

3rd

Secondary Students & Sexual Health

2002 Results of the 3rd National
Survey of Australian
Secondary Students,
HIV/AIDS and Sexual Health

Anthony Smith, Paul Agius,
Sue Dyson, Anne Mitchell
and Marian Pitts.



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Students, HIV/AIDS and Sexual Health**

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Marian Pitts**

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1. EXECUTIVE SUMMARY

The 3rd National Survey of Secondary Students and Sexual Health involved 2,388 young people (55% young women) from Years 10 and 12 from all States and Territories. Consistent with our strategy of increasing the coverage and scope of this important national monitoring system, we have for the first time been able to include students from both the Catholic and Independent school systems. Thus, the results are representative of all students in Years 10 and 12 in Australia.

While there is comfort to be taken from some of the results, particularly in relation to high rates of condom and other contraceptive use, other results are cause for a significant concern.

Knowledge and attitudes

Young people's knowledge of HIV transmission is generally very good, as has been found in previous surveys. However, while the 1997 survey found a decline in a few knowledge items, the present survey identifies a decline in levels of knowledge about HIV transmission generally. More than 10% of students did not know that HIV can be transmitted during sex between men, nearly 25% did not know that a pregnant HIV positive woman could pass on HIV to her baby, and more than 15% did not know that someone who looks healthy could pass on an HIV infection.

Knowledge of sexually transmissible infections (STIs) remains poor but has improved over the past five years. Areas of particular concern relate to the most common infections including chlamydia, gonorrhoea, herpes simplex virus and genital warts. Knowledge about hepatitis A, B and C is also poor but again has improved somewhat over the past five years.

Attitudes towards people with HIV are generally positive, as they have been in previous surveys, as are those towards people infected with Hepatitis C. However, attitudes towards injecting drug users and injecting drug use are negative.

Young people hold generally positive attitudes towards friendship with gay and lesbian peers, although this is more pronounced among young women than young men.

Sexual behaviour and social context

The majority of young people in Years 10 and 12 are sexually active in some way. Vaginal intercourse was reported by approximately one third of students in Year 10 and just over half of those in Year 12. Overall, the proportion of young people who are sexually active has increased over the time of the three surveys (1992, 1997).

Young men in Year 10 are most likely to report three or more sexual partners in the previous year. Among the students who are sexually active, approximately one in three young men in Year 10 reported three or more sexual partners in the previous year. The proportion of young men and young women in Year 12 reporting three or more partners in the previous year has nearly halved since 1992.

The use of condoms and other forms of contraception is common with 65.8% of sexual active young people in Year 10 reporting that they always used condoms. Reports of always using condoms was lower in Year 12 (51.8%) and can be accounted for by higher rates of use of the oral contraceptive pill. In relation to the most recent sexual encounter, 72.4% of young people in Year 10 and 56.6% of those in Year 12 reported that a condom was used.

Just over a quarter (25.9%) of all sexually active students report that they have had unwanted sex at some time in their lives. The most common reasons cited for having engaged in unwanted sex were being too drunk (15.9%) and pressure from a sexual partner (12.6%).

In relation to the most recent sexual encounter, 22.7% indicated that they were drunk or high at the time. However, the majority of students reported overwhelmingly positive feelings in relation to their most recent sexual encounter.

Approximately 2% of the most recent sexual encounters were same sex encounters. In all, some 3.3% of young men and 6.7% of young women report being attracted to their own sex with an additional 1.3% of young men and 2.1% of young women being unsure. Young people report high levels of confidence in their ability to say no to unwanted sex and to convince a partner to use condoms. They are far less confident in their ability to discuss matters related to sexuality, including contraception, with their parents.

Health status

Young people report their health status as generally good, with young men being somewhat more likely than young women to report their health as good. Very few students report having been diagnosed with either STIs or blood-borne viruses: 3.5% of sexually active students report STIs; 0.6% of all students report hepatitis A, B or C, with an additional 0.9% being unsure of the type with which they had been diagnosed.

Consistent with poor knowledge about hepatitis, a significant minority of young people are uncertain whether they have been vaccinated against hepatitis A and B. About a quarter of all students mistakenly believed they have been vaccinated against hepatitis C. Fewer than ten percent of students believed that they were 'likely' or 'very likely' to become infected with hepatitis B, hepatitis C, an STI or HIV.

Rates of alcohol use and binge drinking are increasing. This is most notable among Year 10 students. Also, the alcohol use patterns of young men and young women are becoming increasingly similar. Injecting drug use remains rare.

Body transformation practices such as tattooing and piercing are very common. While most of these practices are undertaken in controlled settings, the opportunity for unsafe practices is clearly present.

Members of the school community, along with parents, friends and siblings, are important sources of advice regarding HIV, STIs and contraception. It is clear that school programs continue to be highly valued as an information source for young people and need to be expanded. While the use of the internet is nearly universal, young people are appropriately dubious of the quality of internet-based information regarding sexuality or sexual health.

2. INTRODUCTION

This, the 3rd National Survey of Secondary Students and Sexual Health, follows surveys conducted in 1992 and 1997. The surveys are descriptive in intent and are designed to inform educational policy and practice within the domain of sexual health.

With each survey administration there is an opportunity to explore emerging issues of concern or modify the approach to particular topics, with the aim of increasing the policy and programmatic relevance of the findings. There is, of course, a necessary tension here since one important role of the surveys is to chart changes in sexual health-related knowledge, attitudes and practices and in order validly to identify change, it is vital to use the same measures each time the questionnaire is administered. Thus, each survey represents a compromise between looking to past administrations to ensure comparability and looking forward to new, emerging or evolving issues.

The present survey incorporates a greater emphasis on sexually transmissible infections and blood-borne viruses. This is done not only with respect to young people's knowledge about sexually transmissible infections and blood-borne viruses but also their potential exposure to blood-borne viruses through the body transformation practices of piercing and tattooing. Greater emphasis is also placed on the context of sexual encounters. In part this reflects the increasing importance of this topic simply because increasing numbers of young people are now sexually active. It also underlines the need to understand more about the circumstances in which young people are sexually active and the ways in which context is correlated with sexual safety.

Another aspect of the evolution of these surveys is reflected in the student sample. In 1992 the sample was drawn from the Government school system in all States and Territories except New South Wales. The 1997 sample included students from Government schools in New South Wales. The current survey constitutes a random sample of schools from the Government, Catholic and Independent school systems in all States and Territories and thus provides even greater confidence that the results fully and accurately reflect the sexual health-related knowledge, attitudes and behaviours of young people in Years 10 and 12.

3. METHODOLOGY AND SURVEY SAMPLE

The questionnaire

The 2002 questionnaire included several of the questions asked in the 1997 survey for comparative purposes, but also included new items pertaining to attitudes towards same sex attracted people, people with Hepatitis, injecting drug use, pregnancy, oral sex, students' most recent sexual encounter, general health, body piercing and tattooing, and the Internet as source of information on sexual health and sexuality. These new issues have been identified over the last five years as important by teachers and health workers in relation to their experience with young people.

The 2002 questionnaire comprised seven sections and is included in Appendix B. Section A related to demographics and student background, while Section B comprised items measuring HIV/AIDS knowledge, perceived HIV risk and attitudes toward people living with HIV and Hepatitis, injecting drug use, and same sex attracted people. Section C comprised items relating to sexual attraction, feelings and confidence in talking to peers and parents/guardians about a range of sexual matters, and peer condom use. Section D included questions covering students' personal experiences of sex generally and in terms of the last sexual encounter – students who had not experienced sexual intercourse were instructed not to respond to questions relating to sexual intercourse. Section E included questions on student alcohol use and injecting drug use, while Section F comprised items relating to body piercing and tattooing and the general health of students. The final part, Section G, comprised a set of true/false knowledge questions relating to sexually transmitted infections and blood borne viruses (two new items testing Hepatitis C knowledge), items related to perceived risk of STIs and blood borne virus infection, Hepatitis vaccination and diagnosis, sources of information relating to HIV/AIDS, STIs, Hepatitis and contraception, and the value of the Internet as a source of information on sexuality and sexual health.

Responses to questions C4 ('Have you ever had sex?') and the age at first experience of sex with and without a condom (questions on D1) were used to establish whether students had experienced sexual intercourse.

Pilot study

The survey instrument was piloted to test the readability and comprehension of individual questions, and to establish average time of completion. For the 2002 survey, the term 'infection' was used in place of 'disease' when referring to sexually transmitted diseases (STDs), as it has greater relevance to current sexual health education. In order to ensure construct validity of STI/STD items across the respective survey administrations (1992, 1997, 2002), the piloting incorporated an analysis of potential differences in student responses to knowledge scales and individual items through the use of different terminology. Distribution of questionnaires to students involved during piloting was arranged to ensure half the class received 'infections' questionnaires, and the other 'disease' versions.

The survey was piloted in two schools in Victoria in December 2001 and March 2002. The first school was an independent co-educational college located in a regional setting; the second was a co-educational government college in a suburban area. In total, 66 students participated in piloting. Most were either 15 or 16 years of age, and 6% had been born overseas. Thirty percent of students had parents who had been born overseas, and 2% of students came from families in which English was not the main language spoken at home.

The instrument piloted effectively. Most students completed the survey within 30 minutes, and there was little missing data. Students were given a blank sheet of paper to record any comments about the survey or problems they might have had with understanding instructions or terminology. Once surveying was completed, brief focus group discussions were held to explore any difficulties or reservations students had regarding the survey or the process.

Subsequent data analysis of STI knowledge scales and other key STI items showed no significant differences between student responses to items using the term 'infection' rather than 'disease' (as used in 1992 and 1997). On the basis of the pilot survey and focus group discussions some modifications were made to the questionnaire.

Sampling method and participation rates

This study used a representative random sample based on Australian Bureau of Statistics data on the school population. A two-stage sampling method was used to select schools and students within them. In the first stage, schools were randomly selected with a probability proportional to the size of the target population. The smaller States/Territories were over-sampled to improve the precision of the results derived for those States/Territories. A replacement school was selected for each of the schools in the selected sample. If an original school was unable to participate then the replacement school was approached. The replacement school was a school from the same sector and geographically closest to the one originally selected. The assumption here is that students in the replacement school, based on geographic proximity, would have similar characteristics to those of the original school. The total number of schools surveyed was 110 (see Table 3.1).

As the willingness of schools to participate in surveying was measurably lower in 2002 than the 1992 and 1997 surveys, it was necessary to vary sampling methodology and to approach all schools (i.e. first and second replacements) in the sampling frame midway through the recruitment process to ensure adequate sample size. Third and fourth replacements for schools were sought once the original replacement set had been exhausted by non-consent.

In the second stage of sampling, a class of Year 10 students and a class of Year 12 students were randomly selected in participating schools. Where the class size was less than 20 an additional class at that year level was randomly selected. In some cases, school structuring of classes was such that random selection of mutually exclusive class units could not be achieved. In these instances, students from each year level were selected at random from de-identified student lists.

The overall response or participation rate was 54% which is lower than the rate achieved in the 1997 survey (68%). Year 10 students (58%) had a higher response rate than Year 12 students (50%). The achieved sample size and response rates for each State and Territory are detailed in Table 3.1.

The survey results have been weighted in the data analyses to correct for over-sampling in the sample design and for differential response rates across States/Territories and schools. Also,

data were stratified by State/Territory for analysis. Although data were sampled proportionally in each state/territory and school sector, stratum weights were derived using total school enrolments by state/territory only in order maintain consistent sample methodology with 1992 and 1997 surveys. Comparison of key analyses using state only and state by school sector approaches to sample weighting and stratification showed no measurable differences. For information on the derivation of the stratum weights see Rosier (1995).

Demographic characteristics of the sample

Sample size and participation rates achieved in each state and territory are summarised in Table 3.1. As was the case in 1992 and 1997, more female students than male students participated in the 2002 survey (Table 3.2). When students only from government schools only are compared the difference in participation between males and females is greater. In the past, teachers have argued that a reason for the gender difference in participation is that female students are more reliable in returning permission forms to school than male students and therefore are more likely to be permitted to undertake the survey.

The large majority of students (90%) were born in Australia (Table 3.3) and, for most, English was the main language spoken at home. Three percent of the sample were either Aboriginal or Torres Strait Islanders (Table 3.4), and a considerable minority (37%) had either a mother or father who was born overseas. The sample comprised more Year 10 students (58%) than Year 12 students (42%), with the median age of Year 10 and Year 12 students as 15 and 17 years respectively.

Table 3.1. Sample size and participation rate in each State and Territory.

State/territory	Total number of schools	Achieved sample size	Response rate (%)
ACT	8	198	60.3
NSW	15	319	57.9
NT	5	115	46.6
QLD	25	632	49.7
SA	9	198	51.2
TAS	16	263	61.6
VIC	30	640	50.6
WA	2	23	49.8
Total	110	2388	54.0

Table 3.2. Gender and year level composition of the sample (%).

	Year 10				Year 12				Total			
	1992	1997	2002 (Govt only)	2002 (all schools)	1992	1997	2002 (Govt only)	2002 (all schools)	1992	1997	2002 (Govt only)	2002 (all schools)
Males	45	46	42	46	43	43	38	44	44	44	40	45
Females	55	54	58	54	57	57	62	56	56	56	60	55
Total	52	50	57	58	48	50	43	42	26	52	22	31
Total Males	412	815	358	632	353	755	242	445	765	1570	600	1077
Total Females	499	969	489	746	477	1011	403	565	976	1980	892	1311
Total	911	1784	847	1378	830	1766	645	1010	1741	3550	1492	2388

Table 3.3 Students' and parents' country of birth (%).

Country		Student	Mother	Father
Australia	Male	89.4	70.0	69.9
	Female	90.7	70.5	71.7
	Total	90.1	70.3	70.9
New Zealand	Male	1.6	2.4	1.8
	Female	1.5	3.0	2.0
	Total	1.6	2.8	1.9
United Kingdom	Male	1.5	9.0	8.5
	Female	1.3	8.2	8.5
	Total	1.4	8.5	8.5
Europe & Middle East	Male	1.1	5.3	7.6
	Female	1.5	5.4	7.6
	Total	1.3	5.3	7.6
Vietnam	Male	0.2	2.1	1.6
	Female	0.2	1.2	1.3
	Total	0.2	1.6	1.4
Other Asia & Pacific	Male	4.5	9.0	6.9
	Female	3.3	7.8	6.1
	Total	3.8	8.3	6.5
America	Male	0.7	0.8	1.5
	Female	0.9	1.6	1.4
	Total	0.8	1.3	1.4
Africa	Male	1.1	1.5	2.1
	Female	0.8	2.1	1.3
	Total	1.0	1.8	1.6
Other	Males	0.0	0.0	0.1
	Females	0.0	0.2	0.2
	Total	0.0	0.1	0.1
	Total males	1028	1019	1014
	Total females	1339	1337	1334

Table 3.4 Aboriginal and Torres Strait Islander students: 2002 sample (%).

		Total
Aboriginal	Male	2.2
	Female	2.1
	Total	2.1
	Total males	887
	Total females	1176
Torres Strait Islander	Male	0.4
	Female	0.7
	Total	0.6
	Total males	872
	Total females	1160

Survey administration

School principals were sent a letter inviting their school to participate and asking them to nominate a school contact person. The contact letter contained a description of the survey and its background, and the processes involved in its administration. The school contact person was either a teacher, a deputy principal or a school nurse. Once agreement was gained from individual schools, research staff would send survey information packs including questionnaires, parent/student consent pro-forma and instructions for conducting the survey. School contacts arranged for consent letters to be sent home to parents, permission slips to be returned, and established the time and place for the survey.

Survey administration was undertaken by the school contact at each school. To protect confidentiality of the students the survey was carried out under exam conditions in most cases. Where possible, students were seated at separate desks and asked not to talk or discuss the survey while completing it. Students were made aware that they could withdraw from the survey at any time they wished. Students were requested not to put identifying information on their questionnaires and were supplied with a blank sealable envelope in which to place the completed surveys.

On completion of the survey, students were provided with an Information sheet showing correct answers to the 'true/false' STI, HIV/AIDS and Hepatitis knowledge questions asked in

the survey (see Appendix B). Students were also given a pocket sized card containing referral telephone numbers for the relevant sexual health centre, Kids Help and Life Lines in the relevant state/territory.

Data management and analysis

The data were entered manually and the entire data set was verified. Microsoft Access 2000 was used to develop a relational database to manage sample data and information relating to administration of the survey. Open-ended questions were coded by trained research staff. Throughout the project procedures were in place to protect the confidentiality of participants. No lists of student names were kept once the data had been collected

The data analysis involved a detailed description of the 2002 data, analysed by gender and year level. In addition, change over time was measured by comparing 2002 data with data collected in the 1992 and 1997 surveys. The bulk of the data analysis was performed using the STATA 7.0 statistical package (Stata Corporation, 2002). The SPSS for Windows 11.0.1 software package was also used for data management and cross-validation data analysis (SPSS Inc, 2001).

Analyses were carried out to detect whether the changes between 2002 and either 1997 or 1992 surveys were statistically significant. Testing for change over time (i.e. between survey administrations) was conducted only for students from Government schools, to ensure any differences were not confounded by the addition of Catholic and Independent school sectors to the 2002 sample. In most cases analyses of data by survey administration involved categorical comparisons (using survey administration as an independent variable), but where linear trends were identified in data over time, survey administration was treated as an interval level variable. For the purposes of testing for change over time, neither age, gender or State/Territory differences were taken into account.

In all three surveys, samples were defined as cluster samples, in that participants were selected by classroom rather than randomly across the year level. Significance testing between survey administrations took this sample clustering into account. It should also be noted that schools in New South Wales did not participate in the 1992 survey.

Unit weighted composite scales were computed to measure student knowledge of HIV/AIDS, STIs and Hepatitis (Chapter 4), and students' self reported general health (Chapter 6). For infection knowledge measures, students' correct answers to true/false questions were aggregated to derive knowledge scores, with higher scores indicating better knowledge. The SF-36 general health composite measure was used to score students for self-reported general health (Ware et al, 1994). Student scores on the SF-36 general health measure were computed using recommended methodology and could range from 0 to 100. A high score on this measure indicated better self-reported general health.

Limitations of the survey

The National Schools Survey provides data on the knowledge, attitudes and practices of young people in relation to HIV/AIDS, STIs and related diseases. It is useful for examining broad patterns in behaviour, knowledge and attitudes, and how these have changed over time. For the first time the National Schools Survey includes Catholic and Independent schools, making the 2002 sample the most representative in terms of student sexual practice in Year 10 and Year 12 in Australia. There are, however, some limitations to this research.

Compared with the rate achieved in the 1997 survey, the response rate for this survey was somewhat lower (54%). It is not entirely clear what factors caused this decline. However, anecdotal evidence suggested that both increased teacher/school contact workload and more frequent research in schools across the country generally had a negative effect on school and student participation in the survey. Other factors, such as changes in school personnel who were involved in administration of the survey and differing levels of authority of appointed school contacts, also made effective implementation of the survey more difficult and may have adversely affected the participation rate. In a considerable number of cases (28 of the 138 consenting schools), despite the schools giving consent to the survey and receiving information packs, the project researchers had difficulty maintaining contact with the schools and surveying was not completed by the data collection deadline.

Non-response can affect survey results systematically when the nature of research discourages participation of particular groups of people for personal and/or cultural reasons. In terms of this survey, the requirement of parental consent may have excluded some students whose parents had limited English literacy skills, and those from communities where parental

permission forms are not culturally appropriate. Also, students with parents who object to a survey on sexual health for religious or cultural reasons may have been less likely to participate. For those who did participate in the research, the questionnaire favoured students with good English literacy skills and those who could complete a complex set of questions in a relatively short period of time in an examination style setting.

4. KNOWLEDGE AND ATTITUDES

Key findings

- *Levels of knowledge about HIV transmission are high yet knowledge about HIV transmission is clearly declining*
 - *Knowledge about STIs remains poor but is improving, as is knowledge about Hepatitis A, B and C*
 - *Attitudes towards people with HIV are generally positive, as are those towards people infected with Hepatitis C*
 - *Attitudes towards injecting drug users and injecting drug use are negative*
 - *Young people hold generally positive attitudes towards friendship with gay and lesbian peers*
-

Introduction

There is no simple relationship between knowledge, attitudes and behaviour. However, accurate knowledge and appropriate attitudes are clearly associated with the adoption and maintenance of health protective behaviours. In previous surveys we have found high levels of knowledge about HIV transmission and supportive attitudes towards people living with HIV. Knowledge about STIs and blood borne viruses, except HIV, has been generally poor.

Knowledge about HIV transmission

Accurate knowledge about HIV transmission is evident among the majority of students (Table 4.1). The overwhelming majority of students knew that sharing a needle and syringe when injecting drugs could lead to HIV transmission (97.4%), that a woman could be infected with HIV from sex with a man (95.4%), that HIV could not be spread through hugging someone who has the virus (97.8%) and that a man could get HIV by having sex with a man (87.4%). Similarly, the majority of students knew that HIV is not transmitted through coughs or sneezes (86.9%) that oral contraceptive pill offers no protection against HIV transmission

(89.8%), and that condoms offer protection against transmission (89.0%). Poorest student knowledge of HIV/AIDS was demonstrated in terms of the spread of the virus by mosquitoes (40.7% correct). Approximately one in four students (24.7%) did not know that a pregnant woman with HIV could pass the infection on to her baby.

The answers to the individual HIV knowledge items were aggregated to form an HIV transmission knowledge scale (Table 4.2). The scale ranges from 0 to 11, with zero indicating that the student answered all questions incorrectly and 11 indicating that the student answered all the questions correctly.

Despite generally high levels of knowledge, students' knowledge of HIV transmission has declined in several areas. In the 1997 survey there were notable decreases in the proportion of students with accurate knowledge with respect to three items about HIV transmission (see Table A.1 in Appendix A). In the present survey, however, the decline in student knowledge of HIV transmission has exhibited a more universal decline. Significantly fewer students knew that HIV could not be transmitted by mosquitoes or by an infected person coughing or sneezing, that a pregnant woman with HIV could pass the infection on to her baby. Fewer also gave correct answers to questions pertaining directly to safe sex practices, sexual transmission of HIV, the role of condoms in HIV protection, and the fact that someone who looks healthy can nonetheless pass on HIV (see Table A.1 in Appendix A).

Table 4.1. Students answering HIV transmission knowledge items correctly (%).

Knowledge Item		Year 10	Year 12	Total
Could a person get HIV (the AIDS virus) by sharing a needle and syringe with someone when injecting drugs?	Males	96.6	98.8	97.5
	Females	96.1	98.9	97.3
	Total	96.3	98.9	97.4
Could a woman get HIV (the AIDS virus) through having sex with a man?	Males	94.3	95.7	94.9
	Females	96.0	95.5	95.8
	Total	95.2	95.6	95.4
If someone with HIV coughs or sneezes near other people, could they get the virus?	Males	82.2	87.0	84.2
	Females	86.7	92.1	89.0
	Total	84.7	89.9	86.9
Could a man get HIV through having sex with a man?	Males	85.7	92.3	88.4
	Females	83.1	91.3	86.5
	Total	84.2	91.7	87.4
Could a person get HIV from mosquitoes?	Males	38.6	37.3	38.1
	Females	42.8	42.5	42.7
	Total	41.0	40.2	40.7
If a woman with HIV is pregnant, could her baby become infected with HIV?	Males	67.9	75.2	71.0
	Females	73.7	85.3	78.7
	Total	71.2	81.0	75.3
Could a person get HIV by hugging someone who has it?	Males	95.6	97.5	96.4
	Females	98.6	99.5	99.0
	Total	97.3	98.6	97.8
Does the pill (birth control) protect a woman from HIV infection?	Males	85.4	89.9	87.3
	Females	89.8	94.3	91.7
	Total	87.9	92.4	89.8
Could a man get HIV through having sex with a woman?	Males	86.6	89.6	87.9
	Females	90.3	88.2	89.4
	Total	88.7	88.8	88.7
If condoms are used during sex does this help to protect people from getting HIV?	Males	88.6	91.8	90.0
	Females	86.0	91.4	88.3
	Total	87.2	91.6	89.0
Could someone who looks very healthy pass on HIV infection?	Males	80.3	79.5	80.0
	Females	83.4	90.0	86.2
	Total	82.1	85.4	83.5

Table 4.2. Students' mean HIV transmission knowledge score.

	Year 10	Year12	Total
Males	9.0	9.4	9.2
Females	9.3	9.7	9.4
Total	9.2	9.5	9.3

In summary, students exhibited high levels of HIV/AIDS knowledge, as was the case in the 1992 and 1997 surveys (Table A.2). Students in Year 12 had better HIV/AIDS knowledge on average than students in Year 10, and young women had better knowledge than did young men. These patterns were also apparent in 1992 and 1997. However, despite this high HIV/AIDS knowledge score, overall knowledge in the area has significantly decreased between each survey administration. The decrease in HIV/AIDS knowledge was consistent for both young men and women at each school year level (Table A.2).

Knowledge about sexually transmissible infections

Students' knowledge of STIs was patchy (Table 4.3). Over three quarters of the students surveyed were aware that both men and women can have a sexually transmissible infection without showing any obvious signs of infection, that condoms offer only limited protection when used during sex, and that the statement, 'HIV only infects gay men and injecting drug users' was false. The majority also knew that not all STIs could be cured.

Knowledge surrounding specific diseases and their effects on health and transmission was poorer. Students' knowledge regarding Chlamydia as an STI that affects both men and women was poor (only one fifth of the sample were aware of this fact), and awareness that this disease can lead to sterility in women was also low (36%). Other areas in which there was poor STI knowledge included: the spread of genital warts (HPV) infection through contact with an infected person without sexual intercourse, oral transmission of gonorrhoea, and the nature and health impact of genital herpes.

Apart from condom use and protection against STIs (where only marginal gender differences were evident) female students demonstrated better knowledge than their male counterparts on all STI knowledge items.

Compared to the results of the 1997 survey, students demonstrated better knowledge with respect to an understanding of the long term effects and nature of the herpes virus, and are

more likely to be aware that gonorrhoea can be transmitted through having oral sex (Table A.3). There is improved understanding that genital warts (HPV) can be spread through contact with an infected person without sexual intercourse, and are more likely to know that Chlamydia is a disease that affects both men and women, sometimes leading to sterility in women. (Correct answers are in Appendix B)

Table 4.3. Students giving correct responses to statements about STIs (%).

		Year 10	Year 12	Total
A man can have a sexually transmitted infection without any obvious symptoms.	Males	69.6	81.4	74.6
	Females	82.7	87.7	84.8
	Total	77.0	85.0	80.4
A woman can have a sexually transmitted infection without any obvious symptoms.	Males	69.7	80.1	74.1
	Females	83.9	89.8	86.4
	Total	77.7	85.6	81.1
Apart from HIV, all sexually transmitted infections can be cured.	Males	52.6	61.9	56.5
	Females	61.2	71.3	65.5
	Total	57.5	67.3	61.6
Chlamydia is a sexually transmitted infection that affects only women.	Males	13.7	17.2	15.2
	Females	15.6	28.6	21.1
	Total	14.8	23.7	18.5
Chlamydia can lead to sterility among women.	Males	23.7	30.1	26.4
	Females	37.8	49.7	42.9
	Total	31.7	41.3	35.8
Once a person has caught genital herpes, then they will always have the virus.	Males	41.6	37.0	39.7
	Females	53.5	66.2	58.9
	Total	48.4	53.6	50.6
People who always use condoms are safe from all STIs.	Males	69.4	80.7	74.2
	Females	74.4	82.7	77.9
	Total	72.2	81.9	76.3
Gonorrhoea can be transmitted during oral sex.	Males	34.2	41.4	37.3
	Females	41.7	46.5	43.7
	Total	38.5	44.3	40.9
Genital warts can only be spread by intercourse.	Males	29.0	37.0	32.4
	Females	45.2	55.4	49.6
	Total	38.2	47.5	42.1
HIV only infects gay men and injecting drug users.	Males	73.1	86.9	78.9
	Females	85.4	91.7	88.1
	Total	80.1	89.6	84.1
Cold sores and genital herpes can be caused by the same virus.	Males	35.2	41.4	37.8
	Females	51.3	55.2	52.9
	Total	44.3	49.2	46.4

The answers to these individual knowledge items were aggregated to form a STI knowledge scale (Table 4.4). The scale ranges from zero to 11, with zero indicating that the student got no questions right and 11 indicating that the student got answered all questions correctly.

Students in Year 12 had higher scores than did students in Year 10. Female students in both years had higher scores than their male counterparts. Although STI knowledge has increased over time generally, the improvement in knowledge is significant only for female students (Table A.4).

Table 4.4. Students’ mean STI knowledge scores.

	Year 10	Year 12	Total
Males	5.1	5.9	5.5
Females	6.3	7.3	6.7
Total	5.8	6.7	6.2

Knowledge about Hepatitis A, B and C

Students’ knowledge regarding Hepatitis remains poor (Table 4.5). Only 13% of students surveyed were aware one could not be vaccinated against Hepatitis C, and half did not know that Hepatitis C could be transmitted by tattooing or body piercing, or that Hepatitis B could be transmitted through sex. Students’ Hepatitis awareness was highest when associating injecting drug use with risk of Hepatitis C infection. Of students surveyed, 71% correctly identified the statement, ‘People who have injected drugs are not at risk of Hepatitis C’, as false. The majority of students were unaware that not all people with Hepatitis C could be cured (58%), or that the virus could be transmitted by sharing a razor or toothbrush of a person infected with Hepatitis C (68%). Nearly half the students did not know that Hepatitis C has long-term health effects.

Unlike students’ pattern of knowledge about HIV or STIs, there was no gender pattern in knowledge about Hepatitis. Young women demonstrated more accurate knowledge with respect to six of the nine items but were less likely than young men to know that it is not possible to be vaccinated against Hepatitis C, that Hepatitis B can be sexually transmitted and that Hepatitis C can be transmitted by sharing razors and toothbrushes. There was also no significant difference between students in Years 10 and 12 (Table 4.6).

Table 4.5. Students giving correct responses to statements about Hepatitis (%).

Knowledge Item		Year 10	Year 12	Total
Hepatitis C has no long term effects on your health.	Males	49.7	52.6	50.9
	Females	54.3	59.0	56.3
	Total	52.3	56.3	54.0
It is possible to be vaccinated against Hepatitis A.	Males	46.9	53.9	49.9
	Females	57.4	54.8	56.3
	Total	52.9	54.4	53.5
It is possible to be vaccinated against Hepatitis B.	Males	59.8	59.4	59.6
	Females	74.4	70.1	72.6
	Total	68.1	65.5	67.0
It is possible to be vaccinated against Hepatitis C.	Males	10.1	16.7	12.9
	Females	11.1	15.0	12.8
	Total	10.7	15.8	12.8
People who have injected drugs are not at risk for Hepatitis C.	Males	63.9	77.2	69.5
	Females	70.7	74.3	72.2
	Total	67.8	75.6	71.1
Hepatitis C can be transmitted by tattooing and body piercing.	Males	42.8	51.9	46.6
	Females	52.7	59.1	55.4
	Total	48.4	56.0	51.6
Hepatitis B can be transmitted sexually.	Males	45.8	47.8	46.6
	Females	35.6	38.1	36.6
	Total	40.0	42.3	41.0
All people that have Hepatitis C can be cured	Males	35.8	39.9	37.5
	Females	44.1	47.8	45.6
	Total	40.5	44.3	42.1
Hepatitis C can be transmitted by sharing razors and toothbrushes	Males	34.2	38.2	35.9
	Females	29.1	29.2	29.2
	Total	31.3	33.0	32.0

The answers to these individual knowledge items were aggregated to form a Hepatitis knowledge scale (Table 4.6). The scale ranges from zero to seven, with zero indicating that the student got no answers right and seven indicating that the student got all of the answers correct.

With respect to the summary score for Hepatitis knowledge, there were no significant differences between male and female students, and students in Years 10 and 12 (Table 4.6)

Table 4.6. Students' mean Hepatitis knowledge score.

	Year 10	Year 12	Total
Males	3.2	3.6	3.4
Females	3.6	3.7	3.6
Total	3.4	3.7	3.5

Notwithstanding the generally incomplete knowledge students had about Hepatitis, there has been a marked increase in general Hepatitis knowledge between 1997 and 2002 surveys (Table A.5). With the exception of one item ('Hepatitis B can be transmitted sexually'), there have been significant increases across each dimension of Hepatitis knowledge. The areas showing most improvement were recognition of vaccinations for Hepatitis A and B, and an understanding of the potential long-term negative effects on health of Hepatitis C.

Attitudes toward people living with HIV/AIDS

Students expressed generally unprejudiced attitudes toward people living with HIV, with female students being more positive than male (Table 4.7). Students showed positive attitudes on questions about friends, with 87% disagreeing or strongly disagreeing with the statement that 'I would stop being friends with someone if that person got HIV'. Similarly, 79% agreed or strongly agreed with the statement that 'Young people who have HIV should be allowed to stay in school'. On less personalised issues young people expressed more negative attitudes, although the majority were still supportive. Two out of three (68%) disagreed or strongly disagreed with the statement that 'People with HIV have only themselves to blame' and 62% agreed or strongly agreed with the statement that 'People who have HIV should be allowed to work with young people'. Although generally there were no significant changes in student attitudes toward people living with HIV between 1997 and 2002 surveys, there was an apparent trend, since the 1992 survey, for students to develop more positive attitudes towards people living with HIV (Table A.7 - Table A.10). Interestingly, this trend was not evident for young men in Year 10, with this cohort exhibiting less positive sentiment towards people living with HIV than their counterparts in either 1992 or 1997 surveys.

Table 4.7. Students' agreement (%) with statements about people with HIV.

Statement			Year 10	Year 12	Total
I would stop being friends with someone if that person got HIV	Males	Strongly disagree/Disagree	73.8	82.0	77.2
	Females	Strongly disagree/Disagree	94.1	93.1	93.7
	Total	Strongly disagree/Disagree	85.3	88.3	86.5
Young people who have HIV should be allowed to stay in school	Males	Strongly agree/Agree	73.4	76.9	74.9
	Females	Strongly agree/Agree	80.6	82.6	81.5
	Total	Strongly agree/Agree	77.5	80.2	78.6
People with HIV have only themselves to blame	Males	Strongly disagree/Disagree	58.2	66.4	61.7
	Females	Strongly disagree/Disagree	73.9	73.2	73.6
	Total	Strongly disagree/Disagree	67.1	70.3	68.4
People who have HIV should be allowed to work with young people	Males	Strongly agree/Agree	53.8	66.2	59.0
	Females	Strongly agree/Agree	63.1	67.7	65.1
	Total	Strongly agree/Agree	59.0	67.0	62.4

Attitudes towards lesbian and gay students

Students were asked for their responses to scenarios involving hypothetical friendships with lesbian and gay students. Generally, students expressed favourable attitudes toward maintaining friendships with people who identified as lesbian or gay. Over three quarters of those surveyed were happy to have a friendship with a lesbian (Table 4.8) and would not end a friendship with someone if they found out she was a lesbian. Although still a majority, notably fewer students expressed favourable attitudes towards friendships involving young men who were gay. Three quarters of the sample (77.4%) disagreed with the statement that they would stop being friends with a male friend if they found out he was gay and 69% reported they would be happy to have a friendship with a male if he was gay.

Table 4.8. Students' agreement with statements about gay and lesbian friends (%).

Statement			Year 10	Year 12	Total
I would stop being friends with someone if I found out he was gay	Males	Strongly agree/Agree	27.1	18.3	23.4
		Not sure	22.3	19.5	21.1
		Strongly disagree/Disagree	50.6	62.2	55.5
	Females	Strongly agree/Agree	3.1	1.0	2.2
		Not sure	3.7	3.2	3.5
		Strongly disagree/Disagree	93.2	95.8	94.3
	Totals	Strongly agree/Agree	13.5	8.5	11.4
		Not sure	11.9	10.2	11.2
		Strongly disagree/Disagree	74.6	81.3	77.4
I would stop being friends with someone if I found out she was a lesbian	Males	Strongly agree/Agree	5.2	0.8	3.3
		Not sure	8.1	7.8	8.0
		Strongly disagree/Disagree	86.7	91.4	88.7
	Females	Strongly agree/Agree	3.0	2.0	2.6
		Not sure	10.2	7.7	9.1
		Strongly disagree/Disagree	86.8	90.3	88.3
	Totals	Strongly agree/Agree	3.9	1.5	2.9
		Not sure	9.3	7.7	8.6
		Strongly disagree/Disagree	86.7	90.8	88.5
I would be happy to have a friend if he was gay	Males	Strongly agree/Agree	38.6	52.1	44.3
		Not sure	24.9	25.5	25.1
		Strongly disagree/Disagree	36.5	22.4	30.6
	Females	Strongly agree/Agree	87.5	89.8	88.5
		Not sure	9.4	5.3	7.6
		Strongly disagree/Disagree	3.1	4.9	3.9
	Totals	Strongly agree/Agree	66.2	73.5	69.3
		Not sure	16.1	14.0	15.2
		Strongly disagree/Disagree	17.7	12.5	15.5
I would be happy to have a friend if she was a lesbian	Males	Strongly agree/Agree	86.6	89.4	87.8
		Not sure	9.6	8.2	9.0
		Strongly disagree/Disagree	3.8	2.4	3.2
	Females	Strongly agree/Agree	71.5	79.5	74.8
		Not sure	21.9	16.1	19.5
		Strongly disagree/Disagree	6.6	4.4	5.7
	Totals	Strongly agree/Agree	78.0	83.8	80.5
		Not sure	16.6	12.7	14.9
		Strongly disagree/Disagree	5.4	3.5	4.6

Young women were more positively disposed towards friendship with young gay men than with young lesbians. Conversely, young men were more positively disposed towards friendship with young lesbians than with young gay men. However, the difference was more marked among young men. This gendered pattern of attitudes towards homosexuality has been observed in other Australian studies of people aged 16 to 59 years (Rissel et al. 2003a).

Attitudes towards people with Hepatitis C and injecting drug use

Students were asked to rate their level of agreement or disagreement with a set of statements pertaining to people living with Hepatitis C, people who inject drugs and their own desire to try injecting drugs (Table 4.9).

Table 4.9. Students' agreement with statements about Hepatitis C and injecting drug use (%).

Statement			Year 10	Year 12	Total
People who have Hepatitis C only have themselves to blame	Males	Strongly agree/Agree	13.1	9.3	11.5
		Not sure	47.0	39.9	44.1
		Strongly disagree/Disagree	39.9	50.8	44.4
	Females	Strongly agree/Agree	4.8	6.1	5.4
		Not sure	43.7	37.1	40.9
		Strongly disagree/Disagree	51.5	56.8	53.7
	Totals	Strongly agree/Agree	8.4	7.5	8.0
		Not sure	45.2	38.3	42.3
		Strongly disagree/Disagree	46.4	54.2	49.7
People who inject drugs are stupid	Males	Strongly agree/Agree	82.6	81.7	82.2
		Not sure	6.0	4.7	5.5
		Strongly disagree/Disagree	11.4	13.6	12.3
	Females	Strongly agree/Agree	77.4	78.6	77.9
		Not sure	9.1	7.5	8.4
		Strongly disagree/Disagree	13.5	13.9	13.7
	Totals	Strongly agree/Agree	79.7	80.0	79.8
		Not sure	7.7	6.3	7.1
		Strongly disagree/Disagree	12.6	13.7	13.1

continued...

Table 4.9. continued

Statement			Year 10	Year 12	Total
I would like to try injecting drugs	Males	Strongly agree/Agree	2.6	2.4	2.5
		Not sure	3.2	4.9	3.9
		Strongly disagree/Disagree	94.2	92.7	93.6
	Females	Strongly agree/Agree	2.5	1.0	1.9
		Not sure	4.5	3.1	3.9
		Strongly disagree/Disagree	93.0	95.9	94.2
	Totals	Strongly agree/Agree	2.5	1.6	2.2
		Not sure	4.0	3.9	3.9
		Strongly disagree/Disagree	93.5	94.5	93.9

Half the students disagreed with the assertion that people living with Hepatitis C have only themselves to blame for infection with the virus. This is in contrast to the finding that 68% of students did not believe that individuals had only themselves to blame for contracting HIV. Young men in Year 10 were more likely than other students to believe the responsibility for contracting Hepatitis C lay solely with the individual. Also notable is the relatively large proportion of students who were unsure about where to apportion blame for contracting Hepatitis C. Considerably fewer students (18%) were uncertain about who was to blame for people becoming infected with HIV.

Despite the large majority of students agreeing with the statement, ‘People who inject drugs are stupid’, a significant minority (20%) were either unsure or disagreed. Male students were more likely to think people who inject drugs were stupid, but this difference is only small.

The large majority (94%) of students did not endorse the statement that they would like to try injecting drugs, and this sentiment was consistent across gender and year level. However, 6% of students were either not sure or agreed with the statement that they would like to try drugs. Students disagreeing with, or unsure about, whether people who injected drugs were stupid, were significantly more likely to either express a desire to try, or were uncertain about injecting drugs (16%) than were those who thought people who inject drugs were stupid (4%).

DISCUSSION

Several studies in Australia have investigated the knowledge and attitudes of young people towards sexually transmitted infections. In a 1994 study with post-secondary students, Rosenthal and Moore found that with the exception of HIV/AIDS, students' levels of knowledge were low, and they perceived themselves to be unlikely to contract an STI. A study the following year with Victorian secondary students, recorded similar findings: the extent and accuracy of knowledge about STIs (with the exception of HIV/ AIDS) was found to be 'disturbingly poor' (Smith et al, 1995). The findings of the 2002 survey indicate that there has been little improvement since these studies were done, or between the five-yearly administrations of this survey.

In 2002, students' knowledge about HIV/ AIDS continued to be generally good, although in some areas their knowledge about transmission is cause for concern. For example, knowledge about whether HIV can be transmitted by mosquitoes, or from a mother to her unborn child, dropped in the 2002 survey. Of greater concern is the lack of knowledge about safer sex, with 15% of young men in Year 10 and 10% of young men in Year 12 young men believing that the pill provides protection for women, around 11% of all students not knowing that condoms provide some protection from transmission, and around 16% believing that a healthy looking person could not pass on HIV infection. Schools programs need to focus on these knowledge deficits.

In relation to sexually transmitted infections, there has been some increase in the overall level of knowledge about STIs since the 1997 survey, but generally the level of knowledge remains low. While this is true for both male and female students, young men have lower levels of knowledge overall (Table 6.4). The group of greatest concern are young men in Year 10. For example, approximately 31% of young men in Year 10 did not know that someone could be asymptomatic when infected with an STI; 47% believed that all STIs can be cured; 76.3% did not understand that chlamydia can lead to sterility or that it is an issue for men and women; and 27% believed that HIV only infects gay men and injecting drug users.

While there has been some improvement in knowledge about blood borne virus transmission since the 1997 survey, overall knowledge remains low. Students appear to have some confusion about vaccination: a considerable number believed that it is possible to be vaccinated against the Hepatitis C virus (87%) while 50% believed that it is not possible to be

vaccinated against Hepatitis A virus. Knowledge about modes of transmission is also of concern: approximately half of all students did not know that transmission was possible via body piercing and tattooing, and more than half (59%) did not know that Hepatitis B could be transmitted sexually. In this last question, the young women's knowledge appears to have declined since 1992, with more than half (63.4%) answering this question incorrectly, compared to 53% of their male counterparts.

A number of questions explored the attitudes of young people to people living with HIV. Overall, young men showed less positive attitudes to these questions and Year 12 students reporting more positive attitudes than those in Year 10. This attitudinal difference between young men and young women is again illustrated by the students' responses to questions about friendships with young gay men and lesbians. Young women were generally more accepting of same sex attracted people, except in response to the questions exploring friendships with lesbians where the gap between male and female students' attitudes closed. With the exception of this question, there is a marked difference in attitudes between the genders, and young men in Year 10 express markedly less positive attitudes than those in Year 12.

Approximately half (44% of male and 53% of female) of the students in the survey either agreed with or were not sure about the statement 'People who have Hepatitis C have only themselves to blame'. This finding, when considered with the generally poor knowledge about blood borne viruses, is a cause for concern.

IMPLICATIONS FOR POLICY AND PRACTICE

While the story that emerges from the 2002 survey can be seen as encouraging, with some gains in knowledge, the need for ongoing, effective, school-based education programs continues to be critical.

In the ten years since the first national schools survey the level of knowledge about HIV/AIDS has shown a consistent decline. Improved outcomes for people with HIV and reduced publicity about HIV/AIDS may lead to complacency about the need for education programs to increase knowledge and understanding and therefore the safety of young people. Of particular concern are the myths and misconceptions about transmission that persist among the young people surveyed.

While there have been some increases in knowledge about sexually transmitted infections

such as herpes, gonorrhoea, genital warts and chlamydia, the survey findings demonstrate that understanding is still inadequate and misconceptions remain. The prevalence of these diseases amongst young people in Australia makes this deficit of even greater concern. School programs need to present STI information in a context that makes it relevant to the lives of young people.

It is also of concern that knowledge levels about blood borne virus transmission are generally low and, while students demonstrate improved knowledge about transmission via injecting drug use, they have a poor understanding about the risks involved in tattooing and body piercing. As a significant number of students now have body piercings of some kind this can be seen as potentially problematic.

It is notable that in all areas, Year 10 students have less knowledge than Year 12 students, and young women have higher levels of knowledge than young men.

There is an urgent need to implement school based education and population based health promotion programs that target young people to ensure that they have the knowledge and understanding they need about STIs and HIV by the time they become sexually active. While knowledge is not, in and of itself, a means of STI prevention, it is a necessary precursor of safe behaviour. Leaving such information until late in secondary school may be too late for many young people. Similarly, information about minimising the risk of BBV transmission needs to be available to young people before they start tattooing and piercing their bodies. Such programs need to be targeted and age appropriate, and consideration needs to be given to gender specific programs to ensure that males and females both have the knowledge and understanding they need to ensure safety and minimise risk.

The findings of this survey that attitudes towards people living with HIV/ AIDS are more positive when the infected person is connected to the young person are supported by Swedish research (Endgardh, 2002), and also have implications for education. Programs that address information in the context of values and attitudes are important because prejudice may impact on information uptake in education programs that are not contextualised. Programs that personalise the issues by using speakers from an HIV positive people's bureau are also to be encouraged. However such presentations should be embedded within a comprehensive sexual health program. Narratives and story-telling are also effective strategies for personalising the issues.

The finding that students generally hold positive attitudes to friendships with gay and lesbian peers is indicative of the potential to address these issues in schools. It should indeed be possible to build on this good will to examine and eliminate the impact of homophobia in the school community. Fears held by teachers and parents that students are intractably homophobic and unwilling to change are not borne out by this research.

5. SEXUAL BEHAVIOUR AND SOCIAL CONTEXT

Key findings

- *The majority of young people in Years 10 and 12 are sexually active in some way*
- *Experience of vaginal intercourse was reported by approximately one quarter of students in Year 10 and just under half of those in Year 12*
- *Overall, the proportion of young people who are sexually active has increased since the 1997 survey*
- *Young men in Year 10 appear the most likely to report more than three sexual partners*
- *The use of condoms and other forms of contraception is common*
- *Unwanted sex remains an issue and seems most strongly related to alcohol use and pressure from sexual partners*
- *Students reported overwhelmingly positive feelings in relation to their most recent sexual encounter*
- *Approximately 2% of the most recent sexual encounters were same sex encounters*
- *Young people report high levels of confidence in their ability to say no to unwanted sex and convince a partner to use condoms. They are far less confident in their ability to discuss matters related to sexuality, including contraception, with their parents*

Introduction

This chapter explores students' sexual experience. The discussion focuses on the types of sexual experience that students have had, including sexual attraction, condom use, feelings after sex, beliefs about peers' sexual behaviour, condom use, and confidence in communication about sex and contraception. The second part of the chapter focuses on those who have had sexual intercourse, and the context and components of their most recent sexual encounter.

Sexual experience

Most students had experienced some form of sexual activity (Table 5.1). Approximately four in five students had experienced deep kissing and two thirds had experienced sexual touching. Student experience of sexual intercourse and oral sex was less common but these activities were still reported by between a quarter and a third of all participants. For each type of sexual experience, Year 12 students were more likely to have experienced sexual activity than their Year 10 counterparts. This difference, while apparent with respect to all activities, is most marked for sex with and without a condom. There were no major differences between young men and women in the level or in the scale of these sexual activities.

Table 5.1. Students reported sexual activities (%).

		Year 10	Year 12	Total
Deep kissing	Males	75.9	84.3	79.4
	Females	77.2	86.6	81.2
	Total	76.6	85.6	80.4
Touching or being touched on genitals	Males	63.5	74.1	67.9
	Females	59.6	74.9	66.1
	Total	61.3	74.6	66.9
Giving or receiving oral sex	Males	39.5	55.7	46.3
	Females	35.6	57.5	44.9
	Total	37.3	56.7	45.5
Sex without a condom	Males	11.1	28.7	18.5
	Females	12.2	35.5	22.1
	Total	11.7	32.6	20.5
Sex with a condom	Males	26.0	46.8	34.8
	Females	23.0	43.7	31.8
	Total	24.3	45.0	33.1

In previous surveys we found that the proportion of students reporting sex either with or without a condom had declined between 1992 and 1997 (Table A.11). The present data indicate that declines observed in that period have been reversed and the proportions observed reporting either sex with or without a condom is now higher than in either 1992 or 1997.

Table 5.2. Students who have ever had sexual intercourse (%).

	Year 10	Year 12	Total
Males	27.8	48.3	36.4
Females	24.2	45.7	33.3
Total	25.8	46.8	34.7
Total Males	600	436	1036
Total Females	777	574	1351
Total	1377	1010	2387

As can be seen from Table 5.2, just over a quarter of Year 10 students report having experienced sexual intercourse and this rises to just under half of the students in Year 12. In both years young women are marginally less likely to report having experienced sexual intercourse than young men. Based on the total sample, the number of students reporting ever having had sexual intercourse without using a condom has increased (Table A.11) as has the number reporting any form of intercourse (Table A.12). Between 1992 and 1997 surveys there was a decrease in the number of students ever having unprotected sex (22% and 18% respectively); the proportion of students in 2002 who had experienced sex without a condom has increased to above the 1992 figure (25%). It is important to note, however, that these proportions are based on the total sample, and given that a higher proportion report having had intercourse it is unsurprising that a greater proportion of students report unprotected sex. When these data are compared, taking into account the different rates of sex intercourse at each survey administration, the proportion of students ever having sex without a condom in 2002 (60%) is lower than the proportion in 1992 (64%), but marginally higher than 1997 (57%). Similarly, more students reported having sex with a condom (40%) than did in 1992 (30%) and 1997 (31%) surveys.

Sexual attraction

The large majority (93%) of students reported sexual feelings only for those of the opposite sex. Less than one percent of students reported exclusively same sex attraction and substantially more (4.6%) reported being attracted to both sexes (Table 5.3). Young men are more likely than young women to report being exclusively same sex attracted whereas young women are more likely than young men to report being attracted to both sexes. These proportions are marginally smaller than those reported in the 1997 survey (Table A.13).

Table 5.3. Students' sexual attraction (%).

		Year 10	Year 12	Total
Males	Only to people of my own sex	1.2	0.7	1.0
	Only to people of the opposite sex	94.7	96.4	95.4
	To people of both sexes	2.4	2.2	2.3
	Not sure	1.7	0.6	1.3
		N=598	N=430	N=1028
Females	Only to people of my own sex	0.1	0.6	0.3
	Only to people of the opposite sex	91.0	91.4	91.2
	To people of both sexes	6.9	5.7	6.4
	Not sure	2.0	2.3	2.1
		N=774	N=573	N=1347
Totals	Only to people of my own sex	0.6	0.7	0.6
	Only to people of the opposite sex	92.6	93.6	93.0
	To people of both sexes	4.9	4.2	4.6
	Not sure	1.9	1.6	1.8
		N=1371	N=1004	N=2375

Overall, 3.3% of young men and 6.7% of young women reported some same sex attraction. An additional 1.3% of young men and 2.1% of young women were not sure about their sexual attraction. Overall, 4.6% of young men and 8.8% of young women indicate other than sexual attraction exclusively to the opposite sex.

Number of sexual partners in the previous year

We now turn to sexual activity in the last year and include only those students who report experience of sexual intercourse (n=881; 25.8% of Year 10 students; 46.8% of Year 12 students). As can be seen from Table 5.7, the overwhelming majority of students who had ever experienced sexual intercourse also reported some sexual activity in the last year.

Approximately half of the young men who had experienced sexual intercourse reported one sexual partner in the previous year as did 61.5% of young women. Year 12 students were more likely than Year 10 students to report having had one sexual partner in the previous year. Between 15% and 19% of students reported having had two partners, with little variation observed with respect to year level or gender. It was more common for young men to report having had three or more partners than young women (23.0% versus 17.3%) as well as it being more common among Year 10 students than Year 12 students (27.2% versus 14.5%). Nearly one in three young men in Year 10 who had ever experienced sexual intercourse reported having had three or more sexual partners in the previous year.

Table 5.4. Sexually active students' reported number of sexual partners in the previous year (%).

		Year 10	Year 12	Total
Males	I have not had sex in the past year	9.7	8.7	9.3
	1 person	42.0	56.0	49.9
	2 people	15.6	19.4	17.8
	3 or more people	32.7	15.6	23.0
		N=161	N=209	N=371
Females	I have not had sex in the past year	2.9	4.3	3.7
	1 person	56.6	65.0	61.5
	2 people	18.0	17.1	17.4
	3 or more people	22.5	13.6	17.3
		N=187	N=260	N=447
Totals	I have not had sex in the past year	6.0	6.4	6.2
	1 person	49.9	61.0	56.3
	2 people	16.9	18.1	17.6
	3 or more people	27.2	14.5	19.9
		N=348	N=470	N=818

Comparison with previous surveys indicates some marked changes in relation to the number of sexual partners reported by students who had ever experienced sexual intercourse (Table A.14). Since 1992, the number of sexual partners reported by sexually active Year 12 students has been declining. Students are now more likely to report having had one sexual partner in the previous year as opposed to reporting 2 partners or 3 or more partners. The picture for Year 10 students is markedly different with an apparent increase in the proportion of both young men and young women who report more than three or more partners in the previous year.

Oral sex

As previously noted, 37.3% of students in Year 10 and 56.7% of students in Year 12 reported having given or received oral sex. The pattern of sexual activity with relation to oral sex was similar to that reported for sexual intercourse (Table 5.5). Of students who have ever had oral sex, most reported having oral sex in the previous year with one person, though a considerable proportion (38%) reported having multiple oral sex partners.

Table 5.5. Number of people students had oral sex with in the previous year: students who have ever had oral sex (%).

		Year 10	Year 12	Total
Males	I have not had oral sex in the past year	15.5	12.6	14.1
	1 person	37.6	53.7	45.7
	2 people	18.4	13.9	16.1
	3 or more people	28.5	19.8	24.1
		N=232	N=230	N=462
Females	I have not had oral sex in the past year	6.1	14.2	10.5
	1 person	50.4	57.0	54.1
	2 people	20.8	19.2	19.9
	3 or more people	22.7	9.6	15.5
		N=271	N=329	N=600
Total	I have not had oral sex in the past year	10.5	13.5	12.1
	1 person	44.5	55.7	50.4
	2 people	19.7	17.0	18.3
	3 or more people	25.3	13.8	19.2
		N=503	N=559	N=1061

As was the case for sexual intercourse, students in Year 10 were more likely to report three or more oral sex partners than were those in Year 12, with young men in Year 10 most likely to have had oral sex with three or more people in the past year.

Students also experienced oral sex with partners without having sexual intercourse (Table 5.6). Most students (55%) experienced oral sex, but not intercourse, with one person in the previous year, although slightly fewer (30%) had oral sex, but not intercourse, with two or more partners.

Table 5.6. Number of people students had oral sex with but not intercourse in the previous year: students who have ever had oral sex (%).

		Year 10	Year 12	Total
Males	I have not had oral sex without intercourse in the past year	14.9	20.5	17.7
	1 person	44.7	51.9	48.3
	2 people	16.9	14.8	15.8
	3 or more people	23.5	12.8	18.1
		N=228	N=228	N=456
Females	I have not had oral sex without intercourse in the past year	11.5	16.6	14.3
	1 person	54.5	63.8	59.5
	2 people	21.4	11.1	15.8
	3 or more people	12.6	8.6	10.4
		N=269	N=317	N=585

Continued...

Table 5.6. Continued

		Year 10	Year 12	Total
Total	I have not had oral sex without intercourse in the past year	13.1	18.2	15.8
	1 person	50.0	58.8	54.6
	2 people	19.3	12.6	15.8
	3 or more people	17.6	10.3	13.8
		N=496	N=544	N=1041

Condom use

Consistency of condom use exhibited marked variation with respect to both gender and year level (Table 5.7). Nearly two thirds of sexually active Year 10 students reported always using condoms. This declined to just over 40% of students in Year 12. Young men at both year levels were more likely to report always using condoms than were young women. The gender difference was most striking among Year 12 students where 52.2% of young men but only 34.0% of young women report always using condoms.

Table 5.7. Sexually active students' reported condom use in the previous year (%).

		Year 10	Year 12	Total
Males	Always used condoms	69.6	52.2	59.7
	Sometimes used condoms	24.1	36.8	31.3
	Never used condoms	6.3	11.0	9.0
		N=149	N=195	N=344
Females	Always used condoms	62.8	34.0	46.1
	Sometimes used condoms	31.5	54.5	44.8
	Never used condoms	5.7	11.5	9.1
		N=182	N=250	N=432
Totals	Always used condoms	65.8	42.0	52.1
	Sometimes used condoms	28.2	46.7	38.9
	Never used condoms	5.9	11.3	9.0
		N=331	N=445	N=776

In relation to consistency of condom use in previous surveys, there is no general pattern of change over time (Table A.15). However, it would appear that young women in Year 10 demonstrate a general tendency towards higher rates of consistent condom use.

Students reporting three or more sexual partners in the previous year were marginally less likely to always use a condom always than those reporting fewer sexual partners (46% versus

54%), however this difference was not statistically significant. In 1997 the same negative relationship between condom use and number of sexual partners was evident, but the difference between these groups greater (41% versus 56%). Although the difference in condom use here is cause for concern, it is clear that students with three or more sexual partners in 2002 report a frequency of condom use that is comparable to the rate of those having sex with fewer partners.

Pregnancy

Sexually active students were asked if they had ever had sex that had resulted in a pregnancy (Table 5.8). Of those that were sexually active, a significant minority of students (6.1%) had had sex that they knew to have resulted in a pregnancy. This was more commonly reported by Year 10 students than Year 12 students. Young women at both year levels were more likely than young men to report sex that resulted in a pregnancy.

Table 5.8 Sexually active students' who had sex that resulted in a pregnancy (%).

		Year 10	Year 12	Total
Males	Yes	6.9	1.9	4.1
	Don't know	10.5	11.3	11.0
		N=160	N=205	N=365
Females	Yes	9.1	6.9	7.8
	Don't know	4.6	4.5	4.5
		N=181	N=262	N=443
Total	Yes	8.1	4.7	6.1
	Don't know	7.4	7.5	7.5
		N=342	N=467	N=808

A proportion of students (7.5%) were uncertain as to whether or not they had sex that had resulted in pregnancy. Male students were more than twice as likely as female students to report being unsure whether they had had sex that resulted in a pregnancy (11.0% versus 4.5%). These more frequent reports by young men may reflect a lack of subsequent contact with their sexual partner. For young women, the 4.5% reporting being unsure as to whether they had ever had sex which resulted in a pregnancy will reflect two things: a late or unusually heavy menstrual period which might have signalled an early miscarriage; or having had sex sufficiently recently that they were still awaiting their period at the time of the survey.

Unwanted sex

Although most students had never had unwanted sex, over one quarter of the sample had experienced an unwanted sexual encounter (Table 5.9).

Table 5.9 Sexually active students who have ever had unwanted sex (%).

		Year 10	Year 12	Total
Males	Yes	22.6 N=156	23.8 N=203	23.3 N=359
Females	Yes	30.2 N=185	26.6 N=254	28.1 N=439
Total	Yes	26.7 N=341	25.4 N=456	25.9 N=798

A slightly greater proportion of young women had experienced unwanted sex (28.1% versus 23.3%). Young women in Year 10 were the most likely to report having experienced unwanted sex.

Students who reported an experience of unwanted sex were offered four potential reasons for that unwanted sex and invited to tick as many of the reasons that applied (Table 5.10).

Table 5.10 Sexually active students who have ever had unwanted sex: reasons (%).

		Year 10	Year 12	Total
Too drunk	Males	15.0	12.9	13.9
	Females	18.8	16.7	17.6
	Total	17.1	15.0	15.9
Too high	Males	5.9	7.7	6.9
	Females	6.7	4.4	5.4
	Total	6.4	5.9	6.1

Continued...

Table 5.10 Continued

		Year 10	Year 12	Total
My partner thought I should	Males	10.9	11.0	11.0
	Females	12.1	15.3	13.9
	Total	11.5	13.4	12.6
My friends thought I should	Males	2.1	3.5	2.9
	Females	1.8	0.8	1.2
	Total	1.9	2.0	2.0

Of the reasons presented to students, being drunk and being pressured by one’s partner were the most commonly reported reasons for unwanted sex (Table 5.10). Being high and being pressured by peers were less often reported as reasons for unwanted sex. There were no marked differences between young women and young men or between Year 10 students and Year 12 students in the pattern of responses.

The most recent sexual encounter

For the majority of students, their most recent sexual partner was someone who they were familiar with before the sexual encounter (Table 5.11). Overall, nearly two thirds of the sample reported that their most recent sexual partner was their steady girlfriend/boyfriend. This was more marked in Year 12 than in Year 10 (73.7% versus 50.4%). A minority described their most recent sexual partner as someone they had met for the first time (10.8% of the total sample) and there were marked gender and year level disparities. Nearly one in five young men (18.1%) indicated that their most recent sexual partner was someone they had met for the first time, compared with fewer than one in twenty young women (4.6%). Reporting that their most recent sexual partner was someone they had met for the first time was nearly twice as common in Year 10 than in Year 12 (15.0% versus 7.6%).

Table 5.11. Sexually active students' relationship to their most recent sexual partner (%).

		Year 10	Year 12	Total
Males	Someone you had met for the first time	24.8	12.8	18.1
	Someone you had known for while but had not had sex with before	35.7	24.4	29.4
	Your current steady girlfriend/boyfriend	39.5	62.8	52.5
		N=146	N=185	N=331
Females	Someone you had met for the first time	6.4	3.3	4.6
	Someone you had known for while but had not had sex with before	33.6	14.2	22.4
	Your current steady girlfriend/boyfriend	60.0	82.5	73.0
		N=167	N=229	N=396
Totals	Someone you had met for the first time	15.0	7.6	10.8
	Someone you had known for while but had not had sex with before	34.6	18.7	25.5
	Your current steady girlfriend/boyfriend	50.4	73.7	63.7
		N=313	N=414	N=727

In relation to previous surveys, there is evidence of changing responses to the question of young people's relationship to their most recent sexual partner (Table A.16). Among young men in Year 10, there is a marked trend for them to be more likely to report that their most recent sexual partner was someone they had met for the first time and a corresponding decline in the likelihood of reporting that their most recent sexual partner was their steady girlfriend/boyfriend. Reporting their most recent sexual partner as someone they had met for the first time appears to have decreased among young women in Year 10 and young men in Year 12 but is unchanged among young women in Year 12.

Age of partner

There were marked gender and year level differences in the age of students' sexual partners at the most recent sexual encounter (Table 5.12). For young men in Year 10, their partner was most likely to be under 16 years or 16-17 years. For young women in Year 10, their partner was most likely to be 16-17 years but just under a quarter were 18-19 years.

Table 5.12. The age of sexually active students' most recent sexual partner (%).

		Year 10	Year 12	Total
Males	Under 16	44.7	10.8	25.7
	16-17	41.2	63.2	53.5
	18-19	5.0	17.5	12.0
	20+	4.4	6.8	5.8
	Not sure	4.7	1.7	3.0
		N=161	N=207	N=368
Females	Under 16	18.2	1.8	8.6
	16-17	52.6	38.6	44.4
	18-19	23.8	36.5	31.2
	20+	5.4	23.1	15.7
	Not sure	0	0	0
		N=185	N=259	N=444
Totals	Under 16	30.5	5.8	16.4
	16-17	47.3	49.5	48.5
	18-19	15.1	28.0	22.5
	20+	4.9	15.9	11.2
	Not sure	2.2	0.8	1.4
		N=346	N=465	N=812

Given that students in Year 12 are typically two years older than those in Year 10, it is unsurprising that they report older sexual partners than do students in Year 10. Compared to young men in Year 10, those in Year 12 were more likely to report that their partners were 16-17 years or 18-19 years. Similarly, young women in Year 12 were more likely than those in Year 10 to report that their partners were 18-19 years or more than 20 years. Compared with previous surveys, there appears to be little consistent change in the ages of sexual partners (Table A.17).

Same sex encounters

One in twenty (5.2%) of the students reported being attracted to both sexes or exclusively to their own sex, and 1.6% of the most recent sexual encounters reported by young men and 2.7% of those reported by young women were homosexual (Table 5.13). Young women were more likely than young men to report a same sex partner, as were students in Year 12 when compared to students in Year 10.

Table 5.13. The gender of sexually active students' most recent sexual partner (%).

		Year 10	Year 12	Total
Males	Partner			
	Male	0.7	2.3	1.6
	Female	99.3	97.7	98.4
		N=159	N=209	N=368
Females	Male	98.4	96.6	97.3
	Female	1.6	3.4	2.7
		N=185	N=259	N=443

Discussion of sex-related issues

Most students (69%) discussed using a condom at the time of their most recent sexual experience (Table 5.14). Students were much less likely to discuss avoiding HIV (23%) or other STIs (24%). Young men in Year 12 were less likely than any other students to discuss issues relating to avoiding pregnancy, HIV and other STIs, sexual pleasure without intercourse and using a condom during sex.

Table 5.14. Sexually active students who discussed sex related issues during the last sexual encounter (%).

		Year 10	Year 12	Total
Avoiding pregnancy	Males	36.3	29.7	32.6
	Females	50.8	52.4	51.7
	Total	44.1	42.3	43.1
Avoiding HIV infection	Males	28.4	17.0	22.0
	Females	25.0	21.4	23.0
	Total	26.6	19.5	22.5
Avoiding other STIs	Males	28.9	17.2	22.3
	Females	29.2	21.4	24.6
	Total	29.0	19.5	23.6
Sexual pleasure without intercourse	Males	34.3	28.3	30.9
	Females	43.8	34.6	38.5
	Total	39.4	31.8	35.0
Using a condom	Males	71.6	57.8	63.8
	Females	85.7	63.6	72.8
	Total	79.2	61.1	68.8

Considering earlier surveys, there has been a trend for young men in both Years 10 and 12 to talk less with their partners about avoiding pregnancy and the use of a condom during sex (Table A.18). Between 1997 and 2002 surveys, the proportion of female students talking

about both these issues with their most recent sexual partner has increased, although the increase in talk about avoiding pregnancy was not statistically significant. More Year 10 students in 2002 said they had discussed seeking pleasure from sex without intercourse the last time they had sex compared with Year 10 students in 1992 and 1997 surveys. The increase in discussing sexual pleasure without intercourse is most pronounced for young women in Year 10.

A total of 22.8% of students reported having discussed none of the identified issues at their most recent sexual encounter. Young men were more likely than young women not to discuss any of the sexual health matters (29.2% vs 17.5%). Also, students in Year 12 were more likely than those in Year 10 not to discuss any of the sexual health matters (28.6% vs 14.9%)

Condom use

At their last sexual encounter 73% of young people reported that they had a condom available (Table 5.15). Slightly fewer Year 12 students than Year 10 students reported that a condom was available.

Table 5.15. Sexually active students reporting a condom was available at the most recent sexual encounter (%).

	Year 10	Year 12	Total
Males	76.2	73.2	74.5
Females	79.5	64.9	71.0
Total	77.9	68.6	72.6
Total Males	160	207	366
Total Females	186	261	447
Total	346	468	814

Slightly fewer students (65.1%) reported actually using a condom the last time they had sex than reported that a condom was available (Table 5.16). As with condom use in the last year, male students (74.1%) and students in Year 10 (72.4%) were more likely than female students (57.8%) and students in Year 12 (59.7%) to use a condom they last time they had sex. Young men in Year 10 reported the highest rate of condom use at their most recent sexual encounter.

Table 5.16. Sexually active students reporting that a condom was used at the most recent sexual encounter (%).

	Year 10	Year 12	Total
Males	76.4	72.3	74.1
Females	69.0	49.8	57.8
Total	72.4	59.7	65.1
Total Males	157	206	362
Total Females	186	262	448
Total	343	467	810

Students were given a set of multiple response questions from which they could list one or more reasons for not using a condom when they last had sex. Table 5.17 shows student responses to these questions. Reported knowledge of a partner's sexual history (35%), being unprepared for sex ('it just happened' - 33%), and trusting one's partner (33%) were the most common reasons given by students for a condom not being used at the last sexual encounter.

Table 5.17. Sexually active students' reasons for not using a condom the last time they had sex (%).

		Year 10	Year 12	Total
I don't like them	Males	34.5	27.9	30.5
	Females	15.3	17.0	16.5
	Total	23.1	20.4	21.3
My partner doesn't like them	Males	21.8	26.5	24.6
	Females	3.7	20.2	15.3
	Total	11.1	22.2	18.5
I trust my partner	Males	10.7	31.5	23.3
	Females	39.3	38.1	38.4
	Total	27.7	36.0	33.3
It just happened	Males	56.9	31.0	41.2
	Females	46.1	21.6	28.9
	Total	50.4	24.5	33.1
We both have been tested for HIV/STIs	Males	5.2	4.1	4.5
	Females	6.3	12.1	10.4
	Total	5.9	9.6	8.4
Too embarrassed	Males	8.9	0.4	3.7
	Females	5.9	1.7	2.9
	Total	7.1	1.3	3.2

Continued...

Table 5.17. Continued

		Year 10	Year 12	Total
I know my partner's sexual history	Males	17.3	32.7	26.6
	Females	23.7	46.5	39.7
	Total	21.1	42.2	35.2
It is not my responsibility	Males	9.1	2.0	4.8
	Females	1.5	2.1	1.9
	Total	4.5	2.1	2.9
Other	Males	20.9	39.5	32.1
	Females	25.8	46.4	40.2
	Total	23.8	44.3	37.5

Consistent with their greater likelihood for having multiple sexual partners and having sex with people not known to them before sex, young men in Year 10 were most likely not to have used a condom because of unplanned sex and less likely because of a reported knowledge of their partner's sexual history or trust in their partner. Interestingly, female students were more likely than their male counterparts not to use a condom on the basis of a reported knowledge of their partner's sexual history and/or because they trusted their partner. Few students (8%) cited being tested for HIV or other STIs as a reason for not using a condom the last time they had sex.

Intoxication

Almost one-quarter of students surveyed reported being drunk or high when they last had sex (Table 5.18).

Table 5.18. Sexually active students who were drunk or high the last time they had sex (%).

	Year 10	Year 12	Total
Males	29.9	27.3	28.4
Females	23.1	14.2	17.9
Total	26.3	20.0	22.7
Total Males	157	205	363
Total Females	186	259	445
Total	344	464	808

Young men in Year 10 were the most likely to report being drunk or high when they had sex last, and were the only group of students for whom the likelihood of having sex when drunk

or high has increased consistently over time (Table A.21). As was case in 1992, more male students (28%) reported being either drunk or high when they last had sex than female students (18%). The finding that young men are more likely to drink and use drugs in combination with sex is notable, given the gap between young men and young women in terms of likelihood of engaging in this practice diminished in the 1997 survey. There were no significant differences by year level.

Unwanted sex

The large majority of students wanted to have sex at their last sexual encounter (Table 5.19). Five percent of sexually active students reported having unwanted sex at their last sexual encounter.

Table 5.19. Students who wanted to have sex the last time they had sex (%).

		Year 10	Year 12	Total
Males	Yes	97.2 N=158	96.5 N=205	96.8 N=363
Females	Yes	89.2 N=186	96.9 N=254	93.6 N=440
Total	Yes	92.9 N=344	96.7 N=459	95.1 N=803

Students in Year 10 (7.1%) were more likely than their Year 12 counterparts (3.3%) to report unwanted sex the last time they had sex. Consistent with their experiences of unwanted sex generally, young women in Year 10 reported the highest rate of unwanted sex at their last sexual encounter.

Feelings about last sexual encounter

Generally, sexually active students reported feeling positive after their last sexual encounter, although there was variation in feelings between young men and young women (Table 5.20). Approximately half the students surveyed in 2002 reported feeling ‘extremely’ happy, good, or loved after their last sexual encounter. Consistent with this general positive sentiment, students less commonly reported negative feelings than positive feelings, with the majority feeling ‘not at all’ upset (82%), not used (74%) or not guilty (66%). Female students were less likely than their male counterparts to reporting feeling ‘extremely’ fantastic, good or happy,

and 'not at all' used, confused, upset or guilty after their last sexual encounter, with young women in Year 10 showing the least positive feelings after sex. Although there were no significant differences in student feelings between year level, young women in Year 12 were less likely to feel worried and more likely to feel loved after sex than were young women in Year 10.

Table 5.20 over page

Table 5.20. Sexually active students feelings after their last sexual encounter (%)

		Year 10	Year 12	Total			Year 10	Year 12	Total
Good					Upset				
Males	Not at all	3.9	2.2	2.9	Males	Not at all	82.6	81.1	81.7
	Extremely	66.3	54.3	59.6		Extremely	2.4	1.7	2.0
Females	Not at all	2.6	3.5	3.2	Females	Not at all	66.5	69.9	68.5
	Extremely	38.8	42.1	40.7		Extremely	2.7	0.2	1.3
Total	Not at all	3.2	3.0	3.1	Total	Not at all	73.9	74.7	74.4
	Extremely	51.6	47.3	49.1		Extremely	2.6	0.8	1.6
Happy					Guilty				
Males	Not at all	3.2	1.8	2.4	Males	Not at all	65.9	74.3	70.6
	Extremely	64.9	53.8	58.7		Extremely	2.5	3.7	3.2
Females	Not at all	2.3	3.3	2.9	Females	Not at all	56.1	66.1	62.0
	Extremely	41.0	44.6	43.1		Extremely	6.5	7.1	6.8
Total	Not at all	2.7	2.6	2.7	Total	Not at all	60.7	69.7	65.9
	Extremely	52.1	48.6	50.1		Extremely	4.6	5.6	5.2
Fantastic					Used				
Males	Not at all	3.4	3.1	3.2	Males	Not at all	76.6	81.9	79.6
	Extremely	68.3	53.4	60.0		Extremely	2.6	3.2	2.9
Females	Not at all	8.8	7.3	7.9	Females	Not at all	67.9	71.0	69.7
	Extremely	33.7	33.3	33.5		Extremely	7.3	6.1	6.6
Total	Not at all	6.3	5.5	5.8	Total	Not at all	71.9	75.8	74.1
	Extremely	49.8	42.0	45.3		Extremely	5.1	4.8	4.9
Loved					Worried				
Males	Not at all	7.4	10.8	9.3	Males	Not at all	48.7	59.0	54.5
	Extremely	48.1	45.9	46.8		Extremely	4.1	4.9	4.6
Females	Not at all	13.5	7.3	9.8	Females	Not at all	39.3	54.3	48.1
	Extremely	41.2	56.8	50.4		Extremely	12.6	8.6	10.3
Total	Not at all	10.6	8.8	9.6	Total	Not at all	43.6	56.3	51.0
	Extremely	44.4	52.1	48.8		Extremely	8.7	7.0	7.7
Confused									
Males	Not at all	68.8	73.8	71.6					
	Extremely	5.6	4.0	4.7					
Females	Not at all	50.5	59.9	56.1					
	Extremely	12.3	11.6	11.9					
Total	Not at all	59.0	65.9	63.0					
	Extremely	9.2	8.3	8.7					

Location of last encounter

Most students had sex at their house or their partner's house the last time they had sex (Table 5.21). Despite this, a considerable proportion (27%) were at a friend's house, somewhere outside, or in a car the last time they had sex.

Table 5.21. Location of students' most recent sexual encounter (%).

		Year 10	Year 12	Total
Their house	Males	28.1	34.0	31.4
	Females	18.1	38.0	29.7
	Total	22.7	36.2	30.5
A partner's house	Males	28.7	31.5	30.3
	Females	46.8	45.3	45.9
	Total	38.4	39.2	38.9
A friend's house	Males	13.3	15.1	14.3
	Females	11.3	7.2	8.9
	Total	12.2	10.7	11.3
Outside	Males	15.6	10.1	12.5
	Females	18.4	3.6	9.8
	Total	17.1	6.5	11.0
In a car	Males	2.8	6.0	4.6
	Females	4.3	4.4	4.3
	Total	3.6	5.1	4.5
Other	Males	11.5	3.3	6.9
	Females	1.1	1.6	1.4
	Total	5.9	2.4	3.9

Year 10 students, compared to those in Year 12, are less likely to experience sex in their own home, which would appear consistent with their greater likelihood of having sex with people not known to them before sex and their greater propensity for sex with multiple sexual partners. Also, young women were more likely than young men to report having their last sexual encounter at their partner's house.

Contraception

Sexually active students were asked what type of contraception, if any, was used during their last sexual encounter, with multiple selections possible. The most common form of contraception used by students was condoms, although a considerable proportion of students, particularly those in Year 12, used the pill (Table 5.22). Students in Year 10 were more likely

to use condoms as a form of contraception the last time they had sex, compared with Year 12 students.

Table 5.22 Type of contraception used at the last sexual encounter (%).

		Year 10	Year 12	Total
Condom	Males	75.1	68.7	71.4
	Females	69.2	51.1	58.6
	Total	71.9	59.0	64.4
The pill	Males	22.3	37.1	30.7
	Females	27.6	51.7	41.7
	Total	25.2	45.2	36.8
IUD (Intrauterine device)	Males	0.7	0.9	0.8
	Females	0.0	0.1	0.0
	Total	0.3	0.5	0.4
Diaphragm	Males	1.3	0.8	1.0
	Females	0.0	0.0	0.0
	Total	0.6	0.4	0.5
The morning after pill	Males	7.0	3.0	4.7
	Females	1.8	4.5	3.4
	Total	4.2	3.9	3.9
Withdrawal	Males	8.4	10.0	9.3
	Females	8.6	17.5	13.8
	Total	8.5	14.2	11.8
Rhythm method	Males	0.7	0.8	0.8
	Females	0.0	2.9	1.7
	Total	0.3	2.0	1.3
Other	Males	2.3	1.7	1.9
	Females	2.1	1.5	1.7
	Total	2.2	1.6	1.8
No contraception used	Males	13.2	5.5	8.8
	Females	11.6	8.6	9.9
	Total	12.3	7.3	9.4

The withdrawal method was the third most common form of contraception employed by students (11.8%), with Year 12 students more likely to practice this method than Year 10 students. Of concern also is the finding that significant numbers of students use the pill as a form of contraception without also using a condom for protection against STIs. Of the 336 students who reported using the pill the last time they had sex, over half used the pill without

also using a condom. Students in Year 12 were more likely to use the pill without a condom than were Year 10 students. Almost 1 in 10 sexually active students reported that contraception was not used the last time they had sex.

Beliefs about peers' sexual behaviour

Students were asked questions pertaining to their peers' sexual behaviour (Tables 5.23 and 5.24) Interestingly, despite students in the 2002 sample reporting no increased use of condoms generally or at the last sexual encounter. They were more likely to perceive their peers using condoms than were students in 1992 or 1997 surveys (Table A.22).

Table 5.23. Students' beliefs about their peers' condom use (%).

		Year 10	Year 12	Total
Males	I don't think they have sex	6.7	2.9	5.1
	None use condoms	0.7	1.1	0.9
	A few do	12.3	10.4	11.5
	About half do	12.7	7.8	10.6
	Most of them do	59.3	72.0	64.7
	All of them do	8.3	5.8	7.2
		N=596	N=431	n=1027
Females	I don't think they have sex	5.1	1.1	3.4
	None use condoms	0.4	0.0	0.2
	A few do	12.1	9.5	11.0
	About half do	10.9	20.5	15.0
	Most of them do	65.0	65.2	65.1
	All of them do	6.5	3.7	5.3
		N=772	N=572	N=1344
Totals	I don't think they have sex	5.8	1.9	4.1
	None use condoms	0.5	0.5	0.5
	A few do	12.2	9.9	11.2
	About half do	11.7	15.0	13.1
	Most of them do	62.5	68.1	64.9
	All of them do	7.3	4.6	6.1
		N=1368	N=1003	N=2371

Almost three quarters of students surveyed in 2002 considered 'most' or 'all' of people of the same age used condoms when they have sex. However, when reported condom use is taken into account (65% of students at the last sexual encounter and 52% of students always used condoms in the previous year), student belief about peer condom use slightly overestimates actual practice.

Table 5.24. Students' beliefs about who mostly suggests using a condom (%)

		Year10	Year 12	Total
Males	Young men	10.0	5.1	8.0
	Young women	33.0	29.4	31.5
	Both	48.1	51.1	49.3
	I don't know	8.9	14.4	11.2
		N=597	N=431	N=1028
Females	Young men	2.9	1.9	2.5
	Young women	50.9	48.3	49.8
	Both	37.7	42.2	39.6
	I don't know	8.5	7.6	8.1
		N=774	N=573	N=1348
Totals	Young men	6.0	3.3	4.9
	Young women	43.1	40.2	41.8
	Both	42.2	46.0	43.8
	I don't know	8.7	10.5	9.5
		N=1372	N=1004	N=2376

Students' beliefs about who suggests using condoms have not changed between 1997 and 2002 surveys, (Table 5.24 and Table A.23). As was the case in 1997, few students (5%) thought that young men alone take responsibility for suggesting the use of condoms when having sex, with the large majority of the opinion that young women alone (42%) or both young women and young men together (44%) suggest using condoms.

Confidence in communication about sex

The large majority of students (90%) were confident or very confident they could talk to their partner about using a condom (Table 5.25). Further, students in 2002 exhibited greater confidence when talking to a regular partner about using a condom than students in 1997 or 1992 (Table A.24).

Table 5.25. Students' confidence in talking to a boyfriend/girlfriend about using a condom (%).

		Year 10	Year12	Total
Males	I would never be in this situation	3.9	4.3	4.0
	Very confident to confident	90.6	90.8	90.7
	A little confident or not at all confident	5.5	4.9	5.3
		N=598	N=436	N=1035
Females	I would never be in this situation	3.0	3.1	3.1
	Very confident to confident	86.6	92.3	89.0
	A little confident or not at all confident	10.4	4.6	7.9
		N=777	N=574	N=1350
Totals	I would never be in this situation	3.4	3.6	3.5
	Very confident to confident	88.4	91.6	89.7
	A little confident or not at all confident	8.2	4.7	6.8
		N=1375	N=1010	N=2385

In 2002, 66% of students said they were very confident about talking to a regular partner about using a condom, compared with 60% in both 1992 and 1997 surveys. Most students (72%) also felt they could confidently say no to sex despite their partner wanting to have sex, however there was no increase in confidence here since the 1997 survey (Table 5.26 and Table A.25).

Table 5.26. Students' confidence in saying no to unwanted sex (%).

		Year 10	Year 12	Total
Males	I would never be in this situation	18.8	17.0	18.0
	Very confident to confident	56.8	60.3	58.3
	A little confident or not at all confident	24.4	22.7	23.7
		N=597	N=434	N=1031
Females	I would never be in this situation	2.3	1.9	2.1
	Very confident to confident	81.3	87.8	84.1
	A little confident or not at all confident	16.4	10.3	13.8
		N=775	N=574	N=1348
Totals	I would never be in this situation	9.4	8.4	9.0
	Very confident to confident	70.7	76.0	72.9
	A little confident or not at all confident	19.9	15.6	18.1
		N=1372	N=1007	N=2379

Young women (84%) showed greater confidence than young men (58%), with young men in Year 10 the least confident in saying no to unwanted sex. When student confidence in saying no to unwanted sex and its actual occurrence are compared, some disparity between the two is evident. Of students that reported feeling either confident or very confident in saying no to unwanted sex, 4% still had unwanted sex at their most recent sexual encounter, and those expressing confidence were no less likely than students not reporting confidence to experience unwanted sex the last time they had sex.

Compared with talking to a partner about using a condom during sex, students were less confident in persuading a partner to use a condom during sex after their partner had refused to use one (Table 5.27 and Table A.26).

Table 5.27 Students' confidence in persuading a new sexual partner to use a condom after they have refused to use one (%).

		Year 10	Year 12	Total
Males	I would never be in this situation	8.7	6.7	7.9
	Very confident to confident	75.3	79.5	77.0
	A little confident to not at all confident	16.0	13.8	15.1
		N=598	N=435	N=1033
Females	I would never be in this situation	8.7	13.4	10.7
	Very confident to confident	75.5	75.7	75.6
	A little confident to not at all confident	15.8	10.9	13.7
		N=774	N=574	N=1347
Totals	I would never be in this situation	8.7	10.5	9.5
	Very confident to confident	75.4	77.3	76.2
	A little confident to not at all confident	15.9	12.2	14.3
		N=1372	N=1008	N=2381

Nonetheless, the majority (76%) of students felt confident about talking to a partner about using a condom despite partner resistance. Students' confidence in persuading a reluctant partner to use a condom during sex has increased slightly since 1992. In 2002, 44% of students reported they were very confident they could persuade their partner to use a condom after refusal, compared with 41% in 1997 and 38% in 1992. Of those who were very confident, young women (43%) were more confident than young men (38%), however the difference here was marginal.

Compared with communicating with their partners, students were considerably less confident when it came to talking to parents about HIV and other STIs (Table 5.28), decisions relating to contraception (Table 5.29) and sex (Table 5.30).

Table 5.28. Students' confidence in talking to parents about HIV and other STIs (%).

		Year 10	Year 12	Total
Males	Very confident to confident	36.6	42.4	39.0
	A little confident or not at all confident	63.4	57.6	61.0
		N=595	N=434	N=1029
Females	Very confident to confident	45.0	50.2	47.2
	A little confident or not at all confident	55.0	49.8	52.8
		N=777	N=570	N=1347
Totals	Very confident to confident	41.3	46.8	43.7
	A little confident or not at all confident	58.7	53.2	56.3
		N=1372	N=1004	N=2375

Table 5.29. Students' confidence in talking to parents about contraception (%).

		Year 10	Year 12	Total
Males	Very confident to confident	37.8	39.1	38.3
	A little confident or not at all confident	62.2	60.9	61.7
		N=593	N=436	N=1029
Females	Very confident to confident	43.3	49.8	46.0
	A little confident or not at all confident	56.7	50.2	54.0
		N=777	N=570	N=1346
Total	Very confident to confident	40.9	45.1	42.7
	A little confident or not at all confident	59.1	54.9	57.3
		N=1370	N=1005	N=2375

In contrast with talking with partners, students who were either confident or very confident about talking to their parents about HIV and other STIs (44%), contraception (43%) and sex (41%) represented the minority. Furthermore, since 1992 students have, over time, become less confident about talking to parents about HIV and other STIs.

Table 5.30. Students' confidence in talking to parents about sex (%).

		Year 10	Year 12	Total
Males	Very confident to confident	38.5	39.3	38.8
	A little confident to not at all confident	61.5	60.7	61.2
		N=596	N=436	N=1032
Females	Very confident to confident	41.0	45.1	42.7
	A little confident to not at all confident	59.0	54.9	57.3
		N=777	N=571	N=1348
Total	Very confident to confident	39.9	42.6	41.0
	A little confident to not at all confident	60.1	57.4	59.0
		N=1373	N=1006	N=2380

Young women demonstrated greater confidence in talking to parents about sex and sexual health than young men, and for each sexual health issue, young men in Year 10 showed the lowest confidence in discussing matters with parents.

DISCUSSION

The majority of young people in Years 10 and 12 are sexually active in some way. Vaginal intercourse is less common than other forms of sexual activity but is reported by approximately a quarter of students in Year 10 and just under half of those in Year 12. This is higher than observed in previous surveys. While the actual number of students who are sexually active does not differ vastly to reports concerning the number of all high school students in the USA who are sexually active (45%), the trend towards an increase contrasts with the findings of the overseas studies (Massachusetts Department of Education 1999; Grunbaum et al, 2001). An analysis of six state Youth Risk Behaviour Surveys (YRBS) between 1991 and 1999 showed a 15% drop in the numbers of high school students who had ever had sexual intercourse, and a 24% drop in those who had had multiple sexual partners. However these changes appear to have occurred among specific groups, such as students in Year 11 and black American students. The prevalence of condom use increased in this period and the percentage of students using alcohol or drugs before their last sexual intercourse also increased by 18% (Brener et al, 2001).

The Australian survey has provided data for the first time on the occurrence of oral sex between young people who have not experienced vaginal intercourse in the last year. This

practice was most commonly reported by young men in Year 10. Given that there is evidence that young people may not consider oral sex to be 'sex' (Rissel et al, 2003a), the meaning attached to oral sex, when not accompanied by intercourse, among these young people requires further exploration.

The picture that emerges from these data is not a simple one of a generalised increase in sexual activity, even though more young people were sexually active than was observed in previous surveys. Among sexually active students, there appears to be an increased number of students in Year 10 who report having had three or more partners in the previous year. This increase has been accompanied by a decrease in the proportion of Year 12 students reporting three or more partners in the previous year. As with previous surveys there is no general relationship between the number of sexual partners a young person has had and the consistency of condom use.

Given the changes in the amount of sexual activity observed, it is not surprising that the patterning of that activity has also changed. Young men in Year 10, the group most likely to report high numbers of partners, were also the most likely to report that their most recent partner was someone they had met for the first time. All students in Year 10 were more likely than in previous surveys to describe their most recent partner as someone they had met for the first time. Perhaps reflecting this decline, there was also a decline among the young men generally in the proportion discussing the avoidance of pregnancy and the use of condoms during their most recent sexual encounter.

The experience of unwanted sex remains unfortunately high and appears not to change with each survey administration. In their most recent sexual encounter about one in twenty students, most commonly young women in Year 10, indicated that they did not want to have sex. The two most commonly cited reasons for unwanted sex were being under the influence of alcohol and the experience of pressure from a sexual partner.

The issue of sexual coercion was addressed in a recent study in New Zealand, in which narratives about sexual coercion were gathered from students in year 12 from six schools over a 12 month period (Hird & Jackson, 2001). The authors report that their analysis of these narratives suggest that young people use a discourse of gender differences to explain male and female sexuality, and account for dating violence. Young women were seen as responsible for

heterosexual relations, and having to negotiate complex discourses in which they are cast as either 'angels' or 'sluts'. Young men were found to draw on what they saw as 'common scientific knowledge' about sexual performance in young men to explain their 'wild desires'.

A 1995 study examined the differences between the emotional reactions of 932 sexually active Australian young people to their most recent occasion of sexual intercourse (Lucke et al, 1995). The majority reported feeling happy or good, however females were more likely to report feeling bad or used. This was exacerbated if they were drunk or high, or had sex with someone who was not their regular partner. There was no difference between young men and young women in the study who reported feeling guilty after their last sexual intercourse. The findings of the 2002 survey are similar: the most recent sexual encounter was a positive experience for nearly all students although more young men than young women described the experience in positive terms.

Of concern is the finding that in nearly one in four of students' last sexual events, the respondent was drunk or high. Notably, it appears that young men in Year 10 are becoming increasingly more likely to report being drunk or high at their most recent sexual encounter. However, condoms were available and used in the majority of instances, most particularly among students in Year 10. The oral contraceptive pill was identified by more of the Year 12 students than Year 10 students as being used at the last sexual encounter. The use of either condoms or the oral contraceptive pill was reported at nearly all of these sexual encounters. However, the use of generally reliable means of contraception was not universal, with just over 10% of sexually active young people reporting that withdrawal was the contraceptive method used.

Another aspect of sexual activity is the occurrence of pregnancy. While relatively few students reported having sex that resulted in a pregnancy, slightly more than one in twenty students had had this experience. In the British National Survey of Sexual Attitudes and Lifestyles (NATSAL, 2000), 30% of men and 26% of women aged 16 to 19 reported that their first experience of sexual intercourse occurred when they were younger than 16. Younger age of sexual intercourse was associated with non-use of contraceptives, 18% of young men and 22% of young women having sexual intercourse aged 13 to 14 years reported not using contraceptives. Early age of first intercourse was also associated with pregnancy under age 18 (Wellings et al, 2001). Another British study investigated factors determining

use of contraceptives at first sexual intercourse among a group of 8000 students aged 16 to 18 (Stone & Ingham, 2002). The study reported that contraceptive use was more likely among young people who had communicated with each other about contraception, had intimate reasons for wanting to have sex, and had parents who demonstrated warmth and positive attitudes about sexuality in general

Students reported high levels of confidence in their ability to say no to unwanted sex, discuss condom use with a sexual partner and persuading a new sexual partner to use a condom after they had refused to use one. Students' confidence in talking to their parents about sex, contraception, and HIV and STI was strikingly lower.

The 2002 survey found that the location of the most recent sexual encounter was most likely to be either the home of the respondent or that of their sexual partner. Young men in Year 10 were the most likely to report that their most recent sexual encounter took place elsewhere, a reflection perhaps of the higher likelihood that they had not known their partner before. A link has been demonstrated in US research between adult supervision and 'opportunistic' sexual activity among teenagers. In one study, Cohen & Farley (2002) found that 91% of young people who last had sex, had it in their own or someone else's home. Over half (59%) of the young women who participated in after-school activities reported being sexually active, compared with 71% of the young women with no after-school activities. While students were most likely to have sex at their own or their partner's home, a quarter had also had sex at friend's house, in a car or outside. Cohen & Farley (2002) also found that young men who spent more than five hours per week after school without an adult present were twice as likely as other young men to have gonorrhoea or chlamydia.

A number of studies have drawn attention to the sexual orientation of young people, and the social and emotional consequences of the prevalence of homophobia in school communities. In the Australian study, *Writing Themselves In*, Hillier et al (1999) found that between 8 and 11% of young people identified as same sex attracted, that is, not exclusively heterosexual. Several studies report that young people who are not exclusively heterosexual are more likely to be bullied at school, experience depression and suicidal feelings and display self-harming behaviours (Dyson et al, 2003; Hillier et al, 1999; Nicholas & Howard, 2001; Rivers, 1999).

This 2002 survey found that approximately 2% of all sexual encounters were same-sex encounters. Considerably more than two percent of students report current same sex attraction. The proportion reporting same-sex attraction is similar to the previous survey. In both surveys the proportion reporting same sex attraction is lowest among young men in Year 12. This may reflect particular issues around the retention of same sex attracted young men in the school system.

IMPLICATIONS FOR POLICY AND PRACTICE

The results of this survey demonstrate that more young people are becoming sexually active. There is also evidence that young people are becoming sexually active at a younger age. These changes are a reflection of a much broader process of social change associated with decreasing ages at the initiation of sexual behaviour (Rissel et al, 2003b). While existing school curricula generally acknowledges that some young people may be sexually active, some re-emphasis may be needed to recognise that the majority of students in Years 10 and 12 are engaging in some form of sexual activity. Consideration needs to be given to the more consistent provision of quality sexuality education at an earlier age, beginning with programs in primary schools. It is also important that the way sex is defined and addressed in these programs is examined to ensure that it captures the reality of the sexual experiences of young people.

The emergence of oral sex as a common practice requires recognition. This is particularly the cases as there is evidence of the engagement in oral sex with partners with whom intercourse is not practiced and evidence that young people are likely not to equate oral sex with sex (Rissel et al, 2003a). This possible disarticulation of oral sex from sex may indicate that if young people engage in oral sex without intercourse, they may be less likely to recognise the risk of disease transmission in oral sex. Therefore, while acknowledging it is less likely to lead to disease transmission than sexual intercourse, some greater emphasis on the transmission risks associated with oral sex may be required.

Year 10 students, most particularly young men, appear to be the group for whom the likelihood of having large numbers of sexual partners is increasing, as is the likelihood that their partner will be unknown to them prior to that occasion. This is also the group most likely to report being drunk or high at their most recent sexual encounter. While there is no simple

relationship between alcohol use, sexual behaviour and condom use, the substance use and sexual practices of Year 10 students, particularly the young men, are in need of special attention.

School programs that articulate the links between substance use and sexual behaviour in social situations should be widely adopted, and particular attention given to making such programs relevant to the lives of young men in Year 10. Such programs also need to focus on issues of gender and power, given the unacceptably high levels of unwanted sex and sexual coercion revealed by this study.

A large scale study in the USA has reported that factors associated with higher levels of sexual activity among 13 to 18 year old students include lower socio-economic status, poor school performance, suicidal thoughts, low parental expectations, feelings that no adult or parent cared for them, and being concerned about their community (Lammers et al, 2000). Similar findings have been reported from the Dunedin Study, a longitudinal study of a birth cohort of young people born in Dunedin New Zealand in 1972/3 (Paul et al, 2000). It found that for young men, predictors of early onset of sexual activity include lack of outside interests, lack of connection with school or religion, a pattern of being in trouble at school, and plans to leave school early.

The rate of use of condoms and other forms of contraceptive use remains high, with most sexual encounters involving the use of either condoms or the oral contraceptive pill. The increasing rates of sexual activity, and increasing rates of sexual activity whilst drunk or high, do not appear to be reflected in poorer contraceptive use. Of concern is the 10% of students who report using withdrawal as the contraceptive strategy at their most recent encounter. Further emphasis on the inadequacy of withdrawal as a contraceptive strategy is required in order to reduce reliance on this method. In addition, the number of young people whose sexual behaviour had resulted in pregnancy, while relatively low, indicates an additional need for ongoing sound and practical education about contraception.

The fact that 2% of the most recent sexual encounters of young people in the survey were same sex encounters indicated that there is a need for school programs to be inclusive in their provision of information about safe sex and relationships for all young people.

Finally, it is of some concern that students indicate their lack of confidence in discussing aspects of sexual health with parents and may point to the need for parents to have more readily available training and information relating to this sensitive area. School programs can play a role in facilitating discussions of this kind between students and parents.

6. HEALTH STATUS

Key Findings

- *Young people report their health status as generally good*
 - *Relatively few students have been diagnosed with an STI*
 - *Fewer still have been diagnosed with Hepatitis*
 - *Consistent with poor knowledge about Hepatitis, a significant minority of young people are uncertain whether they have been vaccinated against Hepatitis A and B*
 - *About a quarter of all students mistakenly believed they have been vaccinated against Hepatitis C*
 - *Fewer than ten percent of students believed that they were likely or very likely to become infected with Hepatitis B, Hepatitis C, an STI or HIV*
 - *Rates of alcohol use, and binge drinking, are increasing. This is most notable among Year 10 students. The alcohol use patterns of young men and young women are also becoming increasingly similar.*
 - *Injecting drug use remains rare*
 - *Body transformation practices such as tattooing and piercing are very common. While most of these practices are undertaken in controlled settings, the opportunity for unsafe practices is clearly present*
 - *Members of the school community, along with parents, friends and siblings, are important sources of advice regarding HIV, STIs and contraception*
 - *While the use of the internet is nearly universal, young people are appropriately dubious of the quality of internet-based information regarding sexuality or sexual health*
-

Introduction

While sexuality can be an important aspect of life for some young people, the achievement and maintenance of high levels of general health are important issues for all young people. Health status is a very broad domain, many aspects of which may be relevant to sexual health. In this section we examine young people's general health, their experience of STIs and BBVs, risk perceptions, injecting drug and alcohol use, body transformation practices and their sources or relevant information in particular their use of the Internet.

Health Status

General health and well being were assessed through the use of the standardised and commonly used questions that form part of the SF-36 health survey and are designed to measure self-reported general health (Ware et al, 1994). The set of questions comprise five general health items from which students' responses are aggregated to form a 100 point general health scale, and a health transition item that compares a student's current health with their health one year ago. Student scores on the aggregated measure can range from 0 to 100; the higher the score on this scale the better the self-reported health. The five-item general health scale has been shown to exhibit construct validity and reliability (Ware et al, 1994).

Students in the survey reported relatively good general health, with a mean score of 70. Male students reported somewhat better general health than female students, however there were no significant differences in mean self-reported general health between Year 10 and Year 12 students (Table 6.1).

Table 6.1. Students self reported general health: mean SF-36 scale scores (0 – 100).

	Year 10	Year 12	Total
Males	74.0	74.6	74.2
Females	67.2	65.8	66.6
Total	70.2	69.5	69.9
Total males	595	433	1029
Total females	777	572	1349
Total	1372	1005	2378

When asked to rate their health generally, the large majority (92%) rated their health as either 'good', 'very good', or 'excellent' (Table 6.2). This proportion is marginally higher than the national figure for persons aged 15 to 24 years (91%), and greater than the proportion for Australians aged 15 years and over, which is 82% (Australian Bureau of Statistics, 2001).

Table 6.2. Students' responses to the general health item: 'In general, would you say your health is?' (%).

		Year 10	Year 12	Total
Males	Poor	1.5	0.3	0.9
	Fair	7.0	5.5	6.4
	Good	23.4	24.6	23.9
	Very good	38.7	46.1	41.8
	Excellent	29.4	23.5	27.0
		N=596	N=435	N=1031
Females	Poor	0.4	0.2	0.3
	Fair	9.1	8.4	8.8
	Good	36.9	40.1	38.2
	Very good	39.5	43.8	41.3
	Excellent	14.1	7.6	11.4
		N=777	N=571	N=1348
Total	Poor	0.8	0.2	0.6
	Fair	8.2	7.1	7.8
	Good	31.0	33.4	32.0
	Very good	39.2	44.8	41.5
	Excellent	20.8	14.5	18.1
		N=1373	N=1006	N=2379

Most students considered their health to be either better (38%) or the same (49%) as one year ago (Table 6.3). Although only a very small proportion (1%) of students thought their health was much worse than it was a year ago, a considerable minority (13%) considered their health had become 'somewhat worse'.

Table 6.3. Students health transition: ‘Compared to one year ago, how would you rate your health in general now?’ (%)

		Year 10	Year 12	Total
Males	Much better	19.0	16.2	17.8
	Somewhat better	28.6	15.9	23.2
	About the same	41.9	56.6	48.1
	Somewhat worse	9.2	10.5	9.8
	Much worse	1.3	0.8	1.1
		N=593	N=435	N=1028
Females	Much better	14.8	9.8	12.7
	Somewhat better	23.4	21.3	22.5
	About the same	49.5	47.9	48.8
	Somewhat worse	10.8	19.6	14.6
	Much worse	1.5	1.4	1.4
		N=776	N=571	N=1347
Total	Much better	16.6	12.5	14.9
	Somewhat better	25.7	19.0	22.8
	About the same	46.2	51.7	48.5
	Somewhat worse	10.1	15.7	12.5
	Much worse	1.4	1.1	1.3
		N=1369	N=1006	N=2376

Analysis of students reporting ‘somewhat worse’ or ‘much worse’ health compared with one year ago showed that those reporting worsening health were more likely to be in Year 12 (17% versus 11%,) and more likely to be female than male (16% versus 11%). Analysis also showed that independent of the effects of year level and gender, binge drinking was associated with the likelihood of reporting worse health. Students who had engaged in three or more binge drinking episodes in the previous two weeks were more likely to report current health was worse compared to the previous year than those who had not (17% versus 12%). The association between binge drinking and worsening health for young women was only significant for young women in Year 10; frequent binge drinking for young women in Year 12 appeared to have no effect on their reported health transition.

STIs and blood-borne viruses

Only a small proportion of students (2.6%) had ever had an HIV test (Table 6.5). Similar proportions of young men in Years 10 and 12 reporting having had an HIV test whereas having had an HIV test was somewhat more common among young women in Year 12 than

in Year 10. There were no significant changes in the proportion of students being tested for HIV across the three survey administrations (Table A.28).

Table 6.5. Students who have had a HIV antibody test (%).

	Year 10	Year 12	Total
Males	2.7	2.6	2.7
Females	1.9	3.5	2.5
Total	2.2	3.1	2.6
Total Males	575	424	1000
Total Females	768	566	1334
Total	1343	991	2334

Of those students who were sexually active, few (n=24) had been diagnosed with an STI (Table 6.6). Although this proportion is marginally greater than the figure reported by students in the 1997 survey, the change over time is not significant (Table A.29). Young women in Year 12 reported the highest rate of diagnosis with an STI.

Table 6.6 Students who have been diagnosed with a STI (%): Sexually active students only.

	Year 10	Year 12	Total
Males	2.5	2.5	2.5
Females	2.3	5.9	4.4
Total	2.4	4.4	3.5
Total Males	163	209	372
Total Females	188	261	449
Total	351	470	821

Of the 24 students who listed the type of STIs they had been diagnosed with, the most common were genital warts (HPV) (n=10), genital herpes (n=8) and candidiasis (n=3).

Only a small proportion of students (1.3%) reported having been diagnosed with Hepatitis A, B or C (Table 6.7), which is similar to the proportion in 1997 (Table A.30). Most commonly, those students who reported having been diagnosed with Hepatitis could not identify whether it was Hepatitis A, B or C.

Table 6.7. Students who have been diagnosed with Hepatitis (%).

		Year 10	Year 12	Total
Males	Hepatitis A	0.3	0.2	0.2
	Hepatitis B	0.9	0.2	0.6
	Hepatitis C	0.2	0.2	0.2
	Not sure which type	1.2	1.1	1.2
Females	Hepatitis A	0.1	0	0.1
	Hepatitis B	0	0	0
	Hepatitis C	0	0	0
	Not sure which type	0.9	0.2	0.6
Totals	Hepatitis A	0.2	0.1	0.2
	Hepatitis B	0.4	0.1	0.3
	Hepatitis C	0.1	0.1	0.1
	Not sure which type	1.1	0.6	0.9

Of those students who could identify the type of Hepatitis with which they had been infected, Hepatitis B was more common than Hepatitis A which in turn was more common than Hepatitis C.

Hepatitis vaccination

Students were asked whether they had been vaccinated against any of the Hepatitis viruses and to rate their likelihood of becoming infected with HIV or any of the STIs. Their responses in 2002 were then compared to the responses of students in the 1997 survey, allowing changes over time to be explored (Table A.31).

Table 6.8 shows percentages of students vaccinated against Hepatitis. As in 1997, knowledge regarding Hepatitis vaccinations remained low, with a relatively large proportion of students being unsure if they had been vaccinated for Hepatitis A, B or C. Notwithstanding this general uncertainty, for each Hepatitis type, the proportion of students reporting vaccinations was significantly higher than in 1997 (Table A.31).

Table 6.8. Students who have been vaccinated against Hepatitis (%).

			Year 10	Year 12	Total
Hepatitis A	Males	Yes	26.1	24.4	25.4
		No	22.7	31.6	26.4
		Don't Know	51.2	44.0	48.2
	Females	Yes	23.7	21.5	22.8
		No	28.7	32.1	30.1
		Don't Know	47.6	46.5	47.1
	Totals	Yes	24.7	22.7	23.9
		No	26.1	31.9	28.5
		Don't Know	49.2	45.4	47.6
Hepatitis B	Males	Yes	45.6	35.6	41.3
		No	16.7	27.1	21.1
		Don't Know	37.8	37.3	37.6
	Females	Yes	52.0	40.2	47.0
		No	20.1	24.7	22.1
		Don't Know	27.9	35.1	30.9
	Totals	Yes	49.2	38.2	44.6
		No	18.6	25.8	21.6
		Don't Know	32.2	36.0	33.8
Hepatitis C	Males	Yes	32.6	21.0	27.7
		No	22.7	34.7	27.8
		Don't Know	44.7	44.3	44.5
	Females	Yes	24.3	15.4	20.5
		No	28.2	36.0	31.5
		Don't Know	47.5	48.6	48.0
	Totals	Yes	27.9	17.8	23.6
		No	25.8	35.4	29.9
		Don't Know	46.3	46.8	46.5

Caution should be exercised when considering these Hepatitis vaccination statistics. In addition to Hepatitis A and B, students were asked to state whether they had been vaccinated against Hepatitis C and, as was the case in the 1997 survey, a considerable proportion thought they had been (23.6%) or were not sure (46.5%) despite no vaccine currently being available. Young men (27.7%) were more likely than young women (20.5%), and Year 10 students (27.9%) more likely than Year 12 students (17.8%) to believe they had been vaccinated against Hepatitis C.

Risk perceptions

Few students thought they were likely to become infected with Hepatitis B or Hepatitis C (Table 6.9). Students who had injected drugs (N=25) were considerably more likely to consider themselves at risk of becoming infected with Hepatitis B or C. In terms of Hepatitis B, 19% of those who had injected drugs thought it was either likely or very likely they would get Hepatitis B in comparison to 3% of students who had not injected. Similarly, of those students who had injected drugs 17% believed it was likely or very likely they would become infected with Hepatitis C compared with 4% of those who had never injected drugs.

Table 6.9. Students reporting they were likely or very likely to become infected with Hepatitis (%).

	Year 10	Year 12	Total
Hepatitis B			
Males	3.2	3.8	3.4
Females	3.7	2.7	3.3
Total	3.5	3.1	3.3
Total Males	584	432	1017
Total Females	767	571	1337
Total	1351	1003	2354
Hepatitis C			
Males	2.9	3.5	3.2
Females	4.9	2.9	4.0
Total	4.0	3.2	3.7
Total Males	586	432	1019
Total Females	770	571	1341
Total	1356	1003	2359

In comparison to Hepatitis, slightly more students thought HIV infection was likely, however the proportion believing they were at risk of becoming infected was again small (Table 6.10). There was no change in the proportion students believing they were likely to become infected with HIV between 1997 and 2002 surveys. In 1997, students were less likely to think they could be infected with HIV (6%) than students surveyed in 1992 (9%) (Table A.32).

Table 6.10. Students reporting they were likely or very likely to become infected with HIV (%).

	Year 10	Year 12	Total
Males	5.7	5.1	5.5
Females	6.1	5.3	5.8
Total	6.0	5.2	5.7
Total Males	358	246	604
Total Females	528	400	929
Total	887	646	1532

It is of some concern that, despite their increased vulnerability to infection, students who had injected drugs (N=25) did not perceive themselves to be at any greater risk of contracting HIV than those who had not injected drugs. The same disparity between injecting drug use and perceived risk of HIV infection was found in the 1997 study.

Students were aware however, that being sexually active brought with it greater risk of HIV infection, and that sex without using condoms, in some situations, increased the risk further. This is reflected in the fact that sexually active students were more likely than students who had not been sexually active to indicate that they were at risk of HIV infection (9% versus 4%).

The majority of students did not see themselves as likely to become infected with a STI (Table 6.11), and there has been a clear trend since 1992 for students to feel less at risk of contracting a STI (Table A.33). Between the 1992 and 1997 surveys, the proportion of students who thought STI infection was likely decreased from 14% to 11%, with even fewer students (6%) in 2002 thinking they were at risk of STI infection. As was the case with perceptions of risk of HIV infection, students who were sexually active recognised the increased risk of STI infection. Students who reported having sex were more likely (9%) than those not sexually active (4%) to believe STI infection was likely. Interestingly, for a considerable proportion of students, the notion that sexual activity increases the risk of sexually transmitted infection and infection with HIV was not the case. Of those that thought being sexually active increased risk of infection with an STI, 58% did not believe infection with HIV was also likely.

Table 6.11. Students reporting they were likely or very likely to become infected with an STI (%).

	Year 10	Year 12	Total
Males	6.2	5.1	5.7
Females	5.8	6.7	6.2
Total	6.0	6.0	6.0
Total Males	586	432	1019
Total Females	773	572	1345
Total	1359	1004	2363

Students were aware of the increased risk of STI infection associated with infrequent condom use, but this risk was only in relation to having sex with people they had not known before. Students not using condoms during their last sexual encounter who knew their sexual partner (current partner or an acquaintance with whom they had not had sex with before), did not report feeling at any greater risk than those who used a condom. Conversely, for students whose last sexual experience was with someone they had just met, not using a condom was associated with greater risk of infection with an STI: 30% of those not using a condom thought STI infection was likely compared with 9% of those who used a condom. The pattern was similar for perceived risk of HIV infection, although differences between perceived risk of those using and not using condoms during sex with people they had just met were not significant.

Alcohol and injecting drug use

Questions about alcohol consumption and injecting drug use were introduced in 1997 and were asked again in 2002. As in 1997, the large majority of students surveyed in 2002 drank alcohol (Table A.34). The results from the 1997 survey showed that 79% of students in Year 10 and 88% of students in Year 12 drank alcohol. In the 2002 survey the number of students drinking alcohol has significantly increased with the proportions increasing to 85% and 94% respectively.

Table 6.12 shows the frequency of students' alcohol consumption. Although the majority of students had an alcoholic drink only 'once a month or less', a considerable proportion did so once a week or more. Male students (39%) were more likely to report drinking on at least one day a week than were female students (29%).

Table 6.12. Frequency of having an alcoholic drink of any kind (%).

		Year 10	Year 12	Total
Males	Never drink alcohol	15.8	7.2	12.2
	Once a month or less	32.6	31.4	32.1
	2 to 3 days a month	21.5	21.2	21.3
	About one day a week	15.5	22.0	18.2
	More than once a week	14.6	18.2	16.2
		n=593	N=436	N=1029
Females	Never drink alcohol	14.5	8.7	12.0
	Once a month or less	39.5	32.0	36.3
	2 to 3 days a month	24.9	28.3	26.3
	About one day a week	14.8	24.0	18.8
	More than once a week	6.3	7.0	6.6
		n=773	N=572	N=1344
Totals	Never drink alcohol	15.1	8.1	12.1
	Once a month or less	36.5	31.8	34.5
	2 to 3 days a month	23.4	25.2	24.2
	About one day a week	15.1	23.1	18.5
	More than once a week	9.9	11.8	10.7
		N=1366	N=1008	N=2373

Both the 1997 and 2002 surveys found that a considerable proportion of students drank large amounts of alcohol when they did drink (Table 6.13). Between 1997 and 2002 there has been an increase in the average amount of alcohol Year 10 students consumed when they drank and

the increase is greater for young women. In 1997, 53% of young women in Year 10 reported having three or more drinks on a day that they had a drink; this figure had increased significantly to 65% in 2002 (Table A.35).

Table 6.13. Number of drinks on a day that a student has an alcoholic drink (%).

		Year 10	Year 12	Total
Males	Never drink alcohol	17.0	7.4	12.9
	1 to 2 drinks	32.6	23.9	28.9
	3 to 4 drinks	16.7	14.3	15.7
	5 to 6 drinks	12.3	18.4	14.8
	7 or more drinks	21.5	36.1	27.6
		n=587	N=427	N=1014
Females	Never drink alcohol	13.8	8.2	11.5
	1 to 2 drinks	36.9	26.3	32.4
	3 to 4 drinks	21.6	32.7	26.3
	5 to 6 drinks	16.9	16.9	16.9
	7 or more drinks	10.7	15.9	12.9
		n=772	N=563	N=1335
Totals	Never drink alcohol	15.2	7.9	12.1
	1 to 2 drinks	35.0	25.3	30.9
	3 to 4 drinks	19.5	24.8	21.7
	5 to 6 drinks	14.9	17.5	16.0
	7 or more drinks	15.4	24.5	19.2
		N=1359	N=990	N=2349

In 2002 young men in Year 10 were also more likely to drink three or more drinks when they drank but the increase was smaller. In terms of the sample overall, students in Year 12 (73%) were more likely than their Year 10 counterparts (59%) to drink three or more drinks on occasions when they did drink.

In 2002, a measure of binge drinking was again included. As was the case in 1997, female students were asked to record the number of times they had consumed three or more drinks on any one occasion in the last fortnight, while male students were asked to nominate the number of times they had consumed five or more drinks on any one occasion in the last fortnight. These measures are consistent with National Health and Medical Research Council guidelines (NHMRC, 2001). In 2002 large numbers of students, both male and female, reported having engaged in binge drinking in the two weeks prior to surveying (Table 6.14).

Table 6.14. Number of binge drinking episodes over the last two weeks (%).

		Year 10	Year 12	Total
Males	None	48.5	37.6	43.9
	Once	12.0	17.7	14.4
	Twice	10.4	7.7	9.3
	Three or more times	29.1	37.0	32.4
		n=592	N=435	N=1026
Females	None	46.3	35.2	41.6
	Once	19.5	16.8	18.3
	Twice	12.1	20.6	15.7
	Three or more times	22.1	27.4	24.4
		n=772	N=571	N=1343

Between 1997 and 2002 surveys, the frequency of binge drinking increased for both male and female students (Table A.36). In 1997, 51% of female students and 46% of male students had engaged in at least one binge-drinking episode during the two weeks prior to being surveyed. In the 2002 survey, these figures had risen appreciably to 62% and 59% respectively.

There were also differences in binge drinking behaviour by year level. Both young men (62%) and young women (65%) in Year 12 were more likely to have engaged in a binge drinking episode in the previous fortnight than were young men (51%) and women (54%) in Year 10.

Only a very small proportion of students surveyed had reported ever injecting drugs (Table 6.15).

Table 6.15. Students reporting that they had ever injected drugs (%).

	Year 10	Year 12	Total
Males	1.4	2.1	1.7
Females	0.8	0.4	0.6
Total	1.0	1.1	1.1
Total Males	n=594	N=436	N=1030
Total Females	n=771	N=573	N=1344
Total	N=1365	N=1009	N=2375

Overall, only 1.2% of students had ever injected drugs (N=25), and 1% had injected in the last twelve months (N=22). Young men at both year levels were somewhat more likely than young women to report having ever injected drugs. Although the proportion of students reporting having ever injected drugs has decreased from the 2% reported in 1997, this change is not significant (Table A.37). As was the case in the 1997 survey, of those students reporting having ever injected drugs, the majority used new needles on occasions when they did inject.

Body piercing and tattooing

New questions relating to tattooing and body piercing were incorporated in the 2002 questionnaire. As Table 6.16 shows, few students have tattoos: of those surveyed, approximately 5% of students have at least one tattoo.

Table 6.16. Students with tattoos (%).

	Year 10	Year 12	Total
Males	5.2	5.4	5.3
Females	3.6	4.4	3.9
Total	4.3	4.8	4.5
Total males	N=600	N=435	N=1035
Total females	N=774	N=572	N=1346
Total	N=1374	N=1007	N=2381

Slightly fewer female students had tattoos than did male students, but this difference was not significant. Year 10 and Year 12 students were equally likely to have a tattoo. The majority of students with tattoos had one tattoo (54%, median = 1), with slightly less than one quarter of surveyed students with tattoos reporting 3 or more tattoos (Table 6.17). Male students with tattoos (35.3%) were more likely than female students with tattoos (8.3%) to have multiple tattooing (three or more).

Table 6.17. Students with tattoos: number of tattoos (%).

		Year 10	Year 12	Total
Males	One tattoo	30.6	40.6	35.2
	Two tattoos	33.3	25.1	29.5
	3 or more tattoos	36.2	34.3	35.3
Females	One tattoo	67.0	77.8	72.4
	Two tattoos	23.4	15.2	19.3
	3 or more tattoos	9.6	7.0	8.3
Total	One tattoo	48.4	60.3	54.1
	Two tattoos	28.5	19.9	24.3
	3 or more tattoos	23.1	19.8	21.6

Of those students with tattoos, most had tattooing work done at tattoo parlours or by professional tattooists (Table 6.18). A small proportion of students had done their own or had someone they knew do the tattooing. Of those students with tattoos (n=117), 33% had tattooing carried out in potentially high risk settings (self tattooing or by a non professional acquaintance).

Table 6.18. Who performed tattooing? (%).

		Year 10	Year 12	Total
Tattooist / tattoo worker in parlour	Males	2.9	3.0	3.0
	Females	3.2	3.7	3.4
	Total	3.1	3.4	3.2
Did them myself	Males	0.9	1.4	1.1
	Females	0.2	0.3	0.2
	Total	0.5	0.8	0.6
A friend, relative or acquaintance	Males	1.8	1.4	1.6
	Females	0.3	0.7	0.5
	Total	0.9	1.0	1.0
I have no tattoos	Males	94.8	94.6	94.7
	Females	96.4	95.6	96.1
	Total	95.7	95.2	95.5

Students engaging in potentially unsafe tattooing practices represented approximately 2% of the total sample. Of students with tattoos, young men (48%) were more likely to have their tattoos done in high risk settings than young women (18%).

Body piercing was much more common than tattooing (Table 6.19), with 60% of students having had a piercing of some kind. Pierced ears were more common (53%) than piercings in other areas of the body (18%), with female students more likely to have ear piercings (female students 79%, male students 17%) and piercings in other areas of the body (female students 27%, male students 6%).

Table 6.19. Students with piercings (%).

		Year 10	Year 12	Total
No piercings	Males	80.8	76.3	78.9
	Females	12.2	8.4	10.6
	Total	41.8	37.3	39.9
Ear(s)	Males	14.4	20.3	16.9
	Females	77.7	81.7	79.4
	Total	50.4	55.5	52.6
Other areas of body	Males	6.0	7.1	6.4
	Females	25.0	29.0	26.7
	Total	16.8	19.6	18.0

Table 6.20 shows the number of piercings students had. The majority (87%) of students with piercings had 2 or more. Taking into account the different rates of piercing between young men and women, a measure of multiple piercing was established where male students with more than one piercing and female students reporting two or more piercings were compared. Using this measure, a slightly greater proportion of female students (49%) than male students (41%) had multiple piercings, however the difference here was not statistically significant.

Table 6.20. Students with piercings: Number of piercings (%).

		Year 10	Year 12	Total
Males	1 piercing	68.4	50.5	59.2
	2 piercings	9.6	28.8	19.4
	3 or more piercings	22.0	20.7	21.3
Females	1 piercing	3.8	8.4	5.9
	2 piercings	48.9	40.0	44.9
	3 or more piercings	47.3	51.6	49.2
Total	1 piercing	11.9	15.0	13.3
	2 piercings	44.0	38.3	41.4
	3 or more piercings	44.1	46.7	45.3

Most students piercings had been carried out by beauticians or workers in chemists or piercing studios (Table 6.21). Fewer students did their own piercing (3%) or had friends, relatives or acquaintances (2.5%) do piercing.

Table 6.21. Who performed the piercing? (%).

		Year 10	Year 12	Total
Doctor or health professional	Males	0.8	1.8	1.2
	Females	10.1	7.2	8.9
	Total	6.1	4.9	5.6
Worker in piercing studio	Males	6.7	9.6	7.9
	Females	27.7	31.5	29.3
	Total	18.6	22.1	20.1
Worker in chemist	Males	5.2	4.3	4.8
	Females	31.9	44.7	37.4
	Total	20.4	27.4	23.3
Beautician or hairdresser	Males	5.2	6.6	5.8
	Females	36.2	34.5	35.5
	Total	22.8	22.5	22.7
Did them myself	Males	3.1	2.7	2.9
	Females	3.1	2.8	3.0
	Total	3.1	2.7	2.9
Friend, relative or acquaintance	Males	1.7	0.6	1.3
	Females	3.0	3.8	3.4
	Total	2.5	2.4	2.5

Like unsafe tattooing, body piercing performed in non-regulated settings may increase the risk of infection with blood-borne viruses. Of the students with piercings (n=1403), 8% reported having had piercing done in non-regulated settings (self piercing and piercing by an acquaintance). Students reporting potentially unsafe piercings represented 5% of the total sample. Young men with piercings were more likely to engage in this practice (18%) than young women (7%). When the different rates of piercing for young men and young women are taken into account, more female students (6%) than male students (4%) actually engaged in unsafe body piercing.

Sources of information

In the 1997 survey students were asked to record the sources they used for information and advice regarding HIV/AIDS, STIs, contraception and Hepatitis. In 2002 students were once again asked to list the sources of information used across these four sexual health areas, however the categories presented to students were changed considerably in order to capture more specific information. For this reason, analysis of students' use of information sources for HIV/AIDS, other STIs, contraception and Hepatitis over time was not possible, and these data are reported only for the 2002 survey.

Table 6.22 shows sources of information used by students for issues relating to HIV/AIDS, STIs, contraception and Hepatitis. The large majority of students surveyed in 2002 had used one of these information sources to find out about HIV/AIDS (89.2%), STIs (87.4%), contraception (91.2%) and Hepatitis (84.5%). Year 12 students were more likely than Year 10 students to seek information regarding contraception, but there were no year level differences in information seeking in terms of HIV/AIDS, STIs, or Hepatitis.

Across each sexual health area, school programs, pamphlets, the media, and teachers were common sources of information, with school programs used the most. In addition to school programs, mothers and female students were used more often for advice about contraception, HIV/AIDS, STIs and Hepatitis. Doctors (22.4%) played a more prominent role in the provision of advice to students about contraception. Although gender differences were seen in specific information source use across the four sexual health areas, there was a tendency for female students to seek advice from mothers and female friends, and young men to confide in their fathers about sexual health matters. See Table 6.22 over page.

Source of information	Year 10					Year 12					Total				
	HIV/AIDS	STIs	Contraception	Hepatitis		HIV/AIDS	STIs	Contraception	Hepatitis		HIV/AIDS	STIs	Contraception	Hepatitis	
Youth worker	Total	6.1	4.6	7.2	5.0	4.0	3.9	5.1	3.8	5.2	4.3	6.3	4.5		
	Male	9.3	6.6	5.6	6.2	6.0	4.9	7.3	4.3	7.9	5.8	6.4	5.4		
	Female	3.5	3.9	7.2	3.0	3.9	2.9	8.0	2.2	3.7	3.5	7.5	2.7		
	Total	5.9	5.0	6.5	4.4	4.8	3.7	7.7	3.1	5.5	4.5	7.0	3.8		
Media	Total	30.6	24.4	25.6	22.1	40.8	34.8	33.4	29.2	35.0	28.9	29.2	25.1		
	Male	36.0	30.8	36.9	26.4	43.9	35.4	39.9	31.1	39.3	32.8	38.2	28.3		
	Female	33.7	28.1	32.4	24.6	42.6	35.2	37.1	30.3	37.5	31.2	34.5	26.9		
Pamphlets	Total	34.8	35.4	32.2	30.9	41.2	39.2	40.8	32.1	37.6	37.1	36.1	31.4		
	Male	42.4	37.7	44.4	31.9	47.3	46.2	50.0	34.4	44.4	41.4	46.8	33.0		
	Female	39.2	36.7	39.5	31.5	44.7	43.2	46.1	33.4	41.5	39.6	42.4	32.3		
Internet	Total	22.5	18.6	20.8	18.4	17.2	14.5	12.9	12.3	20.2	16.9	17.2	15.8		
	Male	15.7	15.9	17.5	9.6	13.2	13.4	15.4	7.4	14.7	14.8	16.6	8.7		
	Female	18.5	17.0	18.8	13.4	15.0	13.9	14.4	9.5	17.0	15.7	16.9	11.8		
Mother	Total	29.9	26.2	28.4	25.9	23.8	21.3	33.4	24.5	27.3	24.1	30.7	25.3		
	Male	32.0	26.3	47.0	28.0	28.7	22.7	49.3	20.9	30.6	24.7	48.0	25.1		
	Female	31.1	26.2	39.6	27.1	26.6	22.1	42.5	22.5	29.2	24.5	40.9	25.2		
Father	Total	26.7	21.5	25.6	21.8	20.1	16.7	27.2	18.8	23.9	19.4	26.4	20.5		
	Male	14.3	10.2	15.8	12.0	12.9	10.9	14.9	12.5	13.7	10.5	15.4	12.2		
	Female	19.5	14.9	19.7	16.1	16.0	13.4	20.1	15.2	18.0	14.3	19.9	15.7		
Other relative	Total	10.0	9.1	7.6	8.3	5.9	5.2	9.2	5.0	8.3	7.4	8.3	6.9		
	Male	9.6	9.1	18.4	8.1	5.5	5.7	14.3	4.3	7.9	7.6	16.6	6.6		
	Female	9.8	9.1	14.1	8.2	5.7	5.4	12.1	4.6	8.1	7.5	13.2	6.7		
Female friend	Total	14.0	13.4	22.1	10.0	19.3	17.3	29.4	13.6	16.3	15.1	25.4	11.5		
	Male	30.4	30.8	51.9	21.4	25.0	24.3	53.4	19.1	28.2	28.0	52.6	20.4		
	Female	23.5	23.5	40.0	16.5	22.5	21.3	43.2	16.7	23.1	22.5	41.4	16.6		

Almost all students (97%) accessed the Internet (Table 6.23), most often at home, school and friends' houses. Young women in Year 10 were more likely to use the internet at school than young men at the same year level, but this gender difference did not exist for Year 12 students. There were no gender differences in Internet use generally, nor were there any differences by school year level.

Table 6.23. Where do you access the Internet? (%).

		Year 10	Year 12	Total
Home	Males	83.9	86.5	85.0
	Females	80.7	83.1	81.7
	Total	82.0	84.6	83.1
School	Males	63.8	73.7	68.0
	Females	74.0	74.4	74.2
	Total	69.6	74.1	71.5
Friend's place	Males	41.2	34.4	38.3
	Females	43.0	29.0	37.1
	Total	42.2	31.3	37.6
Internet café	Males	6.6	9.4	7.8
	Females	4.1	4.6	4.3
	Total	5.2	6.7	5.8
Public library	Males	13.5	15.6	14.4
	Females	18.4	14.3	16.6
	Total	16.3	14.8	15.7
Other	Males	3.6	4.5	4.0
	Females	2.8	2.4	2.6
	Total	3.1	3.3	3.2
Do not use the Internet	Males	3.2	2.3	2.8
	Females	3.5	2.8	3.2
	Total	3.4	2.6	3.0

Despite the almost universal exposure of students to the Internet, most did not use it for information on sexuality or sexual health and, when they did, it was employed only rarely as a source of information (Table 6.23). There were no gender or year level differences in students' Internet use for information on sexuality or sexual health.

Table 6.24. Students using the Internet for information on sexuality or sexual health (%).

		Year 10	Year 12	Total
Males	Never used the internet for this	62.9	66.4	64.4
	Rarely, but have used it for this	29.8	27.4	28.8
	Often	3.7	3.9	3.7
	Very often	3.6	2.4	3.1
		N=563	N=419	N=982
Females	Never used the internet for this	66.6	68.0	67.2
	Rarely, but have used it for this	29.9	27.9	29.1
	Often	2.5	3.9	3.1
	Very often	0.9	0.2	0.6
		N=757	N=550	N=1307
Total	Never used the internet for this	65.0	67.3	66.0
	Rarely, but have used it for this	29.9	27.7	28.9
	Often	3.0	3.9	3.4
	Very often	2.1	1.1	1.7
		N=1319	N=969	N=2288

When seeking information about sexuality or sexual health on the Internet, students were more likely to use web pages than either chat rooms or discussion groups (Table 6.24). There were no marked differences between year levels or between young men and women in the types of internet site used for information on sexuality or sexual health.

Table 6.25. Type of site used for information on sexuality or sexual health (%).

		Year 10	Year 12	Total
Chat room	Males	6.6	3.4	5.2
	Females	5.4	4.5	5.0
	Total	5.9	4.0	5.1
Web site	Males	29.8	30.3	30.0
	Females	27.8	29.2	28.4
	Total	28.7	29.7	29.1
Interest/discussion group/forum	Males	4.4	5.6	4.9
	Females	3.3	5.4	4.2
	Total	3.8	5.5	4.5

Moreover, students expressed greater trust in the sexual health information they obtained from web pages compared with the information sourced from either discussion groups or chat rooms (Table 6.26).

Very few students reported more than a little trust in information obtained from chat rooms and young men appeared slightly more trusting than did young women. Students were more trusting of information from discussion groups than from chat rooms, but only a relatively small minority indicated a lot of trust in those sources of information. In relation to websites, young women were more likely to indicate a lot of trust.

Table 6.26. Students' trust of information from Internet sites (%).

			Year 10	Year 12	Total
Chat rooms	Males	Not at all	58.8	53.9	56.9
		A little	37.6	40.9	38.9
		A lot	3.6	5.2	4.2
	Females	Not at all	61.5	63.8	62.4
		A little	35.0	34.1	34.6
		A lot	3.6	2.2	3.0
	Totals	Not at all	60.2	59.5	59.9
		A little	36.2	37.0	36.5
		A lot	3.6	3.5	3.5
Web sites	Males	Not at all	9.8	6.7	8.6
		A little	50.8	58.4	53.9
		A lot	39.4	34.8	37.5
	Females	Not at all	6.0	3.8	5.1
		A little	48.9	54.5	51.2
		A lot	45.1	41.8	43.7
	Totals	Not at all	7.7	5.1	6.6
		A little	49.7	56.2	52.4
		A lot	42.5	38.7	41.0
Interest/Discussion groups	Males	Not at all	33.5	32.5	33.1
		A little	54.1	57.5	55.4
		A lot	12.5	10.0	11.5
	Females	Not at all	26.9	25.7	26.4
		A little	61.8	67.1	64.0
		A lot	11.3	7.2	9.6
	Totals	Not at all	29.9	28.7	29.4
		A little	58.3	62.9	60.2
		A lot	11.8	8.4	10.4

DISCUSSION

There have been a number of international studies that have focused on the health and well being of young people. In USA health study, high school students from grades 7 through 12 were asked to rate their own health. Physical and mental health problems were reported only 'rarely or occasionally' (Bearman & Burns, 1998). A Canadian study with a similar participant group reports that 90% rated their own health positively (McCreary Centre, 1998). In the 2002 survey the majority of students also reported themselves to be generally healthy, although there appears to be a tendency for young men to report better health than young women. It is of concern that in relation to alcohol consumption, binge drinking and the age of sex partners, the gap between young women's and young men's behaviour is closing.

In the USA, the Youth Risk Behaviour Survey (YRBS) reports that, among more than 10,000 students in grades 9 to 12, three percent of young men and five per cent of young women report having had at least one STI (Crosby et al, 2000). In Britain, the 2000 National Survey of Sexual Attitudes and Lifestyles (NATSAL) reports that one in thirty-three young people aged between 16 and 24 had chlamydia, although most were unaware of being infected (Wellings et al, 2001). Chlamydia has also been found to be a health issue for young people aged 16 to 24 in Sweden, where the incidence of the infection increased from 14,000 cases in 1994 to 22, 263 in 2001, with 60% of new infections occurring among young people and the steepest increase among school aged adolescents (Edgardh, 2002).

In Australia, less than one per cent of young men aged 16-19 years (0.7%) had ever been diagnosed with an STI, and 0.2% had been diagnosed with an STI in the previous year. Comparable figures for young women are 3.0% and 1.2% (Grulich et al, 2003). These figures are borne out in the 2002 survey in which very few students reported having been diagnosed with an STI. However, of those students who indicated that they were sexually active, 3.5% reported having had an STI, with young women in Year 12 reporting a considerably higher rate (5.9%) than other students surveyed. This may reflect service use patterns by this group: young women in Year 12 are also more likely to seek advice about contraception from doctors and may be diagnosed more frequently as a result. It is also possible that other sexually active students are being inadequately screened for STIs, and that their lower levels of knowledge represent a need for improved education and health promotion programs. The most common STIs reported in the survey were genital warts, genital herpes and candidiasis, although it should be noted that the latter is not exclusively sexually transmitted. It should also be noted

that while students reported candidiasis as one of the most common STIs, it was not included in the definition of an STI used in the Grulich et al (2003) study.

In the period between the 1992 and the 2002 surveys there has been a consistent and concerning decline in the numbers of students seeing themselves as being at risk of infection with an STI. In the 1992 survey, 13.5% thought they were 'likely', or 'very likely', to become infected with an STI. In the 2002 survey, only half that number of young men and young women reported seeing themselves to be 'likely' or 'very likely' to become infected with an STI. The reasons for this cannot be determined from this survey, but the matter warrants further investigation and appropriate intervention.

Students were aware of the increased risk of STI infection associated with infrequent condom use. There does appear to be an inconsistency in the way they apply this knowledge, depending on the circumstance of their sexual encounter. If their sexual partner was known to them (either a current partner or acquaintance), they did not report feeling any more likely to contract an STI, regardless of whether a condom was used or not. However, if they had sex with a person not known to them previously and did not use a condom, they did feel more likely to become infected: 30% of those not using a condom thought STI infection was likely compared with 9% of those who used a condom.

It is a matter of some concern that students are using judgements about their sexual partners, rather than knowledge of modes of transmission, as a means of protecting themselves against STIs. This is clearly an area which school programs must continue to address.

With regard to HIV infection, young men in Year 12 were less likely to see themselves as at risk of infection than young women in Year 12, and there has been a decline in the number of young men in Year 12 who have had HIV tests. There has been a consistent decline in students seeing themselves as likely to contract HIV since the 1992 survey, but it should be noted that students have grossly over-estimated this risk in the past.

Very few of the students in the survey report having been diagnosed with any kind of Hepatitis, and there appears to have been a general increase in the numbers of students who report being vaccinated against Hepatitis A and B. Only a small proportion of those surveyed reported seeing themselves as likely or very likely to become infected with Hepatitis B or Hepatitis C. While the risk of infection with Hepatitis C is mostly limited to injecting drug users and those who received blood products prior to screening in 1990, students' perceptions

that they are not at risk should be taken seriously. Although this age group remains a small proportion of those infected, there has been a sharp increase in Hepatitis C diagnosis among 15 – 19 years olds in the past decade (Van De Ven et al, 2001).

A 2001 study of over 3000 NSW students in Years 9 and 11 (Van De Ven et al, 2001) reports that generally poor knowledge about Hepatitis, with confusion about both transmission and vaccination. This finding is corroborated by this 2002 survey, in which approximately one fifth of students stated that they have been vaccinated against Hepatitis C, when no such vaccination exists. This is of particular concern considering that, in addition to this misguided group, almost half of the sample reported that they didn't know whether or not they had received Hepatitis C vaccination. Overall, 70% of students in the survey demonstrated misinformation or a lack of understanding about vaccination against Hepatitis C. This lack of knowledge about a disease which is incurable and has devastating long term effects is a matter of some concern and points to the need for schools programs and other health promotion strategies to address the area.

A number of studies have focused on health risk behaviour and alcohol consumption among young people. While definitions of binge drinking vary between studies and programs, in this survey the 2000 National Health and Medical Research Council (NHMRC) guidelines were used: for young men five or more drinks, and for young women, three or more drinks. In a large-scale study in the USA that used a similar definition, 44% of college students were found to engage in binge drinking during the two weeks prior to the survey and students who were binge drinkers in high school were found to be more likely to continue this pattern in college (Wenchsler, 2000).

The rate of binge drinking among both young women and men increased between the 1997 and 2002 surveys. Regular binge drinking (three or more times in a fortnight) has also increased, with the greatest increase being among young men in Year 10. This information, combined with the findings that 1 in 5 students report being drunk or high at their last sexual experience, is clearly unacceptable in public health terms. It may also indicate that alcohol reduction programs in schools are not having the desired impact. It is notable that there was little difference in self-reported general health between students who engaged in binge drinking regularly and those that did not, and that the incidence of binge drinking does not appear to influence students self-reported health status. This could reflect that the measure used in the survey may not have been sensitive to the link between alcohol consumption and

health status, or indicate that the effects of binge drinking are only apparent over a longer time period.

Few students reported having ever injected drugs, and the majority of these students used a new needle when they did inject. There has been a slight decline in the numbers who reported injecting drug use. Not surprisingly, students who had injected drugs (N=25) were more likely to consider themselves at risk of contracting Hepatitis B or C. It is interesting to note that, despite their increased vulnerability, this group did not consider themselves to be at greater risk of contracting HIV than those who had not injected drugs, although they were aware that sexual contact increased their risk of contracting HIV, and that this was increased when they did not use condoms. Although the proportion of secondary school students injecting drugs remains small, there is an ongoing need for accurate information about the disease risks of this practice to be provided for all young people.

In the 2002 survey a number of questions were asked about body piercing and tattooing for the first time. Tattooing and body piercing can pose a number of risks for young people in relation to the transmission of blood-borne viruses. Van de Ven et al (2001) found that a large proportion of Australian secondary students had (mostly ear) piercings, and that few had tattoos. This finding was supported by the 2002 survey in which body piercing was more common than tattooing among the sample surveyed.

While only a small number of the total sample (5%) reported having one tattoo, the majority (60%) reported having some form of body piercing. Perhaps predictably, more young women reported body piercing than young men, mostly in their ears. Where and how the piercing occurs is of more significance than the numbers of piercings students have.

Studies have found a significant association between non-professional tattoos, and testing positive for Hepatitis B or C (Nishioka, 2002). Hepatitis and HIV can potentially be transmitted if inadequate sterilising of equipment or procedures are used for tattooing or body piercing (Carroll, 2002)

While approximately 33% of those students with tattoos reported having them done in high risk conditions (doing it on themselves, or having it done by an acquaintance), only 8% of those with piercings reported having the piercing done in a high risk setting. However, because many more students are pierced than are tattooed, a larger absolute number of potentially risky events is associated with being pierced than with being tattooed. Taking into

account the lack of understanding about transmission and vaccination against blood-borne viruses shown by students in this survey, it is clear that this is cause for concern and requires further investigation.

In their study of NSW secondary students, Van den Ven et al (2001) found that most students prefer to get information about Hepatitis from health professionals, teachers and parents. In the 2002 survey, students were asked to identify from a range of options, which sources of information they had ever used for advice about HIV/ AIDS, STIs, contraception and Hepatitis. Just over half of the students surveyed have used school programs as a source of information for advice about sexual health matters and approximately one third have used pamphlets, teachers and the media as sources of information. There are some gender differences: doctors are used more by young women for information about contraception, which may be because young women need to access a doctor for the contraceptive pill. Young women were also more likely to seek information from their mothers, particularly about contraception.

While this study did not explore the extent to which these sources of information are trusted, other studies have investigated this. A survey of over 800 students in Years 7, 9 and 11 in Australian secondary schools (Rosenthal & Smith,1995) found that information was most trusted when students perceived sources as having the most 'legitimate' knowledge, namely health professionals, school sources, and informational booklets. Mothers and fathers were also cited as trustworthy providers of information. The media was rated as relatively untrustworthy but it was still used for information. Since the time of that study there has been an exponential growth of the Internet as an information source. In 2002 students reported that, despite almost universal access to the Internet, most do not use it as a source of information on sexuality or sexual health. It is acknowledged, however, that information about sexuality and sexual health may be difficult to access on the Internet when at school. Those who do use the Internet as a source of information are more likely to use and trust web pages over chat rooms or discussion groups.

It is not surprising that school programs are a common source of information for young people. In such programs students can gain access to information on sexual health issues without the embarrassment and personal exposure of having to seek it on an individual basis. They are also provided with an opportunity to discuss the issues with peers in a safe and supportive environment.

IMPLICATIONS FOR POLICY AND PRACTICE

Although most students rate their health positively, there is cause for concern that alcohol use and binge drinking are increasing, with young women catching up to young men in this area. Significant resources have been spent in schools and in the media over the last two decades to educate young people about the responsible use of alcohol and drugs but such programs appear to have had little or no impact. The way in which alcohol and drug use impact on condom use, the uptake of safe sex practices and the experience of unwanted sex and coercion are further causes for concern. Clearly this issue requires further investigation and action. Such action might involve a comprehensive evaluation of school programs designed to reduce students' use of alcohol, and the further linking of such programs into those which cover sexual health and decision making within a social model of health. The impact of marketing of particular kinds of alcoholic drinks to young people may also warrant further investigation.

While students may be accurately assessing that they are unlikely to get HIV given the current nature of the epidemic in Australia, this should not be a cause for complacency. Levels of unsafe sexual behaviour combined with the widely held belief that students are also unlikely to get other STIs indicates their continuing failure to personalise STI risk. This is an area in which further health promotion needs to be carried out. It appears likely that STIs will continue to be spread within this population and will remain under-diagnosed. The higher rate of STIs diagnosed in young women in Year 12 is at least indicative that encouraging young people to use sexual health services would be likely to increase screening, diagnosis and treatment rates. Partnerships between schools and health services in programs designed to orientate students to local services are to be encouraged.

Further sexual risk taking based on judgements about sexual partners rather than knowledge of STI modes of transmission is another area in which school programs need to be strengthened. Misconceptions about STI risks are likely to arise as a result of the practice of teaching young people the biological information about various STIs without making the links between transmission, sexual relationships and personal decision making in a social context.

The Hepatitis C epidemic in Australia has had little impact on the understanding young people demonstrate about the various types of hepatitis and their personal risks of being infected. Hepatitis C is a relatively new issue which needs to be addressed in school programs and related to body piercing and tattooing in unsafe settings as well as to unsafe injecting drug use. There is also a need for young people to be provided with clear information about different types of Hepatitis at the time of vaccination.

Sources of information about sexual health issues which are well-used by young people should be recognised and strengthened. There is some concern about the low use of doctors in this role when other studies have shown young people place high trust in the information health care professionals are able to provide. Policies and programs that make health services more friendly and accessible to young people are to be encouraged.

The emergence of school programs as the most widely used source of information on sexual health issues is a recognition of the excellent work done in this area by teachers throughout Australia and a clear mandate for continuing and extending this work. In this context, the sometimes ad hoc nature of the provision of these programs is of great concern.

Sexual health education programs should be universally provided in all states and territories. They should be comprehensive, developmentally appropriate and designed in ways which realistically reflect the behaviour and information needs of students. In addition, the degree to which parents are used as sources of sexual health information for young people is evidence of the value of partnerships between schools and parents in this important but sometimes contentious area.

CONCLUSION

The findings of this report indicate a continued and ongoing need for comprehensive sexuality education to be provided consistently to all young Australians from an early age. By the time young people reach Year 10 the majority are sexually active in some way, with nearly 40% engaged in oral sex and over a quarter having sexual intercourse. By Year 12 just under half of all students are having sexual intercourse. It is clearly too late to begin sexual health education in middle secondary school. Such education should begin in primary school and continue at a developmentally appropriate level, in partnership with parents, and for as long as young people are in school. The value that students themselves place on the school-based education they receive is evident: just over half the survey respondents nominated it as their most used source of sexual health information.

An area of major concern arising out of this report is the increase over time in risk behaviour evident in the young men at Year 10 level. Their STI knowledge has decreased in critical areas such as the asymptomatic nature of some diseases and the link between chlamydia and potential sterility. They were most likely, of all those surveyed, to have had oral sex with three or more partners in the previous year and to report that their last sexual experience was with someone they had met for the first time. Young men in Year 10 were the group in which binge drinking has increased most over the last decade and were most likely to report being drunk or high when they last had sex. They were also the group who were least confident in saying no to unwanted sex and in discussing sexual health issues with their parents.

Taken together, these factors indicate a constellation of risk behaviours that is unacceptably high and appears to be increasing over time. There may be an argument for the development of specific programs to engage young men before they reach Year 10 and to meet their education needs in a more productive manner. An approach which places health information in the broader context of their social worlds and which assists them to understand and negotiate the strictures of gender expectations is clearly relevant here.

The level of alcohol use amongst all students has increased and, for Year 10 students, the amount being drunk has increased on those occasions when alcohol is consumed. Binge

drinking has increased for both young men and young women in both years, but the fact that the increase for Year 10 young women is the greatest, and that they are catching up with the young men, is a matter of some concern. While it is important that alcohol and drug programs in schools are evaluated to assess their effectiveness, it is unrealistic to imagine that school programs alone can address the problem. Broader socially based alcohol reduction strategies have a role here, but more research is required to provide better understanding of the reasons that young people use alcohol and the cultures which sanction and encourage its use.

The continuing high levels of condom use and other contraceptive use indicate that health promotion messages for young people, school programs and improved condom availability can contribute to behaviour change. Young people can make good decisions about their sexual health if policies, programs and services are available to help them do so.

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