• Feeling unsure about how to access clinical services
• Worrying that their parents could find out
• Thinking that using contraception means they are promiscuous
• Thinking that planning for sex takes away the spontaneity
• Being under the influence of alcohol and other drugs.

Gender roles
Gender roles are a key part of sexual relationships. Young people learn about adult relationships by watching how their parents interact, which can then influence their own sexual relationships.

Young people need to learn that in a relationship, contraception is the responsibility of both partners. Young men and women should be given accurate information about contraception, STIs and unplanned pregnancy to help them make informed decisions.

Making decisions about sex
Young people need to learn how to negotiate sexual experiences positively and responsibly. Ways to help your child make safe and informed sexual decisions include:
• Giving them correct and clear information about contraception, safer sex and STIs
• Encouraging them to talk about sex and its consequences with their partner
• Coming up with ways to deal with unwanted sexual pressure, including peer pressure
• Encouraging them to find answers to their questions about sex by directing them to reliable sources of information
• Making sure they understand how important it is to practise safer sex (such as using condoms)
• Always keeping the lines of communication open.

Ground rules at home
Most young people experiment sexually at some stage, and not allowing them to have sex at home will not stop them from having sexual experiences. You will need to decide on the ground rules about sexual behaviour in your home, which could include whether or not your child is allowed to have their partner in their bedroom or to stay the night. The best time to decide on these rules is when you are talking openly about sex.

Things to remember
• It is normal to feel awkward or unsure when talking with your child about sex.
• Young people need accurate information about sex to negotiate sexual relationships safely and responsibly.
• Sexuality education should cover a broad range of topics, including the biology of reproduction, relationships, making decisions, sexual preferences, contraception and STIs.
• The most influential role models for young people are their parents.

This has been produced in consultation with, and approved by Family Planning Victoria.

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HOW IS OUR SEXUALITY EDUCATION MEETING STUDENTS’ NEEDS?

Anne Mitchell and Pamela Blackman report in this Education Today article on results of the fifth National Survey of Australian Secondary Students and Sexual Health

A national survey of the sexual health of Australian secondary students has been carried out approximately every five years since 1992, each survey wave funded by the Australian Government Department of Health in order to provide accurate information to guide the work of health and education personnel.

Researchers at The Australian Research Centre in Sex, Health and Society at La Trobe University in Melbourne again collected data in 2013 to gain an accurate picture of the sexual attitudes, knowledge and experiences of Australian young people. This research has been widely used in the past and will be relied upon again to guide curriculum and program development in this important area of health education, particularly resources supporting the new Australian Curriculum in Health and Physical Education.

Over the years it has documented some important changes in the social and sexual worlds of young people. Each time a balancing takes place between existing and new questions. In this iteration new questions were added about use of the internet, technology, and social media; attitudes toward fertility, reasons for virginity and experiences with sexuality and relationship education at school. In addition to Year 10 and 12 students, Year 11 students were also asked to participate for the first time since 1992, providing more detailed information about young people’s sexual practices between the ages of 16 and 19.

A total of 2,136 students from 436 government, Catholic and independent schools in all states and territories completed the survey. The majority of the students were recruited through schools but 36% of the final sample was recruited online. In 2013 61% of the participants were female and 39% male.

SEXUAL BEHAVIOUR

Levels of sexual activity were not vastly different from those found in previous surveys. Most students (69%) had experienced some form of sexual activity. Sixty-eight per cent of the sample had experienced deep kissing; approximately 50% sexual touching, and over one-third of the sample had given or received oral sex. Thirty-three per cent of students reported having had sex with a condom and 24% without a condom. Finally, only 9% of the sample reported having had anal sex. It is important to note that, while most of the students are to a degree sexually active, around 30% have had no sexual experience at all. The challenge of accommodating the range of needs these data demonstrate remains a significant one for school programs.

Although most students who reported having had intercourse had only one sexual partner in the past year, a substantial proportion (39%) of students reported having sex with more than one person. A higher proportion of young men (28%) than young women (20%) reported having sex with three or more people in the past year.

Students were asked what forms of contraception, if any, were used at their last sexual encounter. Sexually active students most commonly used a condom (58%) and/or the contraceptive pill (39%) the last time they had sex. Fifteen per cent of sexually active students reported using the withdrawal method at their last sexual encounter. Emergency contraception was not widely used with only 4% of students having accessed it.

Condom use was not generally consistent, only 43% of sexually active students reported ‘always’ using condoms when they had sex in the previous year. A considerable proportion (39%) of sexually active students reported they only used condoms ‘sometimes’ when they had sex, and a small (13%) but nonetheless notable proportion ‘never’ used...
Reasons for unwanted sex varied. This was a feature of the current findings. Significant gender differences which indicate a trend towards less numbers of young men are notable wanting to (28% vs 20%), however the young women were more likely than young men to have experienced sex when they did not want to (28% vs 20%). This suggests that a major factor to increasing condom use may be the availability of a condom at the time of a sexual encounter. This is an area in which both schools and parents could play a greater role.

Issues of consent and sexual decision making remain important areas of learning for young people. Approximately one quarter of the sexually active sample reported ever having experienced unwanted sex. Young women were slightly more likely than young men to have experienced sex when they did not want to (28% vs 20%), however the numbers of young men are notable and indicate a trend towards less significant gender differences which was a feature of the current findings. Reasons for unwanted sex varied.

Gender did play a role however in the reasons for unwanted sex with higher proportions of young women reporting being influenced by their partner (61% vs 37%) and being frightened (34% vs 15%), and a higher proportion of young men being influenced by their peers (22% vs 9%).

Nevertheless, as we have found regularly, students overall expressed positive feelings after their last sexual encounter with only small proportions reporting feeling used upset or guilty. Thus we can deduce that young people are happy about their sexual choices and are on the whole having sex when they want to with people of their choice. Evidence of positive choices was also particularly marked amongst those who had never had sex, which was explored in more detail this time than in the past.

Table 2 illustrates the importance placed on a number of reasons for not having sexual intercourse.

Reasons which indicated personal choices rather than a lack of opportunity were cited as important. Religious (19%) and cultural (17%) beliefs played less of a role in these decisions, as did parental disapproval (17%).

INTERNET, TECHNOLOGY AND SOCIAL MEDIA

Previous surveys have demonstrated that, since its inception, the internet has increasingly become a well-used source of information about sexual health for young people, with 43% citing it this time as a used source. Questions relating to the role of technology more broadly were asked for the first time in this survey. Students indicated that they commonly used forms of electronic communication and digital technologies as part of their social worlds. Social networking sites (93%), sending and receiving instant messages (91%), text messaging (88%), mobile phone calls (86%), and sending/receiving emails (72%) were the most common forms of this communication.

Social networking sites were used at least once a day by 87% of all students. Facebook was the most commonly used social networking site with 91% of students reporting regular use, however many students also reported that they regularly used YouTube (82%) and Instagram (49%). Only 2% of students reported that they did not use any forms of social networking. The vast majority of students regularly accessed these sites using computers (95%) and mobile phones (85%), but less commonly methods such as iPads/tablets (42%) and iPod touch (or similar) devices (39%) were also used.

It is not surprising that the young people who have embraced these forms of communication are using them as part of developing and conducting sexual relationships. Over 50% of all students reported receiving a sexually explicit written text message while over four in ten had sent such a text message (43%), or received a sexually explicit photo of someone else (42%). Just over a quarter of young people reported that they sent a sexually explicit photo of themselves (26%). Higher proportions of young men sent (43% vs 5%) and received (45% vs 40%) sexually explicit photos or videos of someone else. Young men also were more likely to have reported using social media for sexual reasons (31% vs 16%).

**TABLE 1: SEXUALLY ACTIVE STUDENTS WHO HAVE EVER HAD UNWANTED SEX: REASONS**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Males (n = 54)</th>
<th>Females (n = 124)</th>
<th>Total (n = 178)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too drunk</td>
<td>53.7% (29/54)</td>
<td>46.8% (58/124)</td>
<td>48.9% (87/178)</td>
</tr>
<tr>
<td>Too high</td>
<td>24.1% (13/54)</td>
<td>17.7% (22/124)</td>
<td>19.7% (35/178)</td>
</tr>
<tr>
<td>My partner thought I should</td>
<td>37.0% (20/54)</td>
<td>60.5% (75/124)</td>
<td>53.4% (95/178)</td>
</tr>
<tr>
<td>My friends thought I should</td>
<td>22.2% (12/54)</td>
<td>8.9% (11/124)</td>
<td>12.9% (23/178)</td>
</tr>
<tr>
<td>I was frightened</td>
<td>14.8% (8/54)</td>
<td>33.9% (42/124)</td>
<td>28.1% (50/178)</td>
</tr>
</tbody>
</table>

Base: Sexually active students who have had unwanted sex.

Note: Multiple response questions.
### TABLE 2: NON-SEXUALLY ACTIVE STUDENTS’ IMPORTANCE RATINGS OF REASONS FOR NOT HAVING SEXUAL INTERCOURSE

<table>
<thead>
<tr>
<th>REASONS*</th>
<th>Importance</th>
<th>Males (n = 256)</th>
<th>Females (n = 527)</th>
<th>Total (n=783)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not feel ready to have sexual intercourse</td>
<td>Not at all</td>
<td>14.1% (36/255)</td>
<td>5.70% (30/526)</td>
<td>8.5% (66/781)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>31.8% (81/255)</td>
<td>63.9% (336/526)</td>
<td>53.4% (417/781)</td>
</tr>
<tr>
<td>Current (or last) partner is not willing</td>
<td>Not at all</td>
<td>19.1% (48/251)</td>
<td>15.9% (83/525)</td>
<td>17.0% (131/772)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>41.0% (103/251)</td>
<td>51.6% (269/521)</td>
<td>48.2% (372/772)</td>
</tr>
<tr>
<td>I am proud I can say no and mean it</td>
<td>Not at all</td>
<td>13.4% (34/254)</td>
<td>4.4% (23/525)</td>
<td>7.3% (57/779)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>36.6% (93/254)</td>
<td>62.1% (326/525)</td>
<td>53.8% (419/779)</td>
</tr>
<tr>
<td>Against my religious beliefs</td>
<td>Not at all</td>
<td>60.1% (152/253)</td>
<td>45.1% (237/525)</td>
<td>50.0% (389/778)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>14.2% (36/253)</td>
<td>21.5% (113/525)</td>
<td>19.2% (149/779)</td>
</tr>
<tr>
<td>Against my cultural beliefs</td>
<td>Not at all</td>
<td>57.8% (144/249)</td>
<td>43.4% (227/523)</td>
<td>48.1% (371/772)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>9.2% (23/249)</td>
<td>20.7% (108/523)</td>
<td>17.0% (131/772)</td>
</tr>
<tr>
<td>Fear of parental disapproval</td>
<td>Not at all</td>
<td>32.9% (84/255)</td>
<td>22.4% (117/525)</td>
<td>25.8% (201/778)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>14.1% (36/255)</td>
<td>18.4% (96/523)</td>
<td>17.0% (132/778)</td>
</tr>
<tr>
<td>Fear of pregnancy</td>
<td>Not at all</td>
<td>23.5% (59/251)</td>
<td>8.2% (43/525)</td>
<td>13.1% (102/776)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>31.5% (79/251)</td>
<td>39.1% (205/525)</td>
<td>36.6% (284/776)</td>
</tr>
<tr>
<td>Important not to have sex before marriage</td>
<td>Not at all</td>
<td>61.6% (154/250)</td>
<td>44.7% (234/524)</td>
<td>50.1% (388/774)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>13.6% (34/250)</td>
<td>19.1% (100/524)</td>
<td>17.3% (134/774)</td>
</tr>
<tr>
<td>Fear of damaging reputation</td>
<td>Not at all</td>
<td>40.9% (104/254)</td>
<td>28.9% (150/520)</td>
<td>32.8% (254/774)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>11.8% (30/254)</td>
<td>16.4% (85/520)</td>
<td>14.9% (115/774)</td>
</tr>
<tr>
<td>Not met a person I want to have sex with</td>
<td>Not at all</td>
<td>17.1% (43/252)</td>
<td>7.6% (40/526)</td>
<td>10.7% (83/778)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>30.6% (77/252)</td>
<td>53.4% (281/526)</td>
<td>46.0% (358/778)</td>
</tr>
<tr>
<td>I worry about contracting HIV/AIDS</td>
<td>Not at all</td>
<td>18.6% (47/253)</td>
<td>12.2% (64/524)</td>
<td>14.3% (111/778)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>24.1% (61/253)</td>
<td>24.8% (130/525)</td>
<td>24.6% (191/778)</td>
</tr>
<tr>
<td>I worry about contracting STIs</td>
<td>Not at all</td>
<td>16.1% (41/254)</td>
<td>9.2% (48/524)</td>
<td>11.4% (89/778)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>23.2% (59/254)</td>
<td>26.9% (141/524)</td>
<td>25.7% (200/778)</td>
</tr>
<tr>
<td>Too shy/embarrassed to initiate sex</td>
<td>Not at all</td>
<td>23.4% (59/252)</td>
<td>11.2% (59/525)</td>
<td>15.2% (118/777)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>9.1% (23/252)</td>
<td>18.5% (97/525)</td>
<td>15.4% (120/777)</td>
</tr>
<tr>
<td>Not in a relationship long enough</td>
<td>Not at all</td>
<td>11.8% (30/254)</td>
<td>7.2% (38/525)</td>
<td>8.7% (68/779)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>28.0% (71/254)</td>
<td>44.6% (234/525)</td>
<td>39.2% (305/779)</td>
</tr>
<tr>
<td>Important to be in love the first time</td>
<td>Not at all</td>
<td>14.3% (36/252)</td>
<td>5.9% (31/524)</td>
<td>8.6% (67/776)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>34.1% (86/252)</td>
<td>57.4% (301/524)</td>
<td>49.9% (387/776)</td>
</tr>
<tr>
<td>I don’t feel physically attractive/desirable</td>
<td>Not at all</td>
<td>22.6% (57/252)</td>
<td>13.6% (71/522)</td>
<td>16.5% (128/774)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>12.3% (31/252)</td>
<td>21.7% (113/522)</td>
<td>18.6% (144/774)</td>
</tr>
<tr>
<td>Not had the opportunity to have sex</td>
<td>Not at all</td>
<td>17.6% (44/250)</td>
<td>14.8% (77/522)</td>
<td>15.7% (121/772)</td>
</tr>
<tr>
<td></td>
<td>Extremely</td>
<td>29.2% (73/250)</td>
<td>32.0% (167/522)</td>
<td>31.1% (240/772)</td>
</tr>
</tbody>
</table>

Question: ‘Here are some reasons that people may have for not having sexual intercourse. Please indicate how important these reasons are for you. Please click one answer to rate each reason.’ Response options were a 5 point Likert scale with extremes being ‘Not at all important’ and ‘Extremely important’. Adapted from Sprecher & Regan, 1996; Miller et al, 1998; Herold & Goodwin, 1981.

Base: Non-sexually active students. * Some statements are abbreviated.

### TABLE 3: PREVALENCE OF SEXUALITY/RELATIONSHIP EDUCATION

<table>
<thead>
<tr>
<th></th>
<th>Males (n = 827)</th>
<th>Females (n = 1,309)</th>
<th>Total (n = 2,136)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>84.2% (645/766)</td>
<td>87.1% (1,104/1,268)</td>
<td>86.0% (1,749/2,034)</td>
</tr>
<tr>
<td>No</td>
<td>11.9% (91/766)</td>
<td>9.5% (120/1,268)</td>
<td>10.4% (211/2,034)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3.9% (30/766)</td>
<td>3.5% (44/1,268)</td>
<td>3.6% (74/2,034)</td>
</tr>
</tbody>
</table>

Question: ‘Have you ever had sexuality/relationship education at school?’

Base: All students.

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If these behaviours are analysed only for sexually active students, the proportions are a lot higher. Most sexually active students reported receiving (84%) and sending (72%) sexually explicit text messages, and receiving a sexually explicit nude or nearly nude photo or video of someone else (70%), while 50% reported sending a sexually explicit nude or nearly nude photo or video of themselves.

Nearly one-third of sexually active students have used a social media site for sexual reasons (31%) while 17% have sent a sexually explicit image of someone else. Higher proportions of young men than young women reported sending (25% vs 11%) and receiving (76% vs 66%) explicit images of someone else and using social media for sexual reasons (45% vs 23%).

The common use of sexually explicit text messages and sexually explicit photographs and videos indicates that this behaviour is well and truly embedded in the sexual worlds of these young people and is an element of many sexual relationships. This phenomena appears to have been very little modified by the fact that some of these practices are illegal, and resources using this approach as a deterrent to young people appear to have fallen on deaf ears.

A more realistic approach to the harm that can occur to individuals when this technology is misused to humiliate and shame would be to focus on the importance of ethical behaviour in sexual relationships across the board. Young people need to feel confident with issues of consent, self care and care of others as they work towards ethical maturity and both parents and school programs can support them in this process.

### SEXUALITY AND RELATIONSHIP EDUCATION

All of the participants in this survey are students in Australian secondary schools and, as all state and territory curriculum frameworks mandate some form of sexuality education, we felt it was a reasonable expectation that they would have something to say about the nature and quality of that education. Some religious schools may choose not to meet this requirement, but commonly they do provide some version of sexuality education in line with their religious ethos. School sexual health programs were cited by 43% of students as an important source of information on sexual health, followed closely by female friends (41%) and mothers (36%). Teachers were also cited by 28% of students, indicating the importance of schools as sites for sexual health education.

Most students (86%) reported that they had received sex education at school, although approximately 4% expressed uncertainty. (Table 3).

### TABLE 4: STUDENTS’ ASSESSMENT OF SEXUALITY/RELATIONSHIP EDUCATION RELEVANCE

<table>
<thead>
<tr>
<th></th>
<th>Males (n = 827)</th>
<th>Females (n = 1,309)</th>
<th>Total (n = 2,136)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not relevant at all</td>
<td>8.1% (63/778)</td>
<td>5.7% (72/1,272)</td>
<td>6.6% (135/2,050)</td>
</tr>
<tr>
<td>Somewhat relevant</td>
<td>40.1% (312/778)</td>
<td>41.9% (533/1,272)</td>
<td>41.2% (845/2,050)</td>
</tr>
<tr>
<td>Very relevant</td>
<td>28.0% (218/778)</td>
<td>28.4% (361/1,272)</td>
<td>28.2% (579/2,050)</td>
</tr>
<tr>
<td>Extremely relevant</td>
<td>15.4% (120/778)</td>
<td>17.6% (224/1,272)</td>
<td>16.8% (344/2,050)</td>
</tr>
<tr>
<td>Not had sex/relation education at school</td>
<td>8.4% (65/778)</td>
<td>6.5% (82/1,272)</td>
<td>7.2% (147/2,050)</td>
</tr>
</tbody>
</table>

Question: ‘How relevant did you/do you find sexuality/relationship classes?’

Base: All students.

Around one in 10 students reported having no sex education.

Most of this education took place in Health and Physical Education classes (80%) while just less than one-third (31%) took place in Science and Biology classes. For 13% of students it was part of a Religious Instruction program.

Pleasingly, sexuality and relationship education appears to be predominantly taught by teachers (85%), however someone from outside the school (34%), and/or the school nurse (22%) were also commonly involved. Fewer students reported that school counsellors (10%) or chaplains (4%) were involved in the subject’s delivery. It appears that while the impulse to call in an outside expert to deliver these programs is still widespread, outsiders may be operating more in conjunction with classroom teachers.

Despite the high numbers of students who reported receiving sexuality education, not all found it met their needs. Less than half of students (45%) found their sexuality education.
... contraindication. Teenagers are always going to have sex, so school should be educating us how to safely do that rather than make us ashamed”.

Several respondents commented that they felt their sexuality education did not include enough information or emphasis on the importance of consent in sexual relationships (21%). Related to this, many students said that they would have liked more information on the emotional side of sexual relationships and how to build a healthy, positive sexual relationship:

“It was done through more of a biological lens and taught us about STI prevention and anatomy but did not include many topics that are very important, such as communication with partners, different relationship dynamics or unusual circumstances, actually getting pleasure from sex etc”.

Despite the negative comments and the deficits reported it is important to acknowledge the many positive comments made by young people about their sexuality education, and to compliment those teachers who are providing it:

“I already felt that I knew about sexual relationships already due to just general accumulated knowledge, but sex education in school helped to clear some things and terms up.”

“It’s actually been very good and helped out a lot ...”

“I am glad I had Sex Ed. It was super helpful.”

Sexuality education is clearly a topic on which many young people are prepared to offer an opinion, using its relevance to their lives as a criterion to determine its value. It is clear that schools vary in their capacity to make judgements about what students need to know and in delivering on those perceptions. Listening to the voices of young people and trusting in their sense of what is important is likely to be a useful strategy for improving our programs in the future.

**CONCLUSION**

Despite ongoing concerns for the sexual wellbeing of young people, the data from this study demonstrate that the vast majority of young people are confident in their decision-making around their sexual health. Those who are sexually active are, by and large, having sex that they enjoy and feel positive about. The majority of those who are not having intercourse are feeling comfortable and confident that this is what they want. This is clearly a strength of young people and one which should be recognised in the approaches taken to sexual health promotion and sexuality education targeting young people.

There is still much to be done to help young people negotiate the exciting, confusing and sometimes treacherous territory of sexual relationships as they look to reliable and trusted sources, such as schools and parents, for help. Schools are rising to this challenge in great numbers and the implementation of the new Australian Curriculum in Health and Physical Education provides an opportunity to invigorate our programs to meet these needs realistically.

The full report can be downloaded from www.latrobe.edu.au/arcshs

Emeritus Professor Anne Mitchell has been working in sexuality education for over 20 years. She was a founding staff member of the Australian Research Centre in Sex, Health and Society at La Trobe University and is part of the research team on the five-yearly studies of Secondary Students and Sexual Health. She has many years experience in curriculum development and led the team that wrote the national Talking Sexual Health materials.

Pamela Blackman has 23 years experience as a classroom teacher in Health and Physical Education and 12 years as a Regional Consultant in Drug Education with the Victorian Department of Education. She currently works at the Australian Research Centre in Sex, Health and Society at La Trobe University where she moderates the Ansell Sex-Ed website for teachers and is also the School Liaison Officer for the 5th National Survey of Australian Secondary Students.

The Fifth National Survey of Secondary Students and Sexual Health was carried out in 2013 and involved over 2,000 Year 10, 11, and 12 students from the Government, Catholic and Independent school systems and from every jurisdiction in Australia.

The key findings are as follows:

Knowledge
- HIV knowledge is relatively high.
- STI knowledge remains poor; including knowledge about chlamydia.
- Knowledge of the possible symptoms of STIs was somewhat better.
- Hepatitis knowledge remains relatively poor.
- HPV knowledge is very poor. In most cases more than half the sample reported being ‘unsure’ of correct answers to HPV knowledge questions.
- Only 52% of young women reported having been vaccinated against HPV.
- There were few gender differences in HIV knowledge; however young women demonstrated better knowledge compared with young men generally in terms of STIs, particularly for HPV.

Sexual behaviour, beliefs and perceptions
- The majority of students (69%) have experienced some form of sexual activity.
- The proportion of students who had experienced sexual intercourse in the total sample was 34%.
- Almost one quarter of Year 10 students (23%), one third of Year 11 students (34%) and one half of Year 12 students (50%) had experienced sexual intercourse.
- Around 40% of students had experienced oral sex.
- Around six out of ten students (63%) believe that ‘most’ or ‘all’ of their peers use a condom when they have sex.
- The majority (59%) of sexually active students (those who answered ‘yes’ to having either vaginal or anal sexual intercourse) reported using a condom the last time they had sex.
- Of those sexually active students who reported that a condom was available the last time they had sex, 86% reported using it.
- Almost a quarter of sexually active students (25%) had sex with three or more people in the past year.
- Approximately one quarter of sexually active students reported an experience of unwanted sex.
- The majority of the sample reported sexual attraction only to people of the opposite sex (83% of young men and 76% of young women).
- Eight per cent of young men and 4% of young women reported sexual attraction only to people of the same sex. Five per cent of young men and 15% of young women were attracted to people of both sexes. Around 4% of young men and 5% of young women were unsure about their sexual attraction.
- One in eight (12%) of sexually active young men reported their most recent sexual encounter was with someone of the same sex. This compares with 5% of sexually active young women.
- Most sexually active students report positive feelings after having sex.
- Amongst sexually active students the most commonly used form of contraception was the condom (58%) and/or the contraceptive pill (39%).
- Thirteen per cent of sexually active students reported using no contraception the last time they had sex; while 15% used withdrawal.
- Around one half of non-sexually active students reported that they did not feel ready to have sex; that they were proud to say no and mean it, and that they thought it important to be in love the first time they had sex.
- Religious and cultural beliefs or parental disapproval were less frequently cited by non-sexually active students as reasons for not having had intercourse.
- Around 20% of non-sexually active students reported feeling ‘extremely’ happy, good and proud that they had not yet had sex. Large proportions reported that they did ‘not at all’ feel guilty (75%), regretful (63%) or embarrassed (51%) that they had not yet had sex.
The majority of students (78%) expressed a desire to have children at some stage of their life.

The preferred age to have their first child was between 25 and 29 years. A further 16% desired their first child between the ages of 30 and 34 years.

Only around one in ten students anticipated difficulties in conceiving children, but with a high percentage (52% of young women and 32% of young men) indicating they did not know whether they would experience difficulties.

The majority of students correctly identified a family history of infertility (74%) and STIs (72%) as potential factors affecting infertility.

Forty per cent of students reported never drinking alcohol.

Around a third (36%) of all students reported drinking once a month or less.

One in ten students (10%) reported drinking alcohol weekly or more frequently.

Twenty-one per cent of young men (33% of male students who drank alcohol) and 11% of young women (19% of female students who drank alcohol) reported consuming ‘seven or more drinks’ on a day when they drank.

The vast majority of students (81%) have never smoked cigarettes. Only 4% report smoking regularly.

Similarly 83% of students report never having smoked marijuana, with only 3% reporting regular use of marijuana.

There is a very strong association between cigarette and marijuana use.

Students most commonly consulted their mother (36%) or a female friend (41%) about sex and relationships.

The school health program and the internet were nominated as sources of information for around 43% of students.

Doctors and teachers were also nominated as fairly common sources of sexual health information (29% and 28% respectively).

Only one in ten students reported having no sex education at school.

Over three quarters reported the education had been in Health and Physical Education classes (80%).

Sexuality education was mainly taught between Years 7 and 10; 64% reported receiving sex education in Years 7 and 8, and/or 68% reported receiving sex education in Years 9 and 10.

Nearly half (45%) of students found this education to be ‘extremely’ or ‘very’ relevant to them.

Students offered commentary on the value of their sexuality education, what they thought was missing from it and its relevance to their lives.
YOUNG AUSTRALIANS AND SEXUAL HEALTH

EXTRACT FROM YOUNG AUSTRALIANS AND SEXUAL HEALTH – A BRIEFING BY THE AUSTRALIAN CLEARINGHOUSE FOR YOUTH STUDIES

OVERVIEW

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.

A number of sexually transmitted infections (STIs) are becoming more prevalent in Australia, and young people are among those at highest risk.

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).

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.

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.

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.

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Issues in Society | Volume 386
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, to 2012 inclusive, for those aged 20 to 24; notifications for children aged five to 14, and of these, 80 per cent were diagnosed in 2012, and of these, 80 per cent were aged 15 to 19; from 2009 to 2012, inclusive, notifications rose each year from 2009 to 2011 inclusive, for those aged 15 to 19 each year from 2009 to 2011 inclusive, they declined 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.
- 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 19; 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 ‘testing 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 (published in early

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**INCIDENCE OF HIV AND STIs IN YOUNG PEOPLE**

<table>
<thead>
<tr>
<th>HIV</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males 13-19</td>
<td>7</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Females 13-19</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Males 20-24</td>
<td>86</td>
<td>71</td>
<td>70</td>
<td>91</td>
<td>110</td>
</tr>
<tr>
<td>Females 20-24</td>
<td>23</td>
<td>12</td>
<td>20</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GONORRHOEA</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males 15-19</td>
<td>747</td>
<td>796</td>
<td>928</td>
<td>1,027</td>
<td>1,039</td>
</tr>
<tr>
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<td>843</td>
<td>838</td>
<td>1,055</td>
<td>1,283</td>
<td>1,225</td>
</tr>
<tr>
<td>Males 20-24</td>
<td>1,144</td>
<td>1,304</td>
<td>1,625</td>
<td>1,815</td>
<td>2,120</td>
</tr>
<tr>
<td>Females 20-24</td>
<td>663</td>
<td>803</td>
<td>929</td>
<td>1,022</td>
<td>1,106</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHLAMYDIA</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td>Males 15-19</td>
<td>3,701</td>
<td>4,092</td>
<td>5,306</td>
<td>5,492</td>
<td>5,383</td>
</tr>
<tr>
<td>Females 15-19</td>
<td>11,228</td>
<td>12,148</td>
<td>14,614</td>
<td>16,168</td>
<td>15,511</td>
</tr>
<tr>
<td>Males 20-24</td>
<td>8,197</td>
<td>8,384</td>
<td>10,897</td>
<td>12,157</td>
<td>12,220</td>
</tr>
<tr>
<td>Females 20-24</td>
<td>12,964</td>
<td>13,715</td>
<td>15,956</td>
<td>17,584</td>
<td>18,108</td>
</tr>
</tbody>
</table>

APPROXIMATE FRACTION OF YEAR 10, YEAR 11 AND YEAR 12 STUDENTS WHO HAVE HAD SEXUAL INTERCOURSE

Source: Australian Research Centre In Sex, Health And Society (ARCSHS) 2013.

<table>
<thead>
<tr>
<th>Year 10</th>
<th>Year 11</th>
<th>Year 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/4</td>
<td>1/3</td>
<td>1/2</td>
</tr>
</tbody>
</table>

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

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.31

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.33

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,25 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’.26,27,28

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.29 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.30

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.31

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Discussing Sexual Health
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.

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. 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. 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.

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. 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.

### 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.

### 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, and they may use unreliable indicators such as social position, appearance and familiarity to assess the
likely that a potential partner will have an STI. 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.

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’, ‘sluty’ or of poor moral character – that is, a likely carrier of STIs’. In view of this, young people attempting to avoid offence may employ such ambiguous language when discussing condom preference that miscommunication occurs.

Lack of preparation
Young single people often do not carry condoms. 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”.

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.

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.

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.

Lack of information for same-sex-attracted young people
According to Wilson, 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.

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 emphasising heterosexual sex and danger are the norm in most Australian schools with a far smaller number providing critical messages inclusive of SSAGQ youth.

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, 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”.

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.

Men who have sex with men are most likely to be tested, and women are more likely to be tested than men. There are also “encouraging signs that those with multiple partners and higher sexual activity report a higher incidence of testing for STIs”, 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).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).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.62 However, if a GP suggests that a test might be warranted, a patient is likely to comply.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.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.65 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.66 For others the mechanics of applying condoms can be tricky,67 while a few men cannot maintain an erection with a condom in place.68 Even men well into their twenties can have ‘low self-efficacy for correct condom use’ that correlates with erection loss.69

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.71

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.*72
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.

ENDNOTES


7. Ibid.


10. Ibid.

11. Ibid.


13. Ibid., p.170.


15. Ibid.


27. See also Marston, C., King, E. & Ingham, R. 2006, ‘Factors that shape the real deal’, A feasibility study of peer-led sex education for early school leavers’, Sex Education: Sexuality, Society and Learning, vol.6, no.4, pp.1-162, retrieved from, www.cdc.gov/mmwr/preview/mmwrhtml/ss6104a1.htm


33. Ibid.

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


38. Ibid., p.46.


40. Yeung et al. 2014.


42. Stancombe 2008; Yeung 2014.


47. Ibid., p.257.


Let’s talk about sex: young people’s views on sex and sexual health in Australia

REPORT SYNOPSIS AND RECOMMENDATIONS FROM A SURVEY BY THE AUSTRALIAN YOUTH AFFAIRS COALITION AND YOUTH EMPOWERMENT AGAINST HIV/AIDS

REPORT SYNOPSIS

Australia’s young people are facing a sexual health crisis of epidemic scale, with 75% of all Sexually Transmitted Infections (STIs) in Australia occurring amongst young people, and a 20% increase in the rate of STIs diagnosed amongst people aged 15-29 in the past three years. AYAC and YEAH believe that there is an urgent need to develop an understanding of where young people access information on sexual health they deem relevant, accurate and trustworthy.

The Let’s Talk About Sex: National Youth Survey was a joint partnership between AYAC and YEAH to ensure a national consultation process with young Australians aged 15-29 regarding their opinions, experiences and needs around access to sexual health information and education.

In total there were 1,219 responses to the online survey, with an even demographic spread across all states and territories across Australia.

The results of the survey clearly show that, although the clinical, scientific and anatomical approach to sexual health often experienced in the classroom is not satisfactorily meeting the needs of young people, a consistent approach to sex and sexual health information in Australian schools is overwhelmingly supported and expected, with no respondents saying that sexual health should not be taught within schools.

More than 80% of young people support lessons about sex and sexual health information to be the same in every Australian school, with supporting statements focusing on the “right of every student to sexual health education” and the need for “a basic standards and incremental age appropriate sexual health content within all schools covering every topic”. The strong support from young people is backed up by the first National Survey of Australian Secondary Teachers of Sexuality Education, in which 94% of teachers surveyed said they believed that sexuality education should be part of the national curriculum.

Young people responding to the survey clearly showed the need for consistency in the content and delivery of sex and sexual health information within schools. Young people are seeking more information about the complexities of their lived sexual health and development experiences by wanting to access more information about healthy relationships, how to better access youth health services, and sexuality and sexual diversity.

There is also 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. The survey showed that young people most preferred sexual health peer educators (i.e. trained young people, 68%) and sexual health educators from community organisations (68%) to deliver sex education in schools. Whereas only 32% agreed that Health and Physical Education teachers were a preferred choice. These results are echoed in the findings of the 2010 survey of Australian teachers who taught sexual health education.

Survey respondents highlighted that they wanted a spectrum of topics covered within the school curriculum. The research highlighted that a majority of teachers identified that they needed some assistance with one third of 30 sexuality topics while 16% no formal training in sexuality education and a majority relied on in-service training that was a one-off or of short duration.

A majority of young people responding to the survey stated a preference for a little bit older age group versus less than 5% preferred much older. In addition around a quarter of teachers believe that students do not feel comfortable to discuss sexual matters with teachers, and a quarter of schools already adopt a team taught approach, or engage external agencies to deliver sexual health education.

This report supports the partnership approach in the delivery and implementation of sexual health education.

Young people access sex and sexual health information from a range of sources both in and outside of school so an appropriate strategy to address sex and sexual health education for young people must include a cross-sector approach that reflects the vast array of places where young people go to for information on sex and sexual health in addition to the overwhelming support for sexual health to be delivered in all Australian schools.
The report highlights the value of consulting with young people as experts in their own experience and as a key stakeholder group in the development and implementation of sexual health policy and education.

**RECOMMENDATIONS**

This report aims to ensure young people have the opportunity to access accurate, youth-friendly, and inclusive sex education. We endorse the following recommendations to further sex and sexual health education in Australia.

**Youth health policy**

1. Recognise sexual health as a critical area of health and development for the wellbeing of young Australians.
2. Ensure government place young people as central to any STI prevention strategy.
3. Recognise and incorporate into relevant sexual health strategy, policy and services the diverse sources where young people access sex and sexual health information.

**Sex education in the curriculum**

4. Provide a universal and inclusive approach to youth sexual health education in Australia.
5. Ensure the inclusion of age-appropriate and incremental sexual health content within and across the Health and Physical Education Curriculum in the Australian Curriculum from Years 5 to 12.
6. Ensure sex education in schools covers a cross-section of all topics that includes healthy relationships, anatomy and reproduction, safe sex/STIs, sex/pleasure, accessing youth health services and HIV/AIDS.
7. Ensure sexual health content within the National Health and Physical Education Curriculum is based on and addresses each aspect of the World Health Organisation’s definition of sexual health: *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.*
8. Implement key recommendations and priority action areas as listed within the *Second National Sexually Transmissible Infections Strategy 2010-2013* into the Australian Curriculum framework for sexual health in the Australian Curriculum.
9. Ensure sex education is respectful and inclusive of young people who are Same-sex Attracted and Sex and Gender Diverse.

**Delivering sex education in partnership**

10. Ensure schools are resourced to adopt a collaborative approach to delivering sex education that includes sexual health peer educators and youth/community sexual health educators to support teachers.
11. Recognise that young people prefer someone ‘a little bit older’ to teach them about sex education.
12. Recognise and incorporate the evidence and identified need from both young people and teachers to engage external agencies to support the delivery of better sexual health education.

**Incorporating student voice**

13. Ensure the voices and opinions of young people are reflected within sexual health education and sexual health policy in Australia.
14. Ensure ongoing opportunities for direct input from young people in the development process of the sexual health education within the Australian Curriculum in consultation with AYAC, YEAH and other relevant youth organisations.

**Resourcing sex education**

15. Develop a national register of recommended resources and external services for teachers across Australia to improve delivery of school sexual health education in consultation with AYAC, YEAH and other relevant youth organisations.
16. Government to work in partnership with AYAC and YEAH to implement good practice guidelines for engaging peer and youth sector education programs within the Australian Curriculum and schools.

**Sex education beyond the school context**

17. Develop an awareness campaign to ensure young people are aware of reliable and accurate sources of information online and via youth and community health services.
18. Ensure young people have access to sex and sexual health information outside of school on all topics but especially on ‘Sex and Pleasure’ and ‘Sexuality’.

AYAC and YEAH look forward to working with the Australian Government and relevant organisations to ensure that within and outside of schools there are clear and definitive guidelines for the inclusion of comprehensive, youth-friendly and age-appropriate sexual health and development information.

**ENDNOTES**


iii. *Ibid*.

Does sexuality and relationships education teach students how to have sex?

NO

It is much more than simply biology. Sexuality and relationships education begins at birth and continues throughout life. Learning about sexuality involves learning about a wide range of topics including sexual development, reproductive health, interpersonal relationships, emotions, body image, decision-making, values and gender roles (The Clarity Collective, 1990; World Health Organisation, 2002). It is much more than just teaching about sex.

Does teaching about sexuality at school take away from teaching about it at home?

NO

Parents and carers have the most significant influence on their child’s developing sexuality and are their primary sexuality educators. The messages young children receive from parents/carers about their bodies and relationships lay the foundation for future learning about sexuality.

Babies and young children naturally learn about their body through their experience of being cared for by the adults in their life and by exploring and touching their own bodies. Young children also learn by observing the relationships and roles of people around them. Children receive messages about sexuality from the way their questions about sexuality are responded to and answered by parents/carers (Milton, 2000).

Research has shown that sexuality and relationships education programs result in increased parent-child communication about sexuality (Latrobe University, 2008). Education services can work together with parents/carers to support one another in providing sexuality and relationships education. When this happens, children are supported to grow healthy and safe and develop a network of trusted adults with whom they can talk as well as seek help from if needed.

Are students in primary school too young to need information about sexuality?

NO

Children are learning about sexuality all the time, whether or not this is done formally by parents/carers or teachers. This learning takes place every day through observing adult relationships around them, and the images that they see portrayed in the media about gender, body image and relationships (Milton, 2000).

For most boys and girls, puberty changes are experienced in primary school. Signs of puberty can commence at 9 years of age and so receiving sexuality and relationships education prior to the onset of puberty ensures boys and girls are prepared for puberty changes and are not embarrassed or frightened by them. (Blake, 2002; Ray & Jolly, 2002).

Does sexuality and relationships education encourage sexual behaviour in adolescents?

NO

Research demonstrates that sexuality and relationships education programs are more effective when given before young people become sexually active and when programs emphasise skills and social norms. Comprehensive sexuality and relationships education programs have been shown to help delay the onset of sexual
activity and increase the adoption of safer sexual practices in sexually active young people (Senderowitz & Kirby, 2006).

If I don’t feel comfortable isn’t it better not to say anything at all? 

NO

It is quite common to feel uncomfortable talking about sexuality. However, it is important not to let this stand in the way of providing sexuality and relationships education and meeting curriculum requirements. Acknowledging personal discomfort is a useful point to begin and helps educators begin to plan to support themselves. Talking about and teaching sexuality becomes much easier with practice.

If children and young people are not provided with factual information from trusted sources like parents/carers and teachers, they are vulnerable to the often inaccurate and misleading information about sexuality from other sources, such as peers, television and other medias.

REFERENCES


Positive sex education vs online porn!

Who is teaching young people about sex and relationships in the digital era?
This article, first published by Generation Next, explores the issues

Today, pornography’s influence is everywhere. Porn influences mainstream advertising, music videos, fashion and popular culture. Australian children are growing up in a digital world dominated by sexualised imagery that reinforces inequity and the notion that women are objects to be controlled, managed and dominated.

Use of pornography in Australia

Flood and Hamilton undertook the first Australian academic research into adolescent use of pornography in 2003 and found that 73% of boys and 2% of girls aged 16, viewed pornography regularly. Today these figures are estimated to be much higher as access to pornography is free and instantaneous online.

As the volume of users steadily increases the age of users has fallen dramatically. At the same time, the nature of most pornography has become more violent and extreme. What was once called hardcore or fetish pornography is now mainstream. In fact, Australian’s classification board would refuse to classify (RC) the majority of pornography that is freely accessible online as it is too violent and regularly depicts participants (mainly young women) who are in distress and/or who are being violently and inhumanly treated.

In 2010 Australian researchers Maree Crabbe and Dr David Corlett found a marked shift “toward rougher, more aggressive sex…porn producers say consumers want more extreme acts and violence.”

Access to pornography has also changed dramatically since the advent of the first web page in 1991. Prior to online access, pornography was typically consumed via printed material or R 18+ or X 18+ videos purchased at adult stores. Today unclassified, illegal pornography, usually made in the USA or Russia, is available online to anyone who has internet access. It is important to note that in Australia most children by the age of 8 have free and unrestricted access to the net with 30% of children surveyed in 2011 reporting they had seen something online that upset or bothered them.

ABS statistics from 2008-09 indicate that 76% of 12-14 year olds own a mobile phone. In data from 2013, 85.3% of secondary students surveyed regularly accessed the internet via a mobile phone while 94.7% access via a computer.

Creating and sending sexual imagery is now a common expression of adolescent sexual experimentation in Australia. A 2013 Australian survey found 42.9% of secondary school students had sent a sexually explicit text message while 41.6% had received a nude or near nude photo. The extent of the sexting issue became clear in one Victorian DEECD region this year when a sexting crisis was declared. In March 2014 senior DEECD staff and Principals met to try to work out how to help students understand the serious personal and legal consequences of sexual experimentation and expression online.

Given these alarming statistics, many educators, sexual assault workers, health and social service providers are desperate to find ways to educate young people about the harms that are possible when sexual exploration and experimentation occurs online. The burning question we are all asking is:

Does today’s violent pornography negatively impact young people and their intimate behaviours? If the answer is yes then is pornography contributing to the normalisation of sexual violence and gender inequity in our community?

Australian researcher Dr Michael Flood suggests that it does. In a 2009 journal article Flood suggests that pornography is a poor sex educator and “for boys and young men, the use of pornography may exacerbate violence-supportive social norms and encourage their participation in sexual abuse.”

Impact on young people

Researchers, police, health workers and social service providers all agree that inequity is the root cause of sexual assault, sexual abuse, intimate partner and, family violence. With appalling domestic violence statistics well known in our community it is time we looked even further into the genesis of inequity by asking more fundamental questions about how it has become so deeply entrenched in our culture. Why not start by looking at the issues at puberty with relevant and up to date sex and relationship education?

Does today’s violent pornography negatively impact young people and their intimate behaviours? If the answer is yes then is pornography contributing to the normalisation of sexual violence and gender inequity in our community?

On March 23 this year the Sydney Morning Herald ran a story entitled “Sex education needs radical overhaul, say experts.” In the article Lauren Rosenwarne, a gender politics expert from Melbourne University is quoted as saying “Ten is the average age now of seeing porn
for the first time, so if that’s the case, we need to start sex education at nine.” While educators and sexual assault workers know there is a need for more relevant sex education at a primary prevention level many are reluctant to tackle the subject for a range of reasons.

The most important concerns for educators are lack of understanding of the issue and lack of clarity around the laws concerning children and admitting to criminal activity. The fear, confusion and lack of knowledge around this issues means that sex and relationship education in Australia is years behind the young people it is meant to educate.

Discussing sex and relationships in the digital era requires a discussion about the harms of normalising pornography’s industrial view of sex. As bizarre as it might seem questioning pornography and its violent and mechanical view of intimacy is currently a taboo topic shrouded in silence in our culture, our classrooms and for many in our homes. So what can we do to address inequity at its source and make sex and relationship education relevant in the digital age?

First and foremost we can start talking about the way pornography is contributing to gender inequity. We can take the discussion about pornography out of the taboo topic corner and open it up for discussion. We teach children road safely when they are little, why not teach our children about navigating the superhighway online as they explore and experiment with their growing interest in sexual activity?

We can educate and train teachers and parents on how to talk about the issue with young people. Upskilling teachers and parents will help to facilitate open discussion without judgement. Open conversations that are not shrouded in judgement will do much to assist young people to deconstruct the many negative models of sex and relationship that are being offered online. We can offer alternative models of sexuality to that of pornography, we can also talk about sex and gender diverse sexuality openly as we should. Any discussion that engages people, young and older to make conscious, informed and positive choices for better sexual and emotional health and wellbeing has got to be good for everyone.

We can all start a broader based public discussion and media conversation to raise awareness and understanding about the harmful impact of pornography’s violent model of sexuality and relationships and the link it has to normalising violence against women in our culture.

Finally, we can urge governments and universities to undertake further research to help us understand what impact viewing violent and degrading sexual material has on the physical, emotional and mental health of young people.

Equity in intimacy is not a gender issue — it is a human rights issue.

REFERENCES
9. Lauren Rosewarne, gender politics expert from the University of Melbourne.

Linette Etheredge is an educator, documentary filmmaker and academic.

Cross-generational conversations about sex have never been easy. But experts say children benefit when parents and carers have these conversations, rather than letting young people find the answers for themselves.

Where did you first learn about sex? Was it from a book, from your friends at the back of the bike shed, or after an excruciating dinner table conversation with your parents?

Many of us have cringeworthy memories of sex education that involve awkward conversations, embarrassing parent-student nights, or strange pamphlets distributed by the school nurse. So it’s easy to understand many of us would like to avoid these conversations with our children.

But some experts are concerned access to technology is giving children information about sex and exposing them to sexualised content at a younger age than previous generations.

Dr Patricia Weerakoon, sexologist, author and senior lecturer at the University of Sydney says parents and carers need to take responsibility and educate children about sexuality, which is about sex as well as how bodies work, gender, having babies, relationships, sexual expression and values.

“Not talking to children, and thinking ‘don’t children just learn these things’ means we’re finding young people are turning to the internet for sex education,” she says.

In her view, the best way to do this is to give children accurate and age appropriate information.

YOUNG PEOPLE NEED TO KNOW ABOUT SEX

You might think you don’t need to talk to your children about sex because it’s not relevant for them, but a national survey of high school students has found:

- 78 per cent of high school students have experienced some form of sexual activity
- 25 per cent of Year 10 students have had sexual intercourse
- 50 per cent of Year 12 students have had sexual intercourse
- 69 per cent of sexually active students used a condom when they last had sex
- One third of all students reported having unwanted sex (38 per cent of young women, 19 per cent young men).

Evidence also suggests roughly 75 per cent of sexually transmitted infections occur in young people.

However, Weerakoon says many parents still leave sex education up to their child’s school and these education programs don’t give young people much of the information they feel they need.

“I did some focus groups with Year 9 and 10 students, and they were saying things like ‘what’s the use of school telling us about the uterus and how babies are made, we know all that. Somebody needs tell us what happens when you get an erection, and what’s an orgasm’,” she says.

Weerakoon’s focus group findings are in line with results of a survey conducted by the Australian Youth Alliance Coalition (AYAC) and Youth Empowerment Against HIV/AIDS, which found young people felt they were getting enough information on anatomy and reproduction but that they wanted more information on:

- Sexuality
- Sex and pleasure
- How to access youth services
- Safe sex, contraception and HIV
- Healthy relationships.

HOW KIDS ACCESS INFORMATION

The 15 to 29 year olds included in the survey were also asked about where they found information about sex and sexual health, the top five sources included:

- Internet – 85 per cent
- Friends – 76 per cent
- Magazines – 72 per cent
- School – 69 per cent
- TV/movies – 67 per cent.

Only 65 per cent had spoken to their parents or carers. AYAC deputy director Joshua Genner says the survey shows the need for better sex education for young people today.

“If children aren’t provided with age-appropriate sex ed, built on care and respect, then young people find other sources, and that can be really damaging because...
they can be sources that aren't sensitive to their needs, that aren't age appropriate and aren't a part of a holistic picture of what sexual health is,” he says.

While better online resources that deliver accurate information about sex would be ideal, the sheer volume of information on the internet means it is difficult to deliver the right information to the right age group.

“Part of the problem is that the internet is a big and very diverse place and there’s a lot that can be found out there. Some of it’s going to be good and some of it won’t, so of course leaving sexual education to the internet would not be a good thing to do,” Genner says.

TRUSTING ONLINE SOURCES

While young people are accessing information about sex online this doesn’t mean they believe everything they read.

A survey by Family Planning NSW suggests young people have a good ability to filter out information that doesn’t seem credible when they are looking at different websites about sexual health.

Another US study found young people had a greater trust in traditional sex education sources, such as family and schools, than they did in information found online.

However, children and young people are often exposed to sexualised content even when they are not actively seeking it as pop-ups and other advertisements often contain sexually explicit material – even on websites that provide seemingly innocent information.

And with 11-13 being the average age kids are first exposed to pornography, Weerakoon says parents need to be proactive about talking to their children about internet safety.

“I tell parents to talk to their children when they are 9 or 10 about content that is likely to pop up on internet searches, and tell them if anything like this comes up come and talk about it,” she says.

NOT A ONE-TIME THING

Traditionally parents have approached sex education with their children by having ‘the talk’ as the child heads towards puberty, but Weerakoon says speaking with your children about sex should be ongoing and integrated throughout a child’s developing life.

MAKE THE MOST OF EVERY OPPORTUNITY

Weerakoon says it’s important to take advantage of teachable moments to speak with your children about sexual issues, whenever an appropriate opportunity arises. These opportunities can be a chance to talk about more than just the ‘nuts and bolts’, you might also have a chance to talk about your values on relationships and sexuality as well.

Examples of teachable moments may include:

• A scene in a book
• Driving past certain billboards on the freeway
• A scene in a movie or television show

Pointers for parents

What to tell kids at what age

Children develop at different ages, but the following is a rough outline of what ages parents can start talking to their children about certain aspects of sexuality:

0-3 YEARS

> Name body parts accurately, be it vulva, penis or vagina.
> Teach children the difference between public and private behaviours, while avoiding shame and guilt about certain body parts.

4-5 YEARS

> Teach correct names of major internal and external body parts.
> Explain how babies get into a mother’s uterus.

6-8 YEARS

> Start talking to children about what will happen when they begin puberty.

9-12 YEARS

> Talk to children about the changes they are going through, reassure them that menstruation, erections and ejaculation are normal.
> Talk about how young people sometimes have girlfriends and boyfriends.
> Start discussing the importance of self-esteem and body image.
> Address the influence of media and the internet.
> Set boundaries of what is appropriate and what is not.

13-18 YEARS

> Discuss love, intimacy, how to set boundaries in relationships.
> Make sure they know about contraception including the importance of condoms.
> Talk about peer pressure and coercion, and help them identify physical and verbal responses to avoid or get away from situations that make them feel uncomfortable.

While young people are accessing information about sex online this doesn’t mean they believe everything they read ... However, children and young people are often exposed to sexualised content even when they are not actively seeking it as pop-ups and other advertisements often contain sexually explicit material – even on websites that provide seemingly innocent information.
ENCOURAGE QUESTIONS
Keeping conversations informal and casual is the best way to encourage questions and for your children to feel like they aren’t being judged ... It is also very important to be aware of what is going on in your child’s life, especially in such a digital age.

KNOW WHAT’S GOING ON FOR YOUR CHILD
It is also very important to be aware of what is going on in your child’s life, especially in such a digital age.

“Know what your children are doing, be aware and be there for your kids so if they are being asked for nude pictures or if they involved in something else let them know you will be there for them to share with. Parents need to be aware that today’s kids were born into a digital age,” she says.

TALK ABOUT CONSENT
Even if you feel uncomfortable, you should talk to teens about contraception and consent, the guide says. Teens are old enough to understand that being taught how to look after themselves does not mean they are being encouraged to have sex.

It is also important to teach your children about consent and the difference between ‘persuading’ or ‘charming’ someone to have sex and forcing them.

Remind your children:
• No one owes anyone sex.
• ‘Going outside’ with someone at a party or event is not a contract for sex.
• They can change their mind at any time.

Australian Broadcasting Corporation (14 March 2013).
Sex education: still essential in the digital age.
Are young people who get sex education more likely to be sexually active?

**ABC HEALTH & WELLBEING FACT BUSTER FROM EXPERT DR DEBBIE OLLIS**

**Q:** Are young people who get sex education more likely to be sexually active?

**A:** No. Research shows sex education tends to delay onset of sexual activity.

No matter how uncomfortable it makes us feel, at some stage, all children will learn about sex.

Public debate on sex education often focuses on when and how children learn about sex in school and how this information should be included in the curriculum. In private, parents and carers try to figure out what they should say when they have ‘the talk’ with their kids.

Reasons given to explain this reluctance to discuss sex with young people include a concern that doing so might ruin children’s innocence, encourage an unhealthy curiosity about sex or lead to early sexually activity.

When the cervical cancer vaccine became available, for example, the age at which young women should be vaccinated for this sexually transmitted infection became a debate around this very belief – that talking about sex would lead to sex.

But is there any evidence to suggest that this is the case?

Absolutely not, says Dr Debbie Ollis, a senior lecturer in health and education at Deakin University.

“In actual fact, what a number of studies show is that by providing knowledge and understanding, we prepare them to be able to deal with issues.”

**Kids ask age-appropriate questions. There’s this fear that if we give them too much information, we will ruin their innocence. But in actual fact, we know that by providing knowledge and understanding, we prepare them to be able to deal with issues.”**

**Around the world**

A 2009 research review conducted by UNESCO (United Nations Educational Scientific and Cultural Organization) provides some hard data on how sexuality education can influence behaviour.

The review looked at 87 studies from around the world and found:

- None of the programs led to earlier sexual activity in young people
- More than a third of programs delayed sexual activity
- One third of programs lead to a decrease in frequency of sex
- A small percentage (3 per cent) were found to increase frequency of sex
- More than a third of programs lead to a decrease in the number of sexual partners participants had
- None of the programs led to an increase in number of sexual partners.

The review also found that more than a third of the sexuality education programs increased condom or contraceptive use, while more than half reduced sexual risk-taking.

The review also analysed 11 studies on abstinence programs from the United States. In abstinence-only sex education, young people are taught that it’s best to wait – hopefully until marriage – to start having sex. Only two reported showing a delay in the initiation of sex and the rest showed no impact. In addition, none of these studies showed any impact on condom or contraceptive use.

Ollis says a lack of acknowledgement that young people are sexually active can have negative consequences, such as the high rates of teenage pregnancy seen in the United States.

“Yet countries like Holland, Germany and France, that have comprehensive approaches and begin sexuality education in primary schools, have the lowest teenage pregnancy rates of anywhere in the world,” she says.

‘**Sex ed’ grows up**

The key, says Ollis, is the type of sex education young people receive.

No longer called just ‘sex ed’, the sexuality education now taught in Australian schools covers not just the physiological facts about sex but also moral and ethical issues.

“Rather than ... always being concerned with prevention of disease, prevention of pregnancy, prevention of sexual assault – even though those things are really important to include in a comprehensive program – what’s more important is that young people develop a sense that sexuality is a normal part of who we are,” she says.

The benefit of this type of education, says Ollis, is that young people are better able to make sense
of what they see in the media and the world around them, and make informed decisions around issues to do with sexuality.

“That may be around being or not being sexually active; it may be around choices of contraception; it may be around issues to do with their sexual identity; it may be around issues to do with exploring the media’s sexualisation of young people or issues to do with pornography,” she says.

**Education from day one**

Ollis says we should be start sexuality education when children are young – and this can happen at home and at school.

At home, parents can tell preschool children the correct name of body parts, such as penis, vulva or vagina; and start conversations about public and private behaviours.

“I’m not talking about teaching sexual practices in prep (kindergarten), but talking about friendships and understanding your body, that should begin in prep,” she says.

Similar conversations can also happen at home and experts recommend parents:

- Talk early, talk often
- Inform themselves before they start having the conversation
- Remain non-judgemental, even if they are surprised by what they find out
- Make it a regular topic
- Make the most of ‘teachable moments’, such as when you’re watching a movie or reading a book

**The key is the type of sex education young people receive. No longer called just ‘sex ed’, the sexuality education now taught in Australian schools covers not just the physiological facts about sex but also moral and ethical issues.**

- Encourage questions – and if it’s not the right time to answer your child agree to continue the conversation later (and be sure to do so)
- Know what’s going on for your children in many aspects of their lives.

For practical information on how to tackle sexuality education with your children check out ‘Sex education: still essential in a digital age’ on page 46 of this book.

Dr Debbie Ollis is a senior lecturer in health and education at Deakin University. She spoke to Maryke Steffens.
Worried about the sexualisation of children? Teach sex ed earlier

Starting a conversation about sex early in a child’s education is important, writes Jenny Walsh from the Australian Research Centre in Sex, Health and Society

When should sex education begin for children? According to some parent groups who advised the Australian Curriculum, Assessment and Reporting Authority (ACARA), not until Grades 5 and 6. Under this pressure, ACARA pushed back sex education, revising their original guidelines that introduced it at Years 3 and 4.

But just as we’ve decided to push back sexual education to later years, the media has been full of discussion about the sexualisation of children, the effects of marketing on children’s body image and concerns about kids’ exposure to pornography.

Yet what the public and media have misunderstood here, is the capacity for sex education to help combat the negative messages children are learning about sex and their bodies.

We have confused children learning about sex in an appropriate educational context with the sexualisation of children.

LOOK TO THE EVIDENCE

There is complete agreement in the literature that healthy sexual development is dependent on two-way communication between adults and children, and this needs to begin early.

Research from the fields of child abuse and sexual assault tell us that we should begin to teach children the proper names of their sexual body parts, like ‘vagina’, ‘penis’ and ‘anus’, right from the start (in the toddler years) and certainly after school has begun.

This gives children a common language to speak about and understand concepts like acceptable and unacceptable touching.

Later on in the middle school years, children’s perceptions of sex and their bodies change. If looking at my son’s bookshelf is anything to go by, we can reliably call these the ‘Bum Joke years’.

The Society of Obstetricians and Gynaecologists of Canada describe this stage as a time of curiosity, including delight in rude jokes and an interest in, and the capacity to understand, how babies are conceived.

Children are already interested, so now is not the time to shut down the conversation. To do so teaches children something else: that this is a topic fit only for school playground humour.

WHEN DOES PUBERTY BEGIN?

Children need to understand the practical details of managing puberty before it begins to happen in their own bodies, as well as their peers’. And there is increasing evidence that puberty is happening earlier and earlier.

A US study of 4,000 children, published online last week found that boys are reaching puberty two years earlier than previously believed. On average ‘white’ boys started puberty at 10, and ‘black’ children at age 9. Other studies have suggested that girls are also beginning puberty earlier.

Just as we’ve decided to push back sexual education to later years, the media has been full of discussion about the sexualisation of children, the effects of marketing on children’s body image and concerns about kids’ exposure to pornography.

If we want to introduce children to some of the stages of puberty before it begins, then certainly, Year 6 is too...
late. By the time children reach Years 5 and 6, even if covered partly in the previous years, they need to be taught the practical side of the physical, emotional and social changes they’re seeing.

With the advantage of an existing language and capacity to discuss sexual matters these children are more able to critique the media messages and images that they come across.

In recent years, many primary school teachers I work with have, in response to children’s concerns, changed their programs to deal with body image, students’ viewing of pornography online, and exclusion of children who do not fit ‘prescribed’ boy or girl interests.

**GROWING MINDS**

It seems self-evident but children grow in to teenagers. The fourth National Survey of Students Sexual Health, which surveyed almost 3,000 students in Years 10 and 12, found that one quarter of Australian adolescents have sexual intercourse by Year 10, and 50% by Year 12.

80% have had some kind of sexual interaction such as deep kissing and sexual touching by Year 10.

More teenagers are having sex with more partners, and the amount of unwanted encounters is also on the rise. More than a third of high school students have experienced unwanted sex, particularly young women.

Other studies have shown that Australian young people find it hard to communicate sexual boundaries. Because some programs spend their time trying to stop young people from being sexual, rather than helping them towards a healthy sexuality, young people miss the opportunity to consider “how far do I want to go?”

The other important criticism offered by young people is that sex education is often limited to biology and disease without giving them the chance to reflect on their values and priorities. Perhaps, again, we fear that this kind of conversation will give young people license to have sex. Instead we find they are less likely to experience unplanned pregnancies, STIs and sexual coercion.

What the public and media have misunderstood here, is the capacity for sex education to help combat the negative messages children are learning about sex and their bodies.

School-based education programs that focus on helping young people develop values and skills around relationships and sexual decision-making make a difference.

**GREATER KNOWLEDGE**

The evidence shows clearly that sexual learning starts before Grades 5 and 6. Before puberty, knowledge is vital to happily managing our sexual lives.

We have confused children learning about sex in an appropriate educational context with the sexualisation of children.

Our job as educators and parents and policy makers, is not to seal children from their sexual development, nor is it to stop the conversation. We have a part to play in setting guidelines and expectations around this aspect of children’s lives, as we do any other.

Jenny Walsh is a senior member of the Australian Research Centre in Sex, Health and Society at La Trobe University.

WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

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Brainstorm, individually or as a group, to find out what you know about sexual health and relationships.

1. What is contraception and why is it important? (include some examples)

2. What is sexual consent and how does it differ from the legal age of consent?

3. What do the letters STI stand for in relation to sexual health? (include some examples)

4. What is sex education, and why is it important for young people?
Complete the following activities on a separate sheet of paper if more space is required.

There are many factors affecting a young person’s decisions regarding their sexual identity and behaviour. Consider the following factors and explain how each might impact on a young person’s sexuality-related decision-making. Write one to two paragraphs on each; include possible positive and/or negative impacts.

**CULTURAL FACTORS**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**SOCIOECONOMIC FACTORS**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**ENVIRONMENTAL FACTORS**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Complete the following multiple choice questionnaire by circling or matching your preferred responses.

1. **Which of the following sexually transmissible infections is the most common among people aged 15-24?**
   a. HIV
   b. Gonorrhoea
   c. Chlamydia
   d. Genital herpes
   e. Syphilis
   f. Genital warts

2. **What is the most likely way to get a sexually transmissible infection?**
   a. Kissing another person
   b. Wearing tight underwear or jeans
   c. Touching another person
   d. Having sex with an infected person
   e. Using the same glass as an infected person
   f. Using a public toilet

3. **Match the following terms to their correct definitions:**
   1. Chlamydia
      a. This incurable STI can be transmitted through unprotected anal, vaginal and oral sex, and by sharing needles with an infected person. If untreated, it can progress to acquired immunodeficiency syndrome (AIDS).
   2. HIV
      b. Transmitted through vaginal, anal and oral sex, it can cause 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.
   3. Syphilis
      c. This can cause soft, cauliflower-like growths to appear either singly or in clusters in and around the vagina, anus, penis, and/or scrotal area. However, it is much more common to be infected with the virus (also called human papilloma virus or HPV) yet have no symptoms.
   4. Genital herpes
      d. This causes itching, burning in the genital area, discomfort when urinating, a watery vaginal or urethral discharge and weeping, fluid-filled eruptions in the vagina or on the penis. However, many people do not notice symptoms at all.
   5. Gonorrhoea
      e. Caused by a sexually transmitted single-cell parasite. In women, it can cause vaginal itching and pain with a foamy, greenish or yellow foul-smelling discharge. In men, a clear discharge from the penis, irritation of the urethra or a burning sensation after urinating or ejaculating, but most men do not have any symptoms.
   6. Genital warts
      f. 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.
   7. Trichomoniasis
      g. Usually first causes a painless sore on the genitals or anus, but sores are also possible in the mouth inside the vagina or rectum, where they are not easily seen. It can progress to secondary and tertiary stages. The tertiary stage can be fatal.

**MULTIPLE CHOICE ANSWERS**

a = 7, c = 9, g = 5, q = 4, p = 2, d = 0, e = 6, a = 3, j = 1, 1 - 3 = 8, p = 2, f = 1
• In Australia, pregnancy termination (abortion) is the second most common hospital procedure for girls and young women aged 12 to 24 years (Women’s and Children’s Health Network, Sexual and reproductive health of young people). (p.1)
• About 45% of sexually active teenagers in Australia do not use condoms most of the time (ibid). (p.1)
• Half of adolescent pregnancies happen in the first 6 months of sexual activity (ibid). (p.1)
• Teenagers are the most frequent users of emergency contraception (ibid). (p.1)
• Countries such as Australia, USA and Britain, where there is less comprehensive education about sexual health, have significantly higher rates of teenage STIs, teenage pregnancies and terminations (ibid), (p.2)
• Untreated STIs can lead to long-term health problems like infertility, organ damage or blindness (Inspire Foundation, About sexual health). (p.4)
• Research shows alcohol and other drugs affect the decisions people make about safe sex (Centre for Population Health, Making Healthy Choices). (p.11)
• Age of consent laws are designed to protect children and young people from sexual exploitation and abuse. Such laws effectively determine that children and young people below the age of consent do not have the emotional maturity to consent to sexual activities (Commonwealth of Australia, Age of consent laws). (p.13)
• Condoms, even when used correctly, don’t guarantee 100% protection against STIs or unplanned pregnancy (Better Health Channel, Safe sex). (p.14)
• STIs were twice as prevalent among those who had used an illicit drug in the last 12 months or who reported having consumed more than 4 standard drinks on 1 occasion at least once a week (4% respectively compared with 2% of all 15-24 year olds) (AIHW, Australia’s health 2014). (p.15)
• The most effective reversible contraception methods are the ‘fit and forget’ long-acting reversible contraceptives (LARCs) – intrauterine devices (IUDs) and contraceptive implants (SH&FPA, Contraception Choices). (p.17)
• Sterilisation is permanent contraception which can’t be reversed and are 99.5% effective (ibid). (p.18)
• The microbes that cause most STIs are found in semen, blood, vaginal secretions and sometimes saliva. Most of the organisms are spread by vaginal, anal or oral sex, but in some cases, such as genital herpes and genital warts, they may be spread through skin-to-skin contact (myDr, Sexually transmitted infections). (p.19)
• From 1991 to 2012, chlamydia notification rates increased over tenfold from 104 to 1,663 notifications per 100,000 young people (AIHW, Australia’s health 2014). (p.21)
• In 2012, there were 154 HIV notifications for 15-24 year olds, a rate of 5 per 100,000 young people, higher than the 3 per 100,000 in 2001 (ibid). (p.21)
• Teenage pregnancies in Australia have decreased considerably over the last four decades (Women’s Health Queensland Wide Inc, Teenage pregnancy). (p.22)
• 60% of young mothers do not have a male partner when their baby is born (ibid). (p.23)
• A number of STIs are becoming more prevalent in Australia, and young people are among those at highest risk (ACHYS, Young Australians and Sexual Health). (p.33)
• 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 (ibid). (p.33)
• Reported diagnoses of chlamydia more than doubled between 2003 and 2012; more than 82,700 people were diagnosed in 2012, 80% were aged 15 to 29 (ibid). (p.34)
• 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% in 2007 to 1.1% in 2012, and the vaccination program has been extended to include male school students (ibid). (p.34)
• In Australia, a large proportion of students in the final 3 years of high school have had sexual intercourse, but in Years 10 and 11 a larger proportion have not (ibid). (p.34)
• Although among young people as a whole, knowledge of STIs appears to increase with age, some studies have found condom use declining for those in early adulthood (ibid). (p.36)
• Of those who reported having unwanted sex, much higher proportions of young women than young men reported being influenced by a partner or being frightened (ibid). (p.37)
• As many as 70% of cases of chlamydia among young people would be missed if only those presenting with a sexual health concern were tested (ibid). (p.38)
• Australia’s young people are facing a sexual health crisis of epidemic scale, with 75% of all STIs in Australia occurring amongst young people (AYAC and YEAH, Let’s Talk About Sex: Young people’s views on sex and sexual health information in Australia). (p.40)
• Parents and carers have the most significant influence on their child’s developing sexuality and are their primary sexuality educators (FPQ, Common questions about sexuality and relationships education). (p.42)
• For most boys and girls, puberty changes are experienced in primary school. Signs of puberty can commence at 9 years of age (ibid). (p.42)
• One third of all students reported having unwanted sex (38% of young women, 19% young men) (ABC, Sex education: still essential in the digital age). (p.46)
• A UNESCO review has found that more than a third of the sexuality education programs increased condom or contraceptive use, while more than half reduced sexual risk-taking (ABC, Fact Buster: Q: Are young people who get sex education more likely to be sexually active?). (p.49)
• A recent survey found that one quarter of Australian adolescents have sexual intercourse by Year 10, and 50% by Year 12 (Walsh, J, Worried about the sexualisation of children? Teach sex ed earlier). (p.52)
Discussing Sexual Health

AIDS is the late stage of the illness caused by infection with human immunodeficiency virus (HIV).

Age of consent
The age at which an individual can legally have sex. The legal age for consensual sex varies across Australian state and territory jurisdictions. In the Australian Capital Territory, New South Wales, Northern Territory, Victoria and Western Australia, the age of consent is 16 years of age. In Tasmania and South Australia the age of consent is 17 years of age. In Queensland, the age of consent for anal sex (referred to as sodomy in legislation) is 18 years of age, while the age of consent for all other sexual behaviour (described as carnal knowledge) is 16 years of age.

Chlamydia
Chlamydia is a common STI among young people. Most women and about half the men with chlamydia infection have no symptoms or signs of infection. Chlamydia can lead to infertility, if untreated.

Condom
The male condom is a cover for the penis, worn during sex to prevent pregnancy and the spread of STIs. The female condom is a cover that lines the vagina during sex to prevent pregnancy and the spread of STIs.

Contraception
Contraception is used during sexual intercourse to prevent pregnancy. Barrier methods such as condoms are also effective in preventing STIs. There are a number of methods of contraception, non-surgical and surgical. Non-surgical methods include withdrawal or periodic abstinence (rhythm or natural method), condoms (male and female condoms), the pill (combined and mini pills), diaphragm, Depo-provera, spermicides, the morning-after pill, douche and interuterine devices (IUDs). Surgical methods are tubal ligation or hysterectomy in women and vasectomy in men.

Genital warts
People with genital warts may notice soft, cauliflower-like growths appearing either singly or in clusters in and around the vagina, anus, penis, and/or scrotal area. However, it is much more common to be infected with a genital wart virus (also called human papilloma virus or HPV) yet have no symptoms.

Gonorrhoea
An STI that can cause discharge from the vagina or penis and discomfort passing urine. Sometimes there are no symptoms or signs. If left untreated, it can lead to infertility.

Herpes
Infection with herpes simplex virus including cold sores of the mouth and genital herpes. Many people with genital herpes do not notice symptoms at all.

Human immunodeficiency virus (HIV)
HIV is the virus that causes HIV infection and AIDS. HIV can be passed from person to person through sharing intravenous drug equipment. Women with HIV infection can pass the virus to their babies during pregnancy and childbirth. There is currently no way to eradicate the virus once a person is infected, but drugs can slow the damage that HIV causes to the immune system.

Human papilloma virus (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.

Reproductive health
A state of physical, mental and social wellbeing – and not merely the absence of disease or infirmity – in all matters relating to the reproductive system and to its functions and processes, and across all stages of life.

Safe sex
Having sexual contact while protecting yourself and your sexual partner against sexually transmissible infections (STIs) and unplanned pregnancy. Sexual contact that doesn't involve the exchange of semen, vaginal fluids or blood between partners is considered to be safe sex.

Sexual health
A state of physical, emotional, mental and social wellbeing related 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. While sexual health is vital for (and therefore a part of) reproductive health, it is important to also consider sexual health in its own right.

Sexually transmissible infections (STIs)
Also called STDs (sexually transmitted diseases), but the term ‘infection’ is sometimes preferred over ‘disease’ as some STIs (such as chlamydia) can be symptomless. The term ‘VD’ (venereal disease) may also still be used as another name for STIs. Common curable STIs are gonorrhea, syphilis and chlamydia. Viral STIs such as genital warts, herpes and HIV are treatable but cannot be cured.

Syphilis
Syphilis is an STI which can cause serious complications if not treated. There are three possible stages of syphilis: primary, secondary and tertiary. Tertiary syphilis can be fatal.

Unsafe sex
Unsafe sex occurs when precautions are not taken against transmitting infections or against unintended pregnancy. ‘Safe sex’ does not guarantee absolute protection against sexually transmitted diseases and infections, and condoms may not prevent the transmission of genital herpes and warts. Unsafe sex can lead to infections such as gonorrhoea, chlamydia, syphilis, hepatitis and HIV/AIDS, and can have serious and long-term health effects.
Websites with further information on the topic

AIDS Action Council  www.aidsaction.org.au
Australian Institute of Health and Welfare  www.aihw.gov.au
Australian Research Centre in Sex, Health and Society  www.latrobe.edu.au/arcshs
Better Health Channel  www.betterhealth.vic.gov.au
By Choice Not Chance  www.bychoicenotchance.com.au
Child and Youth Health  www.cyh.com
Family Planning Queensland  www.fpq.com.au
Family Planning Tasmania  www.fpt.asn.au
Family Planning Victoria  www.fpv.org.au
Family Planning Western Australia  www.fpwa.org.au
Health Direct Australia  www.healthdirect.gov.au
Love: the good, the bad and the ugly  http://lovegoodbadugly.com
MensLine Australia  www.mensline.org.au
myDr  www.mydr.com.au
Raising Children Network  http://raisingchildren.net.au
ReachOut.com  www.reachout.com.au
Sexual Health and Family Planning Australia  www.shfpa.org.au
Women’s Health Queensland  www.womhealth.org.au
Women’s Health Victoria  www.whv.org.au

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- Women’s and Children’s Health Network
- Australian Research Centre in Sex, Health and Society.

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