THE 8TH AUSTRALIAN SURVEY OF SECONDARY STUDENTS AND SEXUAL HEALTH

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FOREWORD

No birds, no bees! We are a generation demanding better sexual health education across Australia.

Sexual health education is still treated as shameful and taboo within our society and within education. Young people are deprived of quality education on their own bodies and health. Their questions regarding healthy relationships, having safer sex and staying safe online are left unanswered. This risks misinformation and poor sexual health outcomes, leaving young people to source their own information, often from untrustworthy and unrealistic sources such as pornography.

In the contemporary world, our knowledge on health, identity, sex and relationships has expanded and, as these conversations evolve, so must the way we educate.

The SSASH report shines a light on what young people are saying they need— comprehensive, reflective sexual health education. The report reflects on the personal and communal experiences of young people to prompt the progress that the sexual health sector needs to make.

We, as members of the Sexual Health and Education Youth Advisory Board, developed 12 recommendations for changes we want to see in the sexual health sector. Our recommendations started as a series of conversations between young people and grew to include consultations with the sexual health sector. The hope is that these recommendations will be used to inform a national strategic framework to strengthen how parents/ carers, schools, and the community sector support young people's sexual health and sexual literacy.

The following report mirrors our recommendations and points to clear opportunities to strengthen sexual health promotion and education. These include making RSE relevant by expanding the curriculum to include topics such as sexism, pleasure, diversity, disabilities and sex and online literacy. Our recommended actions call for topics such as STIs to be addressed and cultural safety be explored, both themes are reflected in the findings here that show what other young people are asking for. Our recommendations also call for the education to be practical, representative and expansive.

To achieve all this, our recommendations call for a framework that informs best practices around sexual health and wellbeing for young people and develops a standard of practice that is applied at the national level. This framework must be co-designed and evaluated with young people. This report highlights areas where development is required to improve the sexual health sector including improving access to and education of people who support young people, such as teachers. This could be addressed with a national framework.

While the SSASH report highlights key areas of improvements for moving forward, it also outlines data showcasing previous improvements which have been made over the years as a result of research and advocacy. When reflecting on what improvements could be actioned in the sector, it is important to reflect on how we got here and acknowledge the work of advocacy. One example of positive improvement is the report reveals that the majority of young people are being exposed to RSE as well as reporting that more than half of young people have the knowledge that they can access free sexual health services.

The following report and subsequent data are meaningful and reflect what young people want, and what they have been advocating. It reflects our recommended actions and outlines how the sexual health sector can make changes which would have significant impacts on the lives of young people.

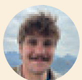
Young people are engaged and are screaming out for something different, this report coupled with our below recommendations outlines what that something different must be.

ORD

As young people, we want information delivered in a way that respects our autonomy and reflects our lived experiences. We want information to be accessible, to include themes such as sexism, rape culture, menstruation and digital culture, and be delivered in a way which is practical and safe. We want sharing of this information to be the baseline normal and be created, delivered and reviewed in consultation with us.

It is time to move beyond the 'birds and the bees' and commit to real, meaningful change. Policy makers, educators and the wider community must act on these recommended actions supported by the findings in this report and prioritise education that is reflective of what young people want.

Outdated metaphors will not teach consent, respect, or digital safety. Real, reflective, relatable education will.



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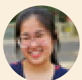

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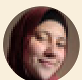

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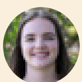

Alexis Pallister

Members of the Youth Advisory Board at the Australian Research Centre in Sex, Health and Society, La Trobe University

RECOMMENDATIONS FOR ACTION FROM THE YOUTH ADVISORY BOARD OF ARCSHS

In our ideal world, we need:

- Everyone with a duty of care to young people to be equipped to answer their questions or provide appropriate referrals
- Practical education about contraception and STI prevention, transmission, treatment and stigma that reflects contemporary sexual experiences
- Realistic and relatable information that is accessible and reflects what young people are experiencing at different ages and stages of development
- To support caregivers with school-aged young people to gain the skills to access and apply sexual health resources
- To teach that all types of bodies, including people with disabilities, can experience pleasure
- To empower young people to advocate for their needs and rights around sexual health and wellbeing
- Young people to have online resources that are safe, reliable and factual, where they can submit anonymous questions for expert advice
- To teach about sexism and rape culture, and how gender impacts sex and relationships
- Data that is responsive to the constant changes in contemporary sexual relationships to inform initiatives that support
- Cultural, religious and spiritual practices to be included and inform tailored resources and expert advice
- To teach about menstrual and sexual health so young people can recognise symptoms and address concerns early
- Young people to be actively involved in the design, delivery and evaluation of sexual health and wellbeing education, policies, and systems that affect them
- LGBTQIA+ people included at every step of sex, sexual health, relationship and consent education
- To enhance literacy, understanding and skills around navigating digital sexual content safely
- A framework that informs best practices around sexual health and wellbeing for young people, and to develop a standard of practice that is applied at the national level

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ACKNOWLEDGEMENTS

The Australian Secondary Students and Sexual Health Survey (SSASH) has benefited from the support and contributions of many individuals and organisations over the past thirty years. The 2024/25 survey (SSASH 8) was made possible through the time, expertise, and involvement of many people and organisations across Australia, and we acknowledge their contributions with appreciation.

First, the study would not have been possible without the young people who participated. Their willingness to share their experiences and perspectives continues to be central to the value and relevance of this research.

We thank the members of the ARCSHS Youth Advisory Board, whose feedback informed the development of the survey content and language.

We acknowledge the contributions of Sam Champion and Ruqia Mohamed at the Youth Affairs Council Victoria, whose work with the youth sector supported engagement and promotion of the survey. Both the Youth Affairs Council Victoria and Sexual Health Victoria provided generous and creative assistance with online marketing of SSASH 8, while many other organisations helped us to promote the survey through their local networks. We are very grateful for all of this support; it absolutely assisted in reaching a broad and diverse group of young people.

We consulted with a large number of individuals and organisations in the development of SSASH 8. These consultations helped us to design the instrument and provided important advice on recruitment. We are grateful to all those who participated in a consultation. For support with these consultations, we would like to thank Sexual Health Victoria, NSW Ministry of Health, WA Health, Family Planning NSW, SECCA (Disability and Sexuality Education WA), True QLD, and the Youth Affairs Council Victoria.

We also acknowledge the researchers and staff who have contributed to the SSASH project since 1992. Their work has shaped the development, implementation and evolution of the survey and continues to inform its direction.

We acknowledge and pay our respects to the Elders and Traditional Custodians, past and present, of the lands on which this research was conducted, and extend that respect to all Aboriginal and Torres Strait Islander peoples.

Finally, we acknowledge the Australian Department of Health, Disability and Ageing, which has funded this study since its inception in 1992.

PAST SSASH RESEARCHERS

Paul Agius, Catherine Barrett, Pamela Blackman, Graham Brown, Maria Donald, Michael Dunne, Sue Dyson, Paulina Ezer, Christopher Fisher, Wendy Heywood, Lucille Kerr, Jo Lindsay, Jayne Lucke, Robyn Nilsson, Gosia Mikołajczak, Anne Mitchell, Kent Patrick, Marian Pitts, Beverley Raphael, Doreen Rosenthal, Anthony Smith and Andrea Waling.

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Suggested citation:
Power, J., Kauer, S., Duffus, B. & Bourne, A. (2026). *The 8th Australian Survey of Australian Secondary Students and Sexual Health 2025*. Australian Research Centre in Sex, Health & Society, La Trobe University. Melbourne, Australia.

ISBN: 978-1-7642889-4-1
DOI: 10.26181/31958556

CRICOS Provider Code: 00115M

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Editing by Vanessa Winter and design by Elinor McDonald.

1. EXECUTIVE SUMMARY

The 8th Australian Survey of Secondary Students and Sexual Health (SSASH 8) is a cross-sectional survey of school aged young people run by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University.

SSASH 8 collected detailed information on young people's sexual health, including: sexually transmissible infections (STI) prevention and testing, contraceptive use, sexual health knowledge, relationships, sexual experiences, digital sexual experiences, and perceptions of school-based relationships and sexuality education (RSE).

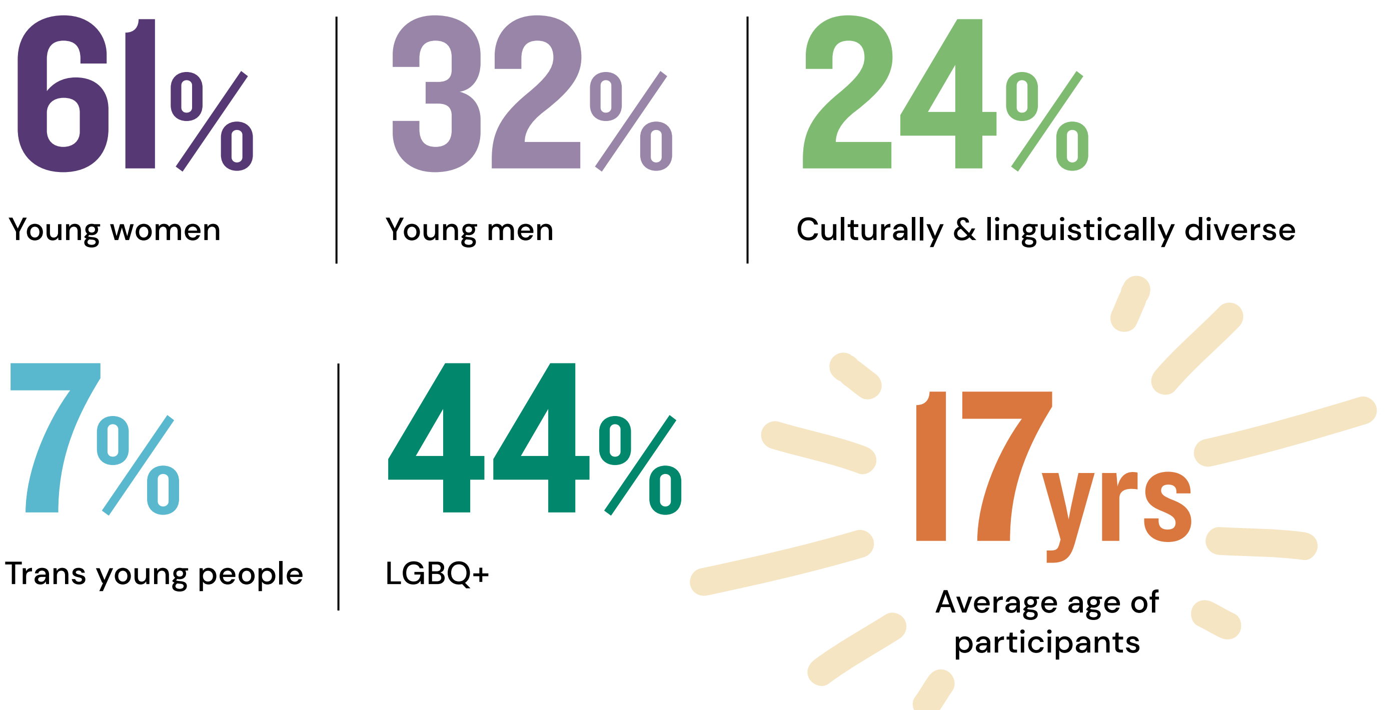
Data for SSASH 8 were collected between October 2024 and April 2025 via an online self-complete instrument. Young people were recruited to the survey via online advertising, using a professional research panel, and flyers distributed at youth events and services.

WHO PARTICIPATED

The survey included 4,396 young people from across Australia aged 14 to 18 years, with a diverse mix of cultural, gender and sexual identities represented (see Figure 1.1). Key characteristics of the sample include:

- an average age of 17 years
- 61% young women, 32% young men, and 7% trans and gender diverse young people (based on self-identified gender)
- participants from all states and territories, with the majority (70%) from major cities
- one in four (24%) from culturally and linguistically diverse backgrounds
- 3.5% identified as Aboriginal or Torres Strait Islander
- a wide range of sexual identities, with 44% identifying as lesbian, gay, bi+ or queer (LGBQ+) or other sexualities, include asexual

Figure 1.1. Characteristics of the young people who participated in SSASH 8



SEXUAL EXPERIENCES AND RELATIONSHIPS

Half of the young people who participated in the study (50%) were sexually active which, for the purposes of this report, we define as having experienced oral sex, penile-vaginal (penis-in-vagina) or penile–anal (penis-in-anus) sex (see Figure 1.2).

We recognise, however, that these kinds of penetrative sex are not necessarily how young people define being 'sexually active', and in this report we can see that young people had experienced a range of sexual practices, including kissing (72%) and sexual touching (59%).

Of those who were sexually active, the mean age at which young people became sexually active was 15 years (15.6 for oral sex; 15.9 for penile–vaginal or penile–anal sex) and, as expected, the number of young people who were sexually active increased with age.

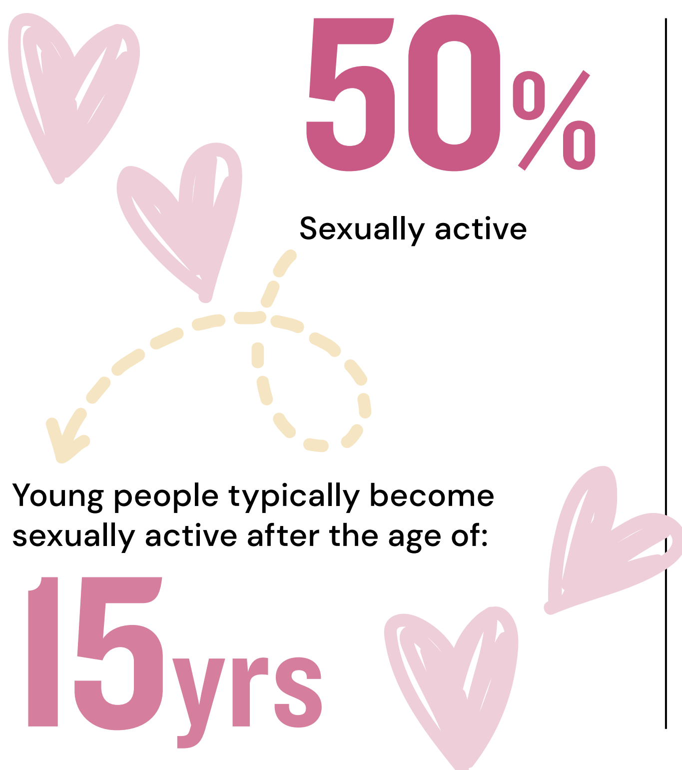
Most described their most recent sexual experience as enjoyable (75%) and safe (85%). However, around 40% also reported experiencing mixed feelings after this experience (excitement and happiness alongside stress or guilt) highlighting the complexity of early sexual experiences.

Across the total sample, more than half (61%) reported that they had 'ever' been in a romantic relationship that lasted more than 3 months. Young people generally described their relationships

as positive, with most young people reporting feeling safe (91%), supported (85%) and able to be themselves (87%) with their partners.

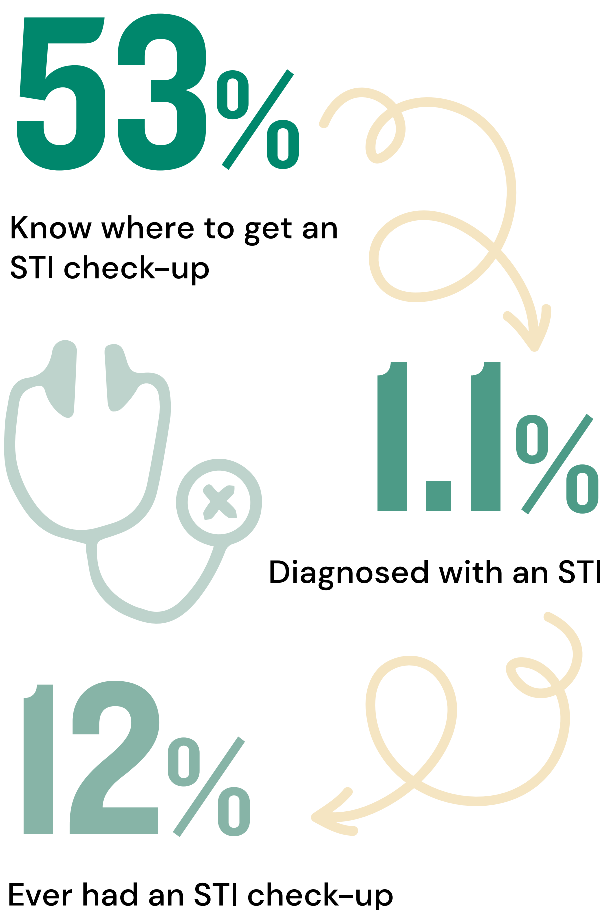
When asked about attitudes to gender roles in their romantic and sexual relationships, 32% indicated that they believed that women prefer men to be in

Figure 1.2. Sexual experiences of participants



charge of relationships, while 17% believed that men should make the first move when having sex.

Figure 1.3. Participants' experience with condom use and STIs



CONDOMS, CONTRACEPTION AND STI PREVENTION

Condoms continue to be an important form of prevention against unwanted pregnancy and STIs for young people. However, many young people report infrequent use of condoms (see Figure 1.3). Specifically, of those who were sexually active:

- 26% reported that they 'always' used condoms
- 11% reported never using condoms

When asked about condoms the most recent time they had sex:

- 80% reported condoms were available at most recent sex
- 51% reported using a condom at most recent sex

Most sexually active young people used some form of evidence-based (known to be effective) contraception, although one in 10 relied on the 'withdrawal method' which is a notably unreliable form of contraception. Specifically, the most recent time they had sex, evidence-based methods used were:

- 51% used a condom
- 35% used the oral contraceptive pill
- 17% used long-acting reversible contraception (LARC), such as an IUD or Implanon
- 4.7% used emergency contraception

STI TESTING AND ACCESS TO SEXUAL HEALTH CARE

Overall, only 12% of young people had been for a STI screen or checkup, although 33% indicated they had spoken to a GP or another doctor about matters related to sex or relationships.

Young people were asked if they had ever needed help for sexual issues but could not get it, with 19% indicating that this had occurred. These young people indicated they had not received care due to:

- Concerns about judgement (52%)
- Fears parents would find out (46%)
- Cost (43%)

There were notable gaps in young people's understanding of how to access sexual health services:

- 59% understood that young people can access free sexual health services
- 53% indicated they knew where to find a doctor for STI testing

- 44% were unaware that they could get their own Medicare card before age 18
- 68% believed their parents could access their Medicare records until they turn 18

Needing to ask parents for their Medicare card or believing a parent may know if they attend a clinical service may not be a barrier to all young people but, as indicated above, fear of parents finding out can be a barrier to care for some young people.

When asked about attitudes to STI, young people's responses indicated that stigma may be a barrier to accessing testing or care:

- 87% believed that STIs could seriously affect their health
- 78% believed that having an STI would be embarrassing or shameful
- 76% believed that STI testing was uncommon among young people

DIGITAL SEXUAL EXPERIENCES

The majority of young people (77%) had viewed pornography unintentionally (e.g. been shown a video by friends or come across pornography online). Slightly fewer (74%) reported that they had intentionally viewed pornography (i.e. deliberately searched for it). The average age at which young people first viewed pornography:

- *Unintentionally* was 11.5 years
- *Intentionally* was 13 years

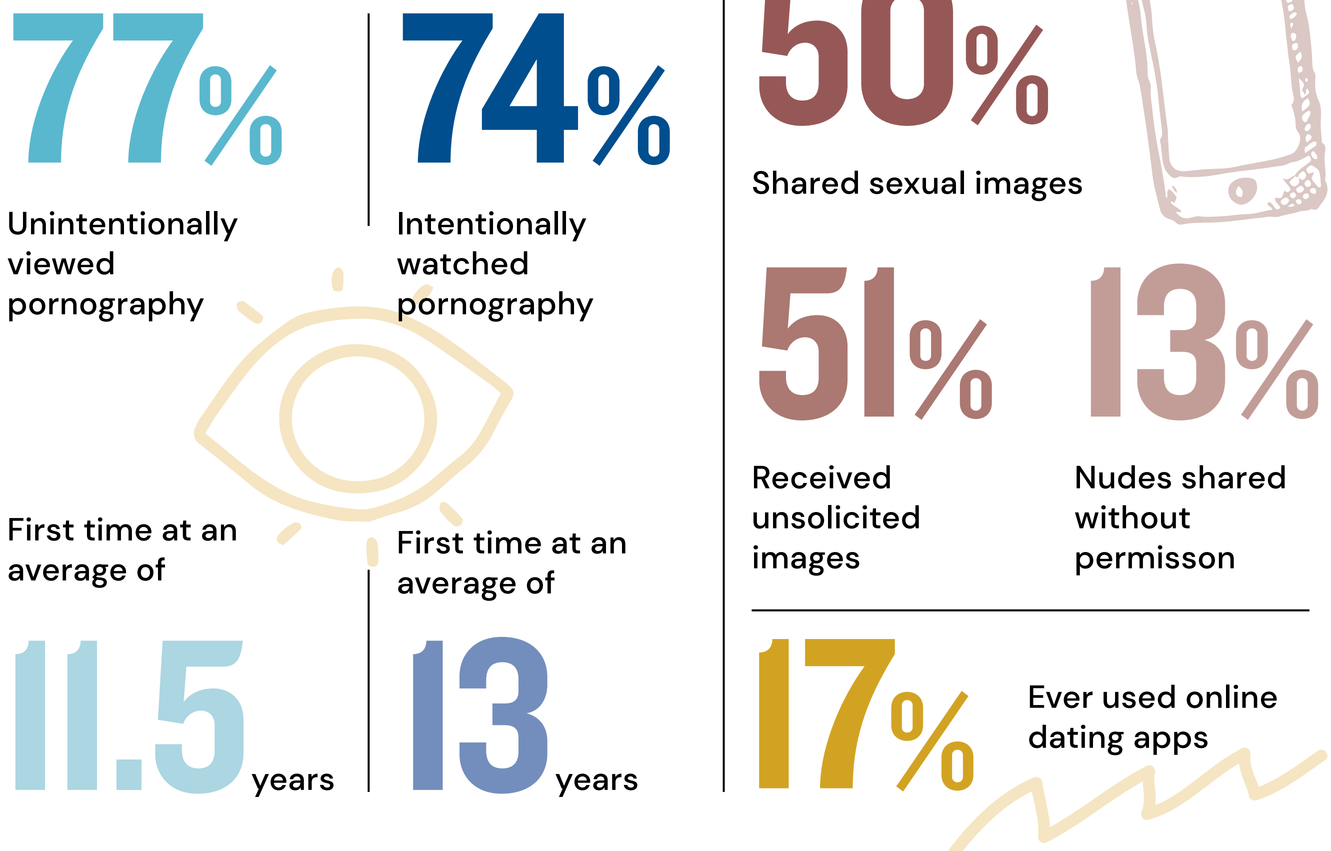
Young people described their experience of pornography as both informative and uncomfortable, reflecting its dual role as a learning tool and a source of unrealistic or distressing content for some young people.

Sending or receiving nude or sexual images using a mobile phone ('sexting') was common, with 50% reporting having sent or received a 'sext' at least once. Of those who had 'sexted':

- 77% had sent an image to someone they were in a relationship with
- 35% had sent an image to someone they were dating/having sex with but not in a relationship with
- 51% had received nude or sexual photos that they did not want to, or agree to, receive
- 13% had experienced a nude or sexual image of themselves being shared without their permission

A minority of young people engaged in online dating, with 17% reporting they had used dating apps and 8% reporting having a face-to-face date/meet-up with someone they met on an app, typically in public settings to support their safety (see Figure 1.4).

Figure 1.4. Participants' digital sexual experiences



INTIMATE PARTNER VIOLENCE, SEXUAL VIOLENCE AND UNWANTED SEXUAL EXPERIENCES

Unwanted sexual experiences and intimate partner violence remain critical issues for young people. These experiences can have lasting impacts on young people's emotional wellbeing and the formation of future relationships.

Among the 61% of young people who had ever been in a relationship:

- 37% said they had felt frightened of someone they were in a relationship with at some point (23% of the entire sample)
- 44% reported they had experienced verbal abuse within a relationship, for example, by being called names, insulted or shamed (27% of entire sample)
- 31% reported having experienced technology-facilitated harassment or tracking by a partner (19% of the entire sample)
- 18% reported have experienced physical violence, for example, being hit, pushed, or grabbed by a partner (11% of the entire sample)
- 2.6% reported being forced by a partner to have sex (1.5% of the entire sample)

Young women and trans young people were more likely than young men to report having experienced violence, harassment or fear within a relationship.

Young people were asked about their experiences of unwanted sex by asking: 'Have you ever experienced sex, including oral sex, when you did not want to (i.e., sex that you did not want or desire, regardless of whether you agreed to it or not)?':

- 21% had experienced sex they did not want, including oral sex
- young women and trans young people were more likely than young men to have experienced unwanted sex
- bisexual young people were more likely than heterosexual, gay or lesbian young people to have experienced unwanted sex

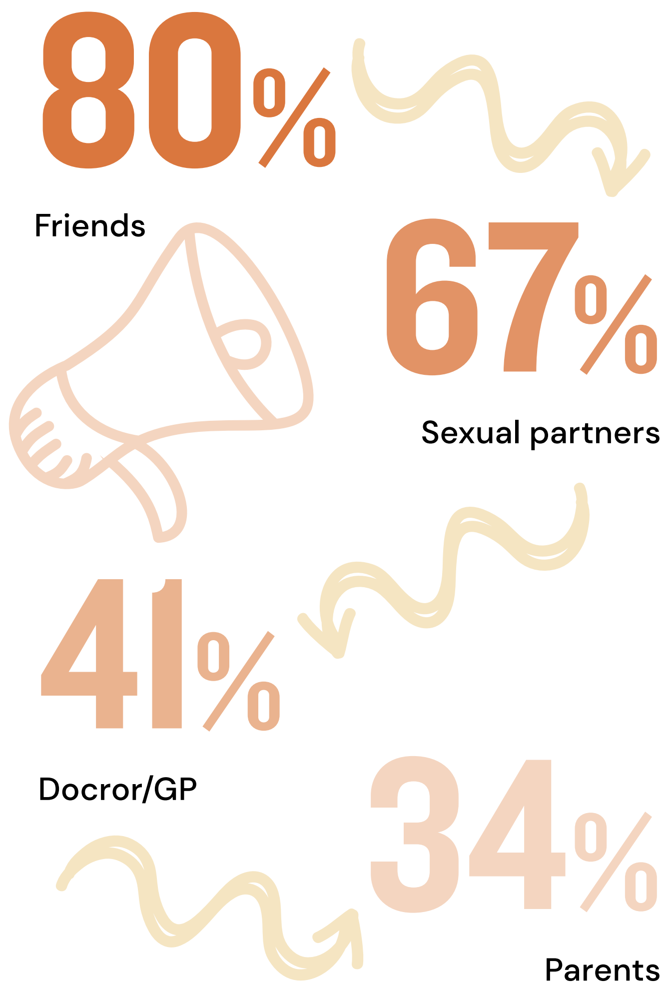
Young people were asked if they had ever experienced unwanted sex as a result of the following situations:

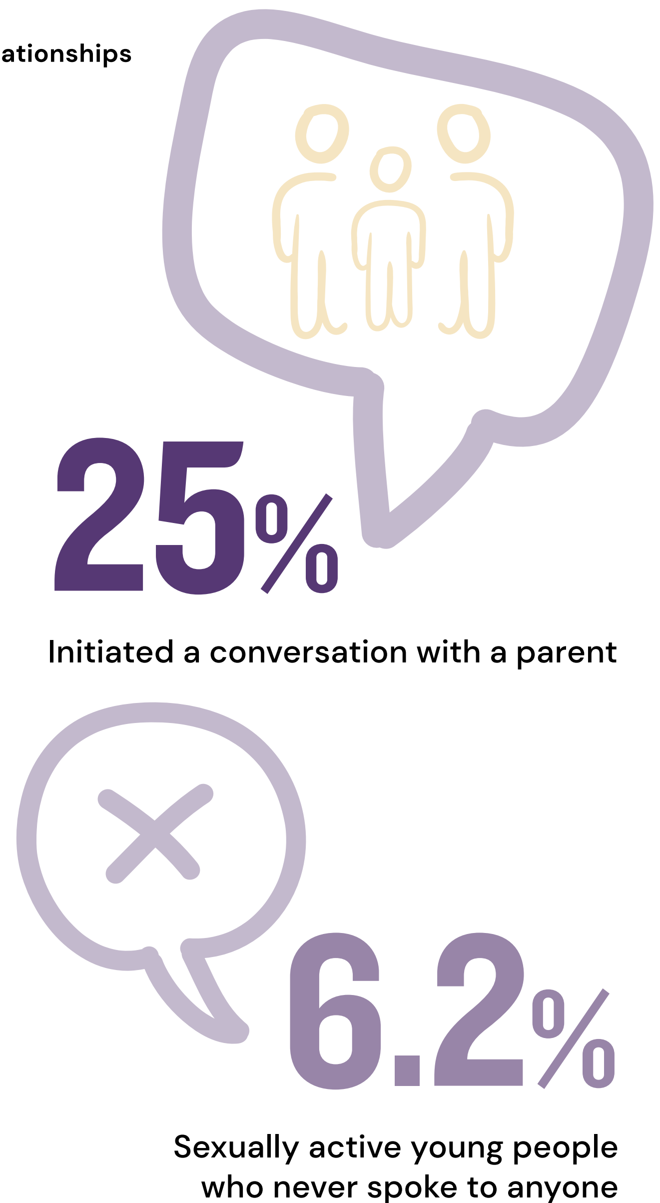
- to avoid upsetting a sexual partner, to keep the peace (13%)
- to avoid hurting someone's feelings (12%)
- someone kept asking even when the answer was no (12%)
- they were too intoxicated to consent (6%)

they were physically forced to have sex (6%)
they were threatened (2%)

COMMUNICATION AND HELP-SEEKING

Figure 1.5. **Who young people spoke to about sex and relationships**





Most young people reported being comfortable talking about sex and relationships with key people in their lives (see Figure 1.5). When asked to name the top three people they would prefer to speak to about sex and relationships, young people said:

- their friends (80%)
- their sexual partner (67%)
- a GP or another doctor (41%)
- their parent/s (34%)

When asked whether they had ever spoken with someone about sex and relationships, older young people (16+) and those who were sexually active were more likely to have initiated conversations with people about sex and relationships. However, 6.2% of sexually active young people reported that they had never spoken to anyone about sex and relationships.

We asked young people how they felt about talking with their parents about important issues, including sex and relationships, and:

- 79% felt that their parents were supportive in everyday life
- 48% said that they could discuss most things that were important to them with a parent
- 25% had initiated conversations with a parent about sex or relationships
- 21% were 'very confident' talking to their mother about sex and relationships, and 7% were 'very confident' talking with their father

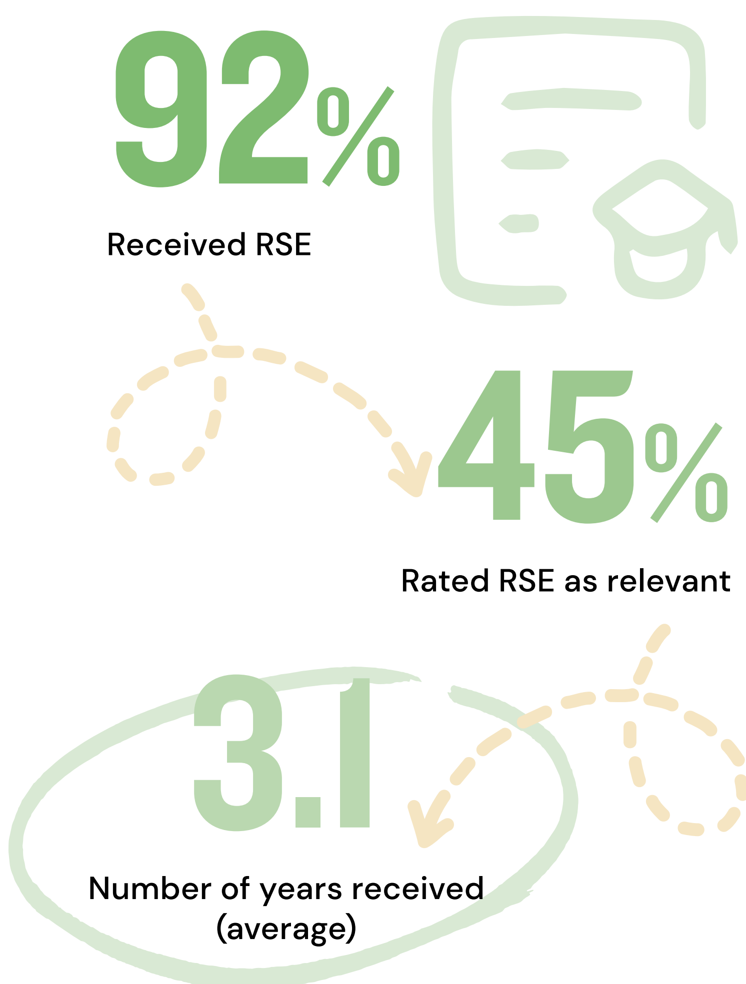
Topics that young people had spoken to their parents about included:

- relationships (54%)
- sex (50%)
- pornography (33%)
- sexting (27%)

Young people who had spoken with their parents about sex and relationships reported higher levels of STI knowledge and were more likely to initiate sexual health discussions with a GP.

RELATIONSHIPS AND SEXUALITY EDUCATION

Figure 1.6. Participants' experiences of RSE



Almost all young people received relationships and sexuality education (RSE) at school (see Figure 1.6), but less than half found it relevant:

- 92% received RSE at school
- 45% found it relevant

Young people were most likely to have received RSE between year 6 and year 10. Less than one in four had received any RSE in years 11 or 12.

When asked about the last/most recent time they received RSE:

- 31% had received only a single RSE lesson
- 35% had received between two and four lessons
- 23% had received five to 10 lessons
- 12% had received more than 10 lessons.

Young people were most likely to have been taught about puberty and reproduction, sexual consent, condom use, contraception and STIs or HIV. Fewer young people had learned about where to receive help for sexual matters or more detailed information on the practice of sex (e.g. what sex is like).

Young people were clear about what they want: RSE that is inclusive, practical, culturally responsive and delivered in safe, respectful environments by confident educators. They wanted content that reflects real relationships, digital realities, and the diversity of young people's lives.

IMPLICATIONS

The findings point to clear opportunities for strengthening sexual health promotion and education for young people in Australia:

- Make RSE more relevant by focusing content around relationships, consent, communication, pleasure and diversity.
- Ensure strategies to address primary prevention of sexual and intimate partner violence reach younger adolescents.
- Improve access to youth-friendly health care, including cost-free and confidential pathways to care.
- Address stigma around STIs and sexual health help-seeking.
- Support priority populations with culturally safe, inclusive and community-designed approaches to sexual health promotion and clinical care.
- Recognise digital sexual cultures as a core part of young people's learning about sex relationships and as important in sexual communication.

Young people are engaged, thoughtful and eager for information that is delivered in a way that respects their autonomy and that reflects their lived realities'. This survey underscores young people's capacity and the need for systems that meet them with clarity, care and relevance.

2. INTRODUCTION

Welcome to the 8th Australian Survey of Secondary Students and Sexual Health (SSASH 8). SSASH is the largest and longest running Australian study collecting data about the sexual health of school-aged young people. SSASH is an important dataset that informs progress against goals within the national and state/territory STI strategies and provides important insight into the sexual health needs of young people to inform education and service delivery.

The first SSASH survey was conducted in 1992 at the height of HIV epidemic in Australia. At this time, it was urgent to understand what young people knew about HIV transmission and prevention. Nearly 35 years later, the landscape looks very different. Thanks to the availability of modern antiretroviral medication since the late 1990s, HIV is now considered a chronic, manageable condition, and the introduction of new medical prevention strategies — including pre-exposure prophylaxis (PrEP) and 'treatment as prevention' — means HIV prevention no longer carries the same sense of urgency for young people that it once did (Callander et al., 2023).

Yet other issues remain urgent. In Australia, recent decades have seen increasing rates of STIs, including gonorrhoea, chlamydia and infectious syphilis. In 2025, syphilis was declared a communicable disease incident of national significance in Australia (Australian Centre for Disease Control, 2025), due to a rapid escalation in new cases and uncertainty about how to effectively address this. Young people are disproportionately affected by STIs relative to other age groups (King et al., 2025). There is therefore a continued and pressing need to understand young people's knowledge about STIs, their access to testing and treatment, and their attitudes toward STI prevention including HPV vaccination and condom use.

Alongside this, awareness of the urgent need to improve education about sexual violence and consent has grown markedly in the past 5 years. In 2022, mandatory consent education was introduced into Australian schools following a major campaign ('Teach us Consent') led by young people demanding better education to prevent sexual violence (Mackinlay et al., 2024). This occurred alongside the global #MeToo movement and increasing public concern about the prevalence of sexual and intimate partner violence experienced by women.

While sexual violence and STI prevention are often addressed in policy and research silos, these issues are fundamentally connected through a shared concern with young people's capacity to navigate safe and respectful relationships. With this in mind, the SSASH study takes a broad view of young people's sexual and relationship experiences to provide a more comprehensive picture of their sexual health needs.

In the contemporary context, this includes a focus on online sexual engagement. Recent years have seen growing concern about harmful online content. In Australia, this led to the introduction

of a world-first social media ban for young people under 16 in late 2025. This reform is one component of a broader suite of eSafety strategies aimed at addressing image-based sexual abuse and other online harms (eSafety Commissioner, 2026). However, concerns about harmful outcomes related to young people's digital sexual engagement are only one part of the story. The online environment also provides space for young people to learn about sex and relationships. In this study we aim to present a broad view of young people's online sexual engagement, focused on risks, benefits and young people's approach to online safety.

The previous version of this survey, SSASH 7, conducted in 2021, showed that many young people report their sexual relationships to be safe and positive experiences in their life (Power et al., 2022). For many young people, sexual relationships are an important and meaningful part of their lives. Within these relationships, many young people learn about themselves and other people, and come to understand their sexuality and their bodies (Hirst, 2008; Marí-Ytarte et al., 2020).

This is an important perspective to retain. Sexual and romantic relationships can, and ideally should, be positive experiences for young people. Yet sexuality education research often focuses primarily on risks and harms. As a result, we know comparatively little about how relationships can support young people's wellbeing, or the benefits they may offer when they are safe and respectful.

Accordingly, one aim of the SSASH surveys is to generate evidence that informs strategies to support young people to navigate safe, respectful and enjoyable sexual relationships, when they are ready to do so. Where possible, we identify the skills and supports associated with positive outcomes, including the role of school-based relationships and sexuality education (RSE) and consent education.

Equity is a central analytic lens here: we consider whether some groups of young people face greater barriers to accessing RSE or achieving good sexual health than others. These findings help identify areas of need and inform potential responses. At the same time, however, we recognise that research identifying particular groups as more vulnerable or at greater risk than others can have unintended consequences. It may inadvertently position individuals or groups as problematic, dangerous or inherently vulnerable. Even when broader social or structural drivers are acknowledged, analyses often emphasise higher rates of harm or negative outcomes in vulnerable groups, which can obscure the strengths, capacities, and sources of joy that come with these identities or within communities. This is particularly concerning given that groups most often highlighted in equity analyses are those already marginalised or stigmatised — including people of colour, people from refugee or migrant backgrounds, First Nations people, LGBTQI+ people, and those at the intersections of these identities.

As researchers, educators and policymakers, we have a responsibility to use data carefully and to reflect on the narratives we construct. In addressing inequities, it is important not only to identify risk, but also to attend to strengths, capabilities, and the conditions that enable wellbeing.

"AS RESEARCHERS, EDUCATORS AND POLICYMAKERS, WE HAVE A RESPONSIBILITY TO USE DATA CAREFULLY AND TO REFLECT ON THE NARRATIVES WE CONSTRUCT."

From this perspective, our focus shifts from asking 'What makes young people vulnerable to poor outcomes?' to asking 'What contributes to positive sexual experiences among young people?' or 'How can communities be better resourced and supported to enable young people's sexual health and wellbeing?'

In SSASH 8, we have sought, wherever possible, to focus on what supports good sexual health. This includes identifying factors associated with positive outcomes and the capabilities young people draw on, such as communication skills. While some comparative analyses remain necessary (e.g. examining differences in service access between regional and metropolitan young people), these have been approached with care.

3. METHODS

The 8th Australian Survey of Secondary Students and Sexual Health (SSASH 8) is an anonymous online survey of young people. Here we overview the processes involved in the design and implementation of SSASH 8.

STUDY DESIGN

SSASH 8 is a cross-sectional survey of young people aged 14 to 18 years and living in Australia. All data were self-reported by young people using an online survey instrument. Data for SSASH 8 were collected between 14 June 2024 and 30 April 2025.

The SSASH 8 instrument was substantially revised from previous versions, drawing on feedback and advice from a wide range of organisations in the sexual and reproductive health and youth sectors, as well as from young people who were members of the ARCSHS Youth Advisory Board. The instrument was also designed to inform goals relating to young people within the Fifth National Sexually Transmissible Infections Strategy 2024 to 2030 (Australian Centre for Disease Control, 2025).

Data were collected and managed using REDCap electronic data capture tools (Harris et al., 2019) hosted at La Trobe University. The survey took approximately 15 to 20 minutes to complete.

Ethics

Ethics approval for SSASH 8 was granted by the La Trobe University Human Ethics Committee (HEC24064).

No contact details or identifying information were collected within the survey instrument. Young people were advised that all questions, aside from eligibility questions at the beginning, were optional and that their data could still be used even if they elected to skip some questions.

At key points throughout the survey, and at the end, participants were given details for Kids Helpline, Lifeline and relevant state-based sexual health services and advised to connect with these services if they felt any distress while completing the survey.

No complaints or adverse events were reported to the research team or the Human Ethics Committee.

SAMPLING AND RECRUITMENT

Recruitment strategy

Early iterations of the SSASH survey (1992 to 2013; Dunne et al., 1993; Lindsay et al., 1997; Mitchell et al., 2014; Smith et al., 2003, 2009) were conducted in schools. A random sample of schools were invited to participate in the study and, for those which agreed to participate, classroom time was allocated to survey completion for students in years 10 and 12.

From 2013 (SSASH 5; Mitchell et al., 2014), it became increasingly difficult to engage schools in the study. This co-coincided with the rise of social media, which created new opportunities for reaching a large and diverse group of young people outside of schools. SSASH 5 in 2013 used hybrid recruitment, in schools and online. Then, from 2018 to 2021 (SSASH 6 and 7; Fisher et al., 2019; Power et al., 2022), recruitment was conducted entirely through social media advertising. In 2013 and 2018, the demographic profile of students engaged online was similar to that of earlier studies.

Consistent with SSASH 6 and SSASH 7, recruitment for SSASH 8 included social media advertising targeting young people. This involved paid advertisements on Instagram and TikTok and unpaid advertising on our dedicated SSASH Instagram account. We also provided advertising material (images, text, social media tiles) to youth and sexual health organisations across the country that had agreed to post information about the survey on their websites and social media feeds. The Youth Affairs Council Victoria (YACVic; www.yacvic.org.au) and Sexual Health Victoria also produced bespoke social media content about the survey which was shared through their social media networks, including paid 'boosted' posts on Instagram.

Our recruitment period for SSASH 8 occurred at a time when social media sites were introducing stricter protocols on advertising to young people. This meant that much of our paid advertising was restricted to people aged 16 years and older, while some was restricted to 18+. Narrowly focused algorithms also made it difficult to reach a diverse audience. In response, we expanded our

recruitment to explore options for face-to-face survey promotions.

For SSASH 8, we partnered with YACVic to help engage youth services in promoting the survey. YACVic hired a young person to contact youth and sexual health services across the country to talk to them about the survey and ask whether they had opportunities to help us promote the survey to young people (such as events, drop-in centres, waiting rooms or workshops). For organisations that agreed, we sent flyers with QR codes linking to the online survey and information sheets for youth workers that provided details about the survey and about sexual health issues raised in the survey. Using this strategy, we sent out several hundred flyers which were placed in youth services and handed out at events, including 'schoolies week' stalls run by community organisations.

To broaden recruitment further, we also engaged a professional youth survey panel, Student Edge. Student Edge maintains a membership base of secondary school students and young adults who have consented to participate in research and complete surveys on a range of topics. Panel members within the target age range were invited to participate via email and in-platform notifications sent by Student Edge, which then directed participants to our online survey. To ensure adequate representation of key subgroups relevant to the study aims, targeted oversampling was undertaken for younger participants aged 14 to 15 years and for young men, who are often under-represented in sexual health research. Participants recruited through the Student Edge panel receive incentives administered by Student Edge, typically in the form of 'Edge Credits' for completed surveys, which can be redeemed for gift cards or cash via PayPal.

Of the final sample, most participants were recruited via social media (n = 2,908, 66%), followed by Student Edge (n = 958, 22%), organisational or website referrals (n = 503, 11%), and flyers (n = 27, 0.6%).

Sampling methodology

SSASH 8 includes a large and diverse sample of young people. However, the sample was derived through a non-probability, convenience-based design which should be considered when interpreting the findings. The sample is not statistically representative of all Australian young people, and results should be understood as reflecting the experiences of those who were reachable and willing to participate under the available recruitment conditions. We will provide weighted data, more reflective of population parameters, in a future publication.

Although SSASH 8 is a non-probability sample, minimum quota sampling was used to reflect the relative proportion of young people in the population by gender, school type and school year level. This means that we aimed to achieve a minimum number of young people in each group so that our final sample broadly reflects the population with regards to these demographic characteristics.

Our quota estimates were based on 2022 census data from the Australian Bureau of Statistics (2023b) for Years 8–10, as this cohort would progress to Years 10–12 in 2024. Table 3.1 and Table 3.2 present the minimum quotas derived from census data, the proportions achieved in the final sample, and differences. Several quotas were not met and others were exceeded, reflecting the practical challenges of online recruitment. Notably, young women aged 17 to 18 are over-represented in this study. Young people from Western Australia are also over-represented relative to other states and territories, likely reflecting the high level of engagement among the sexual and reproductive health and youth sectors in that state.

Note, our quota sampling estimates were based on binary gender due to limitations of census data which do not include trans young people. Our age range of 14 to 18 also includes some students who are in year 9, as well as recent school leavers, which is not reflected in our sampling estimates.

Table 3.1. Sample composition of school type, gender and year level in relation to the 2019 census data

School type	Gender	Year level	2022 Census Proportions %	Survey Proportions %	Difference (survey-census) %
Government	Female	Year 10	9.1%	7%	-2.1%
		Year 11	9.3%	7.2%	-2.1%
		Year 12	9%	24.1%	15.1%
	Male	Year 10	10%	5.7%	-4.3%
		Year 11	10.1%	4.9%	-5.2%
		Year 12	9.8%	12.3%	2.5%
Catholic	Female	Year 10	3.8%	2.2%	-1.6%
		Year 11	3.8%	1.7%	-2.1%
		Year 12	3.5%	9.4%	5.9%
	Male	Year 10	3.8%	0.7%	-3.1%
		Year 11	3.7%	0.9%	-2.8%
		Year 12	3.6%	3.7%	0.1%
Independent	Female	Year 10	3.4%	2%	-1.4%
		Year 11	3.5%	2.5%	-1%
		Year 12	3.5%	9.7%	6.2%
	Male	Year 10	3.4%	0.9%	-2.5%
		Year 11	3.4%	1%	-2.4%
		Year 12	3.4%	4.1%	0.7%

Table 3.2. Sample composition of state in relation to the 2019 census data

State/territory	2022 Census Proportions %	Survey Proportions %	Difference (survey-census) %
ACT	2.7%	2.2%	-0.5%
NSW	29.8%	27.9%	-1.9%
NT	2.6%	0.5%	-2.1%
QLD	21.3%	16.4%	-4.9%
SA	6.5%	5.8%	-0.7%
Tas	3%	2.8%	-0.2%
VIC	23.8%	28.5%	4.7%
WA	10.4%	16%	5.6%

Participants

A total of 8,014 young people accessed the survey on REDCap. Of these, 1,051 did not meet the inclusion criteria. A rigorous data screening process was then conducted to exclude participants who appeared to have completed the questionnaire disingenuously, including those who: did not meet minimum completed questions; answered 'unsure' or 'prefer not to answer' for all STI knowledge questions and general questions about sex; completed the minimum required questions in under 3 minutes (suggesting that they did not read the questions or consider their answers, resulting in inaccurate or unreliable data); or provided obviously misleading answers to text responses (mischievous responders). See Figure 3.1 for the study recruitment flowchart. This process excluded a further 2,567 responses. The final dataset included 4,396 responses. This rigorous process was instrumental in maintaining the quality and relevance of the dataset for subsequent analyses.

Figure 3.1. Participant recruitment flowchart

MEASURES

SSASH 8 included a wide range of questions on sexual and relationship experiences and attitudes, STI knowledge and prevention, access to sexual health care and relationships and sexuality education (RSE). The survey was administered online and included both multiple-choice and open-ended questions.

About the individual

Socio-demographics questions primarily sourced from the ABS included: state, gender, age (Australian Bureau of Statistics, 2020); information about school (Australian Bureau of Statistics, 2023b); wellbeing (Ahmad et al., 2014); parent–adolescent closeness (V. King et al., 2018); language, cultural and religious background (Singleton et al., 2019); sexuality (adapted from Weinrich et al., 2014); and accessibility/remoteness index for Australia (Australian Bureau of Statistics, 2023a; Glover & Tennant, 2003).

STI knowledge and screening

Practical STI knowledge and sexual health literacy was measured using 19 true/false questions assessing young people's knowledge about STI prevention and protection, STI transmission and symptoms, and access to care and STI treatment and management. Twelve of these questions were sourced from the previous SSASH survey (Power et al., 2022) with revisions made to the wording to reflect current terminology and language use. Seven new questions asked about young people's knowledge about access to sexual health services and Medicare, and broadly about whether STIs were prevalent in Australia, whether STIs could be treated by medicine, and whether human papillomavirus (HPV) led to cancer. STI beliefs, screening and diagnosis questions were adapted from Adam et al. (2019) and were asked in previous SSASH surveys. Only young people who had indicated they were sexually active were given questions about STI screening and diagnoses.

Sexual experiences

Questions about sexual experiences were adapted from previous SSASH surveys (e.g., Dunne et al., 1993; Power et al., 2022). These included first age of kissing, sexual touching and oral, penile-vaginal and penile–anal sex. Young people who indicated that they were sexually active were asked about their experiences (questions adapted from Mercer et al., 2013) including the number and gender of sexual partners and information about their most recent sexual experience, including the gender and age of and relationship with their most recent sexual partner. Young people were also asked about how enjoyable their most recent sexual experience was, how safe they felt, how worried they were about their desirability, and how they felt about the experience (adapted from SSASH 5; Mitchell et al., 2014). Young people were also invited to describe their feelings further in an open-ended textbox.

Young people who were not sexually active were asked what they would like to know before they had sex, their reasons for not having sex (adapted from Power et al., 2022) and were invited to share their thoughts and feelings about sex.

Sexual relationships

Young people were asked whether they had ever been in a romantic relationship (Power et al., 2022). Follow-up questions were then asked about aspects of their most recent relationship including: whether they felt safe, comfortable and supported; and whether they felt good and could be themselves around their partner (adapted from Furman & Buhrmester, 2009). Young people were also asked a short series of questions about their attitudes toward gender roles in relationships (adapted from Morokoff et al., 1997; Parton, 2019).

Unwanted sex, sexual violence and intimate partner violence

Young people who indicated they had been in a romantic or sexual relationships were asked if they had ever been frightened, harassed, verbally abused, physically abused or sexually abused by their partner. These items were adapted from existing relationship-quality measures and in consultation with relevant organisations to ensure that they were clear, relevant and youth-friendly (Australian Institute of Family Studies, 2025; Hobbs, 2022; Morokoff et al., 1997).

Consistent with previous surveys (SSASH 5, 6 and 7; Fisher et al., 2019; Mitchell et al., 2014; Power et al., 2022), sexually active young people were asked whether they had experienced unwanted sex, specifically: 'Have you ever had sex, including oral sex, when you did not want to? (i.e. sex that you did not want or desire regardless of whether you agreed to it or not)'. Rates for the total sample are reported regardless of whether the young person was sexually active, with young people who reported not ever having oral, penile-vaginal or penile–anal sex counted as not having experienced unwanted sex. Those who had experienced unwanted sex were asked about the context and whether they had ever talked to someone about the experience (adapted from Humphreys & Kennett, 2022).

Sex in the digital world

This section included questions about sharing sexual images (sexting), online dating and pornography. Sexting questions were adapted from previous SSASH surveys (Fisher et al., 2019; Power et al., 2022), and included the frequency of sending sexual or nude images via a mobile phone and their relationship with the recipient. Young people were also asked whether their own sexual or nude images had ever been shared without their permission and whether they had ever received sexual images without consent.

Given the increasing role of online dating in young people's lives, a brief set of questions were developed about young people's experiences meeting sexual partners online. Young people were asked whether they had ever used an online dating app, the age at which they first did so, and whether they had met up with potential partners in person. For those who had met someone in person, we also asked whether they informed a friend or family member before meeting the person, as an indicator of safety-planning behaviour, and where the meeting took place.

Questions about pornography were sourced from previous SSASH surveys and the eSafety Commissioner (2023). The survey asked whether young people had ever viewed pornography, and it followed up by asking about the age of the first unintended and intended viewing, frequency of viewing, and attitudes toward pornography (adapted from eSafety Commissioner, 2023).

Safe sex and contraception

Based on the National Survey of Sexual Health and Behavior (2023), Richters et al. (2014) and previous SSASH surveys, sexually active young people were asked about condom availability and use, contraception and STI prevention methods that they used during their most recent sexual experience, and reasons for not using condoms, if applicable. Questions about attitudes towards condoms were adapted from Adam et al. (2019).

Communication about sex

As with previous SSASH surveys, a range of questions asked how confident young people were talking about sex and relationships with parents, friends, GPs, school staff, and sexual partners; whether they had ever initiated conversations with these people; and who they would prefer to talk to about sex and relationships. Young people were also asked if they had ever talked to a GP or parents about sex and relationships and whether there were any barriers to seeking help (based on Benzaken et al., 2011; *National Survey of Sexual Health and Behavior, 2023*).

For the 2024 survey, more emphasis was placed on parental–adolescent discussions, with questions including whether young people had discussions with a parent about sex, relationships, sexting and pornography and who initiated these conversations.

Sexually active young people were asked whether they had ever discussed using a condom, STIs, pregnancy and what they did and did not want to do regarding sex with their most recent sexual partner (adapted from the *National Survey of Sexual Health and Behavior, 2023).*

Relationships and sexuality education

Questions about the experiences of RSE covered a range of areas, including receipt of RSE, perceived relevance, who taught the classes and the subjects in which RSE was delivered (Power et al., 2022). Participants also answered questions about what topics were discussed in RSE (adapted from Johnson et al., 2016; Power et al., 2022); why RSE was not relevant to them (if applicable); topics they would like to learn about (Power et al., 2022); whether classes were ever split by gender; whether they had been asked what they wanted to learn; whether they had ever missed or opted out of RSE; and whether parental permission was required. An additional open-ended question invited participants to describe how they would like to learn about sex and relationships.

DATA ANALYSIS

All analyses were conducted in R (R Core Team, 2025) using RStudio (Posit team, 2025) as the development environment. Participant response rates varied across questions due to missing data, the use of non-forced answer options, and the implementation of question branching.

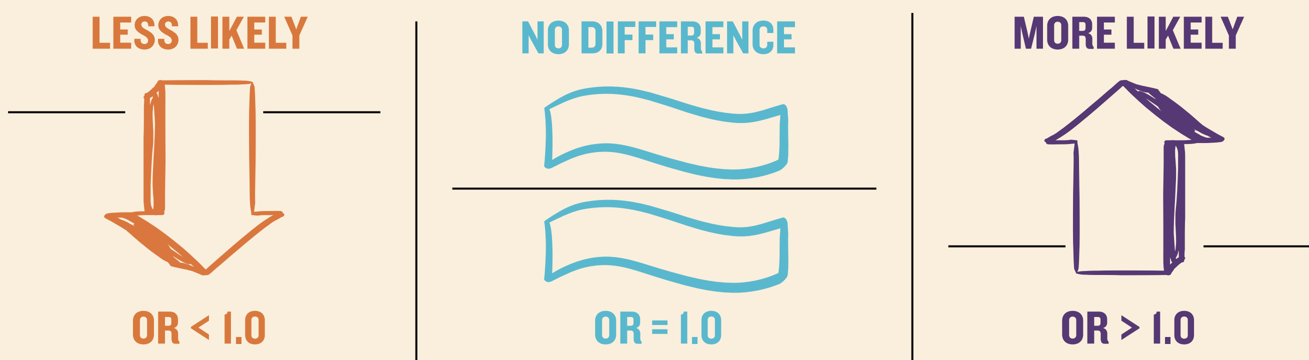
Descriptive statistics were calculated for all variables. Multiple regression analyses were used to examine demographic differences across key variables of interest, including gender, sexual identity, age or year level, and school type (where appropriate). For brevity, only results where p-values are less than .001 are reported to avoid over-interpreting small effects in the data. Adjusted odds ratios (ORs) and 95% confidence intervals (CIs) are reported for multiple logistic regression analyses as the primary indicators of direction and magnitude of the association. In a few instances, linear regression analyses have been conducted for continuous variables (ß and 95% confidence intervals reported).

Openended responses were coded thematically, with illustrative quotes included and edited for clarity and readability.

UNDERSTANDING ODDS RATIOS

Throughout this report we present findings that are statistically significant in the footnotes. In most cases, we report findings of logistic regression analysis which produces odds ratios to describe the outcome of the analysis. Below is a brief guide to understanding odds ratios.

Odds ratios (ORs) compare how likely an outcome is for one group compared with another. They do not show actual percentages, instead they tell us if a group is more or less likely to have reported a particular outcome. An odds ratio of 1.0 tells us that there is no difference between the groups. An odds ratio over 1.0 tells us that the group of interest is more likely to have reported that outcome compared to the reference group. For example, if the outcome was 'seeking help' and we are comparing 'women' (the reference group) with men (the comparison group), an odds ratio of 1.5 means that men were 50% more likely than women to seek help. If the odds ratio for men was 0.5 then men would be 50% less likely than women.



An odds ratio tells us three things:

- Whether the groups differ on the outcome (OR ≠ 1)
- The direction of the difference (OR > 1 = more likely; OR < 1 = less likely)
- The size of the difference (the further the OR is from 0 the larger the difference between groups)

Confidence intervals (CIs) show us the range that we are confident the true result is in. If the confidence interval crosses 1.0, we cannot be sure that the direction of change is definitely going in one direction. For example, compared to the reference group if the:

- 95% CI > 1 = group more likely
- 95% CI < 1 = group less likely
- 95% CI crosses 1 = no difference between groups

EXAMPLE: OR = 1.5 (95% CI = 1.1 TO 1.9)

In this example, the OR (1.5) means that the group is about 50% more likely to experience the outcome than the reference group. The 95% CI range is above 1 (95% CI 1.1–1.9) which means it is statistically significant and we are confident that the group of interest is more likely to have reported the outcome of interest.

'Adjusted odds ratio' means that when we compare groups, we have taken into account important differences between young people (such as gender, sexuality, age, and school type) when conducting our analysis. By controlling for these factors, the adjusted results give a clearer picture of the relationship we're interested in, rather than one that might be distorted by underlying differences in who took part.

See Szumilas (2010) for more information on how to interpret odds ratios.

Because a substantial minority of participants opted out of providing postcode information, separate analyses were conducted to explore differences between young people living in major cities and regional/remote areas where appropriate. To examine intimate partner violence where numbers of reported cases was low, we used Firth's logistic regression to reduce bias caused by the small number of reported cases. This method provides more reliable estimates when standard logistic regression is affected by sparse data or separation (Firth, 1993; Heinze & Schemper, 2002).

Changes over time

To examine changes across survey waves, descriptive comparisons were conducted for questions asked in multiple surveys. As the SSASH surveys are cross-sectional, differences observed over time reflect shifts in the characteristics and experiences of each survey cohort rather than changes within individuals. Percentages are reported for each survey year to identify broad trends. Only year 10 and 12 students were recruited from 1992 to 2008, with year 11 students included from 2013. Therefore, only data from year 10 and 12 students are reported to maintain consistency, except for questions that were not asked in earlier years, which have data from year 11. Young people were recruited solely through schools until 2008, therefore these trends should be interpreted in the context of changes to recruitment methods in later survey years.

TERMINOLOGY

Gender

In this report, we differentiate young people according gender identity rather than sex assigned at birth, to ensure our research reflects young people's lived experiences and how they define themselves. This means that some young people who identify as man/male or woman/female may have trans experience but not identify as trans. Trans young people in this study have specifically identified their gender as trans. By framing our study around self-reported gender, we aim to acknowledge and respect participants' identities, and produce findings that are both inclusive and representative of their lived realities.

Trans person

We use the umbrella term 'trans' in an inclusive manner, incorporating trans, non-binary and gender diverse young people as well as those who use a range of other terms to describe their non-cisgender identity.

Woman

We use the term 'woman/women' or 'young woman/women' to describe participants who identified as female or as women, which includes both cisgender and trans young people.

Man

We use the terms 'man/men' or 'young man/men' to refer to participants who identified as male or as men, encompassing both cisgender and transgender individuals.

Oral sex

Oral stimulation of the genitals.

Penile-vaginal sex

Penile-vaginal sex refers to penis-in-vagina sexual intercourse (vaginal sex).

Penile-anal sex

Penile–anal sex refers to penis-in-anus sexual intercourse (anal sex).

Sexuality

Sexuality refers to sexual identity or orientation. In this study we refer to four groups:

- **Heterosexual:** refers to young people who identify as 'straight' or heterosexual, or who are attracted to the opposite gender.
- **Gay/lesbian:** refers to young people who are attracted to people of the same gender as themselves.
- **Bisexual:** is used as an umbrella term for young people who are attracted to more than one gender including men, women and trans people. This includes young people who identify as bi+, pansexual or other non-monosexual identities.
- **Queer/questioning/ace:** refers to young people who are unsure about their sexual orientation, those who use a term that is not listed and those who identify as asexual (ace). Although asexuality (characterised by experiencing little to no sexual attraction to others) is a distinct identity, it was grouped with queer/questioning for analytic purposes due to small cell sizes and to maintain consistency across reporting.

LGBQ+

In this report, we use the term 'LGBQ+' to refer to young people who identified their sexual orientation as lesbian, gay, bisexual or unsure; or used a different term to define their sexuality (other than heterosexual). We recognise gender and sexuality as distinct and separate, and have deliberately analysed them as such. In this report, we have used the term LGBQ+ in reference to sexual orientation. Information about trans young people are reported with gender.

Geographic location

We have used the Accessibility/Remoteness Index of Australia (ARIA+) classification to determine the remoteness of young people's location (Australian Bureau of Statistics, 2023a; Glover & Tennant, 2003). ARIA+ is a standardised measure that categorises areas based on their accessibility to essential services, which can influence health, education and other resources using postcodes. Young people who were not comfortable providing their postcode were asked to describe the remoteness of the area they lived in using the ARIA+ criteria. From this we classified young people into two groups for comparative purposes:

- **Major cities:** refers to young people classified as living in a Major City of Australia, which includes capital cities, surrounding suburbs, and inner metropolitan areas as defined by the Australian Statistical Geography Standard (Australian Bureau of Statistics, 2023a; Glover & Tennant, 2003).
- **Regional/remote:** refers to young people living in inner regional, outer regional, remote or very remote Australia as defined by the ASGS.

4. DEMOGRAPHIC CHARACTERISTICS

A total of 4,396 young people aged 14 to 18 years who were living in Australia completed the survey. This chapter provides an overview of the demographic characteristics of the sample in order to contextualise the findings of this study and demonstrate the diversity of young people who participated in the study.

AGE OF PARTICIPANTS

The mean age of participants was 17.0 (SD = 1.3) with over half aged 18 years (n = 2,296, 52%). Figure 4.1 shows the distribution of age in the sample. The skew toward older participants in SSASH 8 likely reflects challenges recruiting younger people through social media due to advertising restrictions. To account for this, we have adjusted all inferential statistics by age where relevant.

GENDER AND SEXUALITY

Questions about gender identity and sexuality were based on the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables (Australian Bureau of Statistics, 2020). An additional question asked young people if they identified as trans or had any trans experiences. Young people were also able to write in their own response if they did not identify with any of the options provided. Young people's gender identity is presented in Figure 4.2.

Most participants identified as young women (n = 2,666, 61%), followed by young men (n = 1,422, 32%). There were 308 (7%) trans young people. Of these, 229 (74%) identified as non-binary, while 79 (26%) preferred to use a different term to describe their gender. Among those who preferred a different term, genderfluid (n = 32, 41%), agender (n = 12, 15%) and genderqueer (n = 12, 15%) were the most common identities described.

The majority of participants were cisgender (their gender identity matched their sex assigned at birth; n = 3,838, 89%) and 404 (9.3%) participants reported having a trans experience or identifying as trans. Most of the trans young people were assigned female at birth (n = 261, 89%).

Figure 4.1. Age distribution of participants (n = 4,396)

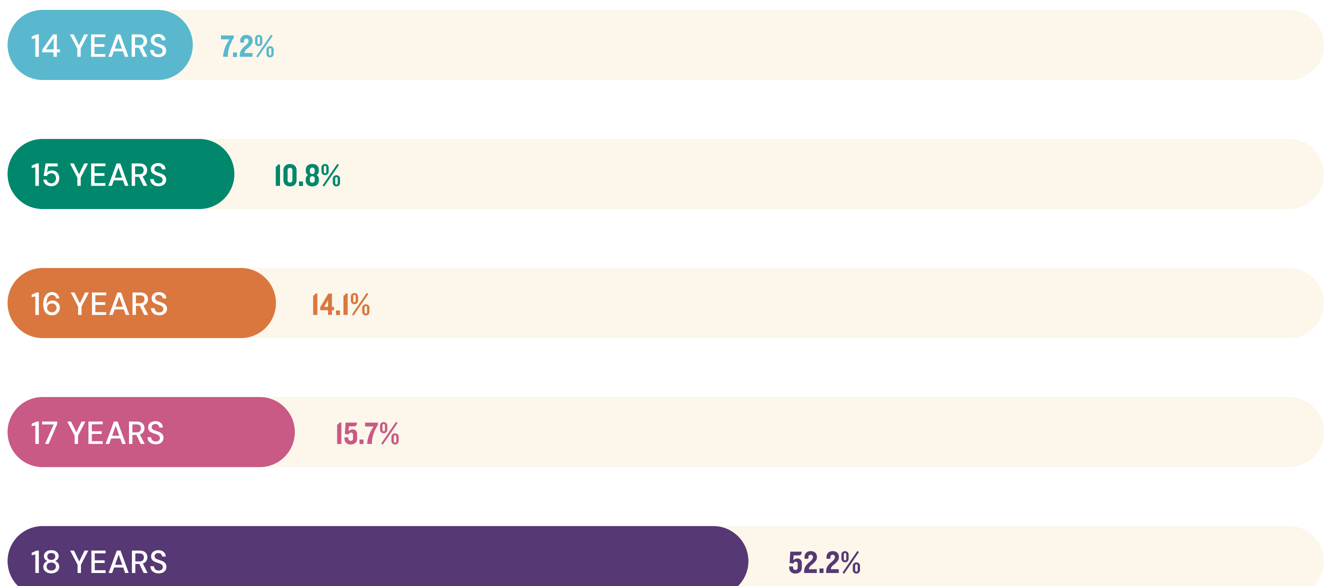
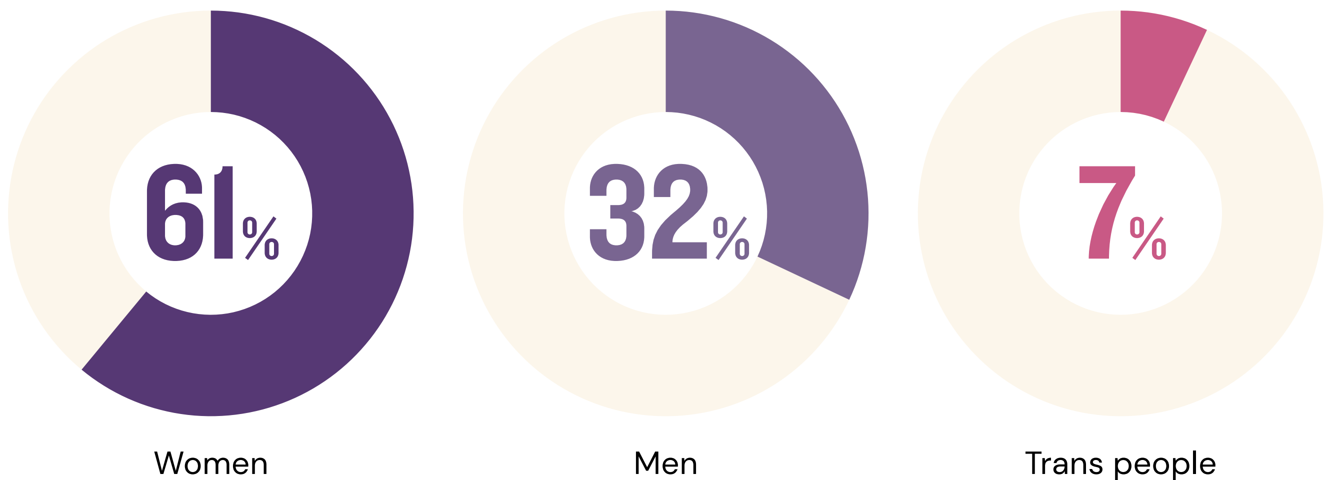


Figure 4.2. Gender identity of the sample (n = 4,396)



The majority of participants identified as heterosexual or straight (n = 2,389, 56%), followed by bisexual (n = 1,024, 24%) and gay or lesbian (n = 283, 6.7%). A fourth category of 'queer/questioning/ace' (n = 551, 13%) comprised young people who identified as queer (n = 219, 5.1%) or asexual (n = 82, 1.9%), who were unsure or undecided (n = 233, 5.4%), or used another term to describe their sexuality (n = 49, 1.1%).

Most trans people identified as LGBQ+ (n = 302, 98%), mostly bisexual (n = 125, 42%), followed by queer/questioning/ace (n = 112, 38%), or gay/lesbian (n = 53, 18%). Only a few young people (n = 5, 1.7%) identified as heterosexual. Young people's sexuality is presented in Table 4.1.

This sample likely includes an over-representation of LGBQ+ young people although we do not have a comparable population-based dataset to check this against. The Australian Bureau of Statistics (2022) estimates that 4.5% of over 16-year-olds in Australia identify as LGBTI+, and that the number is higher among younger people: 9.5% of those aged 16–24 identify as LGBTI+, inclusive of 5.7% who identify as bisexual.

Table 4.1. Young people's sexuality, by gender (n = 4,247)

	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Heterosexual	986 (72%)	1,398 (54%)	5 (1.7%)	2,389 (56%)
Gay/lesbian	98 (7.1%)	132 (5.1%)	53 (18%)	283 (6.7%)
Bisexual	196 (14%)	703 (27%)	125 (42%)	1,024 (24%)
Queer/questioning/ace	97 (7%)	342 (13%)	112 (38%)	551 (13%)

We asked young people who identified as trans or LGBQ+ if anyone knew about their gender or sexual identity. Most participants (n = 1,770, 94%) had told someone about their sexual or gender identity. Most commonly, they had told a friend (n = 1,716, 90%), students at their school (n = 1,203, 63%) or a parent (n = 1,107, 58%). The mean age of disclosure/ 'coming out' was 13.81 (SD = 2.15) years.

PLACE OF RESIDENCE

Young people across all states and territories of Australia participated in this study. The largest proportion of participants were from Victoria (n = 1,254, 29%) followed by New South Wales (n = 1,227, 28%). Fewer participants were from the Australian Capital Territory (n = 97, 2.2%), Tasmania (n = 122, 2.8%) or the Northern Territory (n = 21, 0.5%). The distribution of participants across states and territories is shown in Figure 4.3.

Figure 4.3. **State and territory distribution of participants (n = 3,230)**

0.5%
n = 21

16.4%
n = 719

16%
n = 702

5.8%
n = 254

27.9%
n = 1,227

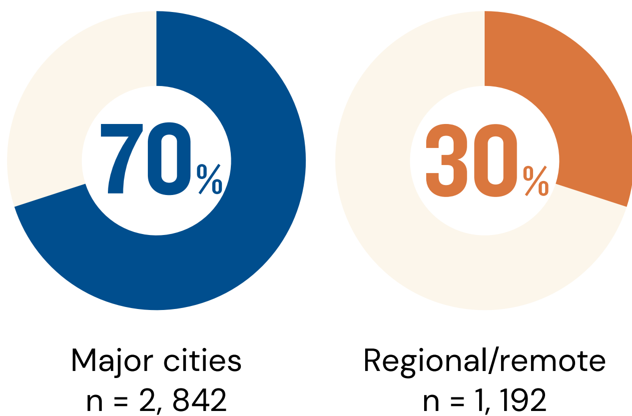
ACT
2.2%
n = 97

28.5%
n = 1,254

TAS
2.8%
n = 122

Note: Missing data as not all young people provided their postcode

Figure 4.4. **Percentage of young people living in major cities and regional/remote areas (n = 4,034)**



Most young people lived in major cities (n = 2,842, 70%, see Figure 4.4). This is comparable with the population in Australia (Australian Bureau of Statistics, 2021). Table 4.2 presents the distribution of participants across different Accessibility/ Remoteness Index of Australia (ARIA+) categories.

Table 4.2. ARIA+ classification of participants (n = 4,034)

ARIA+ classification	Overall n (%)
Major Cities of Australia	2,842 (70%)
Inner Regional Australia	877 (22%)
Outer Regional Australia	197 (4.9%)
Remote Australia	109 (2.7%)
Very Remote Australia	9 (0.2%)

Note: The ARIA+ classification is based on the postcode of the participant when provided (n = 3,222), otherwise their description of the remoteness of their area was used (n = 818).

SOCIO-ECONOMIC STATUS

Socio-economic status was assessed using the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD; Australian Bureau of Statistics, 2021) determined by participants' postcodes. IRSAD scores reflect the relative socio-economic status of the broader community in which participant's live, rather than the specific characteristics for each individual. A low score indicates greater disadvantage and a high score indicates greater advantage.

Table 4.3 displays the distribution of IRSAD scores for participants' residential locations. Many participants (n = 1,140, 35%) were from the most advantaged areas in Australia and only 10% (n = 326) from the most disadvantaged. Therefore, the average IRSAD score for young people in this study was slightly higher than the national benchmark of 1,000 (mean = 1,017, SD = 76).

Table 4.3. Distribution of participants by IRSAD quintile (n = 3,220)

Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) quintile	Overall n (%)
1 (most disadvantaged)	326 (10%)
2	439 (14%)
3	671 (21%)
4	644 (20%)
5 (most advantaged)	1,140 (35%)

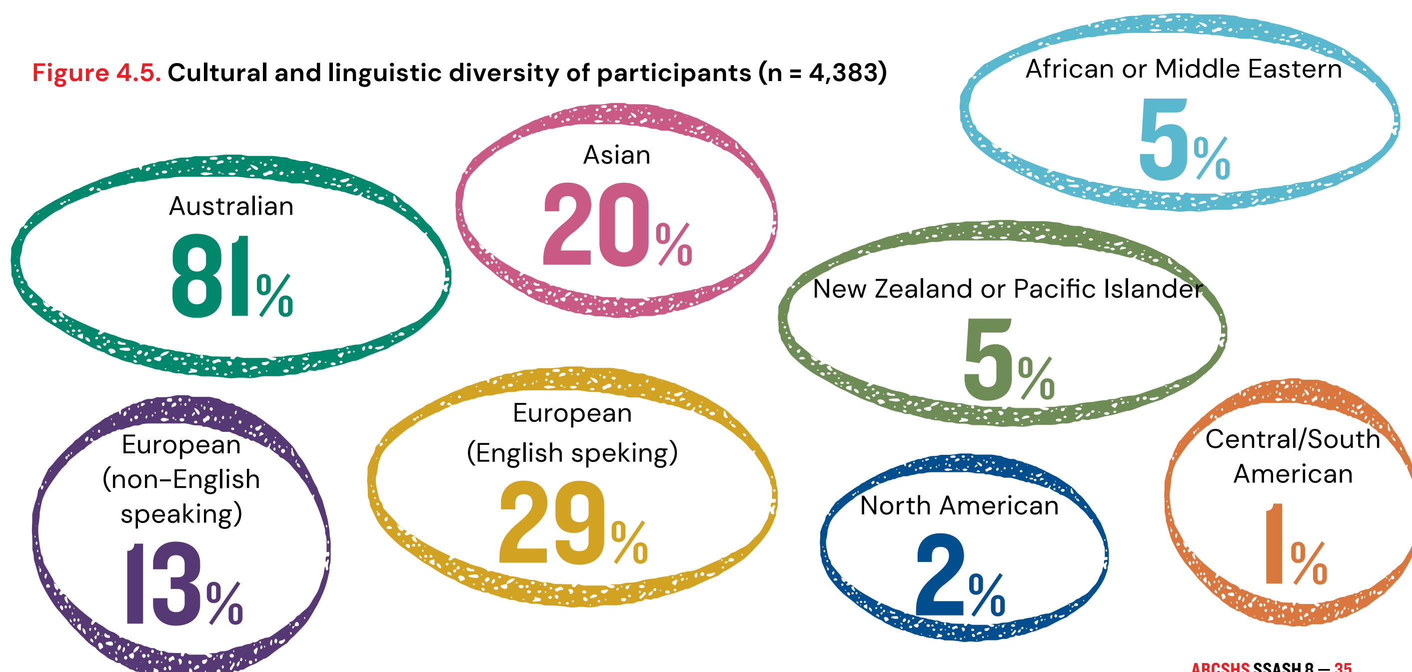
CULTURAL AND LINGUISTIC DIVERSITY

Participants were primarily Australian born (n = 3,796, 87%) and spoke English at home (n = 3,437, 79%). A total of 153 (3.6%) identified as Aboriginal or Torres Strait Islander.

There were 400 young people (9.1%) who were born in a non-English speaking country and 924 (21%) who spoke a language other than English at home. When combining birthplace and language, nearly one-quarter (n = 1,037, 24%) of young people can be described as culturally and linguistically diverse (CaLD).

Young people reported a range of cultural backgrounds (not mutually exclusive). While most described themselves as Australian (n = 3,515, 80%), many young people also reported European backgrounds, both English-speaking countries (n = 1,250, 29%) or non-English-speaking countries (n = 554, 13%). There were 1,250 participants (29%) who described themselves as Asian. Figure 4.5 illustrates the cultural and linguistic diversity within the sample.

Figure 4.5. Cultural and linguistic diversity of participants (n = 4,383)



RELIGIOSITY

Most participants (n = 2,643, 64%) did not identify as religious. Christianity was the most common reported faith (n = 1,044, 25%), followed by Hinduism (n = 135, 3.3%) and Islam (n = 92, 2.2%). Less than 1% identified with Aboriginal traditional religions, Judaism, Buddhism, Sikhism or other faiths. Overall, 1,488 (36%) identified as religious and 1,097 (27%) reported that religion was an important part of their life. Table 4.4 presents the distribution of religious affiliation in the sample.

Table 4.4. Religious affiliation of participants

Religious characteristics	Overall n (%)
Religion (n = 4,131)	
No religion	2,643 (64%)
Christianity	1,044 (25%)
Hinduism	135 (3.3%)
Islam	92 (2.2%)
Buddhism	63 (1.5%)
Judaism	35 (0.8%)
Aboriginal traditional religions	26 (0.6%)
Sikhism	10 (0.2%)
Other religion	83 (2%)
Importance of religious faith (n = 1,415)	
Not at all	318 (22%)
Somewhat	654 (46%)
Very	443 (31%)

HEALTH AND CHRONIC HEALTH CONDITIONS

While health is not typically considered a 'demographic' characteristic, we report it here to provide a more detailed description of the sample and issues that may affect sexual health outcomes or access to services.

Most participants reported that their physical health was good or excellent (n = 3,145, 72%), while only 1,947 (45%) reported good or excellent mental health (Figure 4.6).

A third of participants (n = 1,374, 33%) reported having a chronic health condition that lasted over 6 months. Among these young people, the most common conditions were mental health conditions (n = 943, 68%), neurodivergence such as autism (n = 936, 68%), physical conditions affecting mobility (n = 432, 32%) or a sensory condition such as hearing or vision impairment (n = 303, 22%).[1]

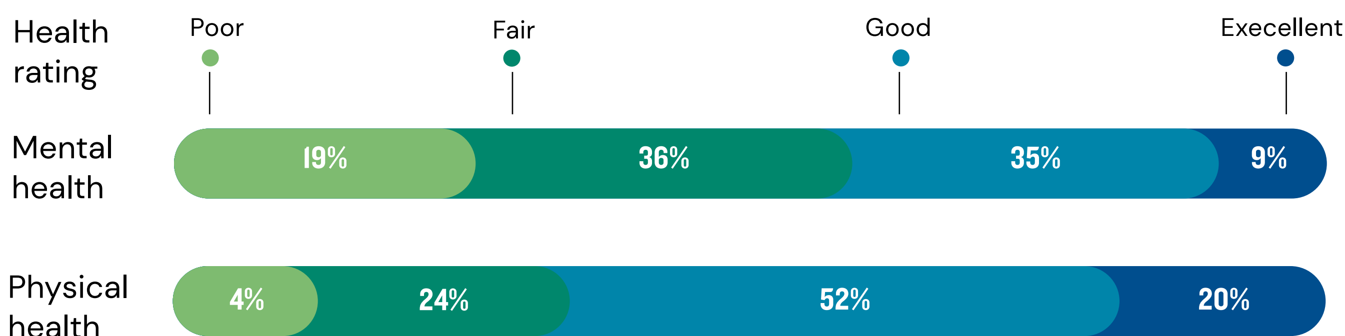
These students were asked if they received any supports to help them with school. One in four (n = 263, 25%) said they did not receive supports. Others indicated that they:

- attended regular appointments with medical professionals (n = 483, 46%)
- had an individualised learning plan (n = 277, 27%)
- had teacher's aide (n = 59, 5.7%)
- attended a school that specialised in supporting students with high needs or disabilities (n=134, 13%)

More than one in ten young people (n=134,14%) reported that they were not getting the support they needed at school.

1 These percentages are based on those who reported having a chronic health condition (n = 1,369).

Figure 4.6. Young people's reported health ratings (n = 4,379)



SCHOOLING

SSASH 8 is a survey of school-aged young people and, therefore, the majority of young people (n = 3,659, 85%) were enrolled in school. A further 0.8% (n = 35) were home schooled. The remaining sample were no longer attending school (n = 706, 16%).

Over half (n = 1,850, 54%) were in year 12 at the time of the survey and attended government schools (n = 2,213, 51%). Most participants (n = 2,931, 84%) attended a mixed gender school. Table 4.5 lists the school characteristics of the sample.

Table 4.5. School characteristics of the participants

School characteristics	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Year level (n = 3,406)				
Year 9 (age in years: M = 14.5, SD = 0.53)	196 (17%)	279 (13%)	13 (6.4%)	488 (14%)
Year 10 (age in years: M = 15.5, SD = 0.56)	199 (18%)	314 (15%)	18 (8.9%)	531 (16%)
Year 11 (age in years: M = 16.5, SD = 0.61)	186 (16%)	312 (15%)	39 (19%)	537 (16%)
Year 12 (age in years: M = 17.7, SD = 0.53)	549 (49%)	1,169 (56%)	132 (65%)	1,850 (54%)
School type (n = 4,358)				
Government	811 (58%)	1,265 (48%)	137 (45%)	2,213 (51%)
Independent	193 (14%)	466 (18%)	43 (14%)	702 (16%)
Catholic	182 (13%)	423 (16%)	30 (9.9%)	635 (15%)
Other type of school (including homeschooling)	21 (1.5%)	60 (2.3%)	21 (6.9%)	102 (2.3%)
Not in school	202 (14%)	432 (16%)	72 (24%)	706 (16%)
Gender composition of schools (n = 3,491)				
All-boys	155 (13%)	1 (<0.1%)	2 (1%)	158 (4.5%)
All-girls	10 (0.9%)	359 (17%)	33 (16%)	402 (12%)
Mixed	996 (86%)	1,761 (83%)	174 (83%)	2,931 (84%)

Note: M = mean, SD = standard deviation.

5. SEX AND RELATIONSHIPS

This chapter focuses on young people's experiences of sexual and romantic relationships. Our aim was to capture the range of sexual practices young people have experienced, and the average age these practices first occur, to provide guidance for education and health promotion. We also sought to provide a comprehensive picture of young people's relationships and sexual experiences so that discussions of risk and safety sit within a broad, nuanced understanding of young people's experiences, both positive and negative.

SEXUAL PRACTICES AND AGE OF FIRST EXPERIENCE

Young people were asked if they had experienced a range of intimate and relational practices, including viewing pornography (both intentionally and unintentionally), kissing, sexual activities (i.e., oral, penile-vaginal or penile–anal sex), romantic relationships, online dating and sexting. Figure 5.1 shows the proportion of young people who had experienced these sexual practices.

Figure 5.1. **Percentage of young people who engaged in sexual practices (n = 4,350)**

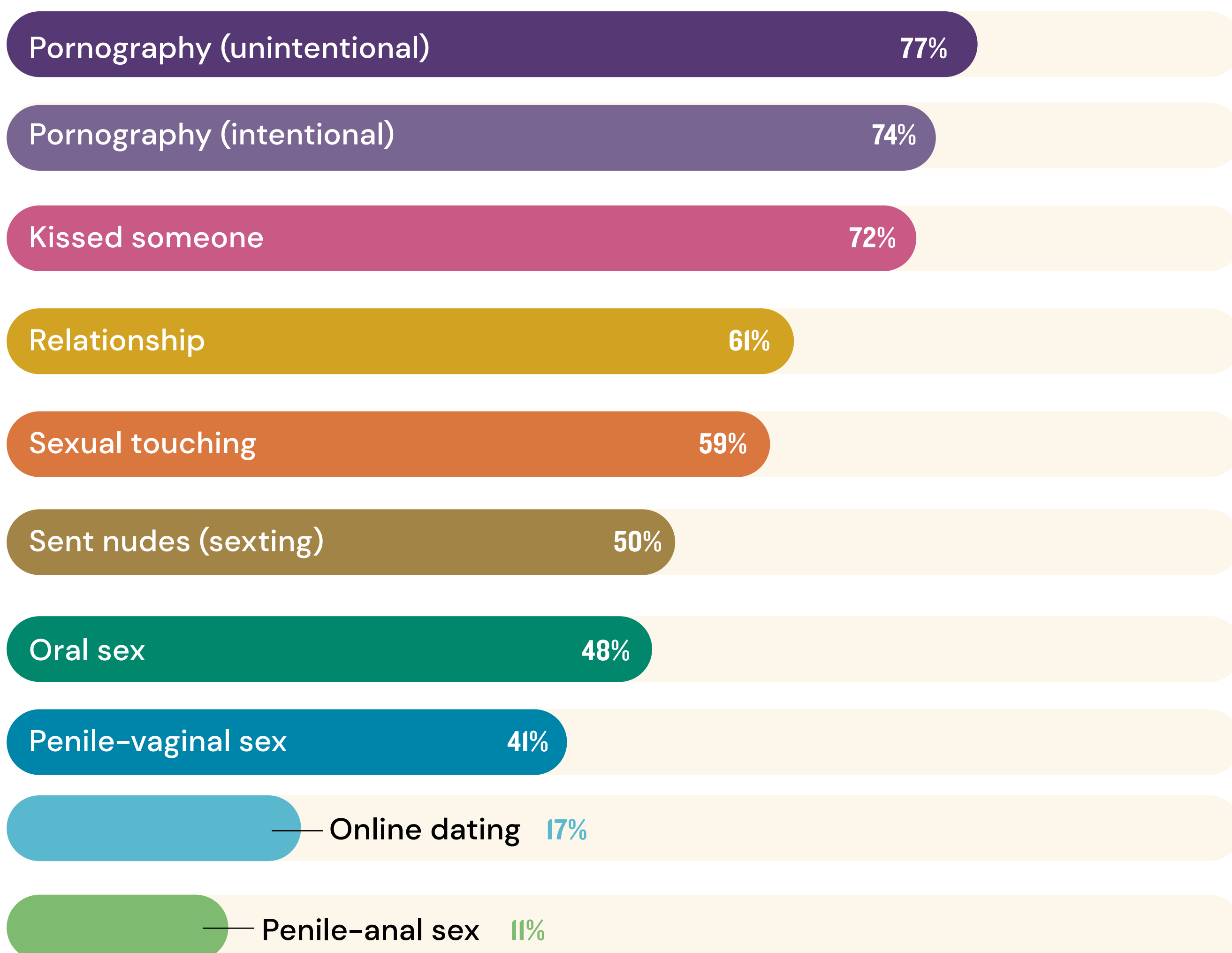


Table 5.1 presents the average age at which participants first engaged in each sexual practice by gender. A graphical depiction of mean age is presented in Figure 5.2. As expected, the range of sexual practices young people had experienced increased with age.[2]

Pornography exposure typically occurred in early adolescence. The average age at which young people first unintentionally viewed pornography was 11.5 years. While the average age for intentional viewing was 13 years. Unintentional viewing refers to situations where a young person is exposed to pornography inadvertently without actively seeking it out. This may occur if they accidently open a link to an online pornography site, are shown images or videos by a friend, or come across pornographic magazines or other material at home or in other places. Intentional viewing is where young people deliberately seek out pornography or search for it, which usually occurs online. There were differences in age of first exposure to pornography based on gender and sexual orientation. This is discussed further in Chapter 8.

The average age at which young people reported first viewing pornography was somewhat younger than for other sexual experiences:

- Sexual touching was first experienced by young people at an average age of 14.8 years.
- Experiences of oral sex started at an average age of 15.6 years and 15.9 years for penile–vaginal sex.
- Penile–anal sex, while less commonly reported, was first experienced at an average age of 15.9.

Online dating was not common. For those who had tried online dating, the average age at which they first did this was 16.7 years.

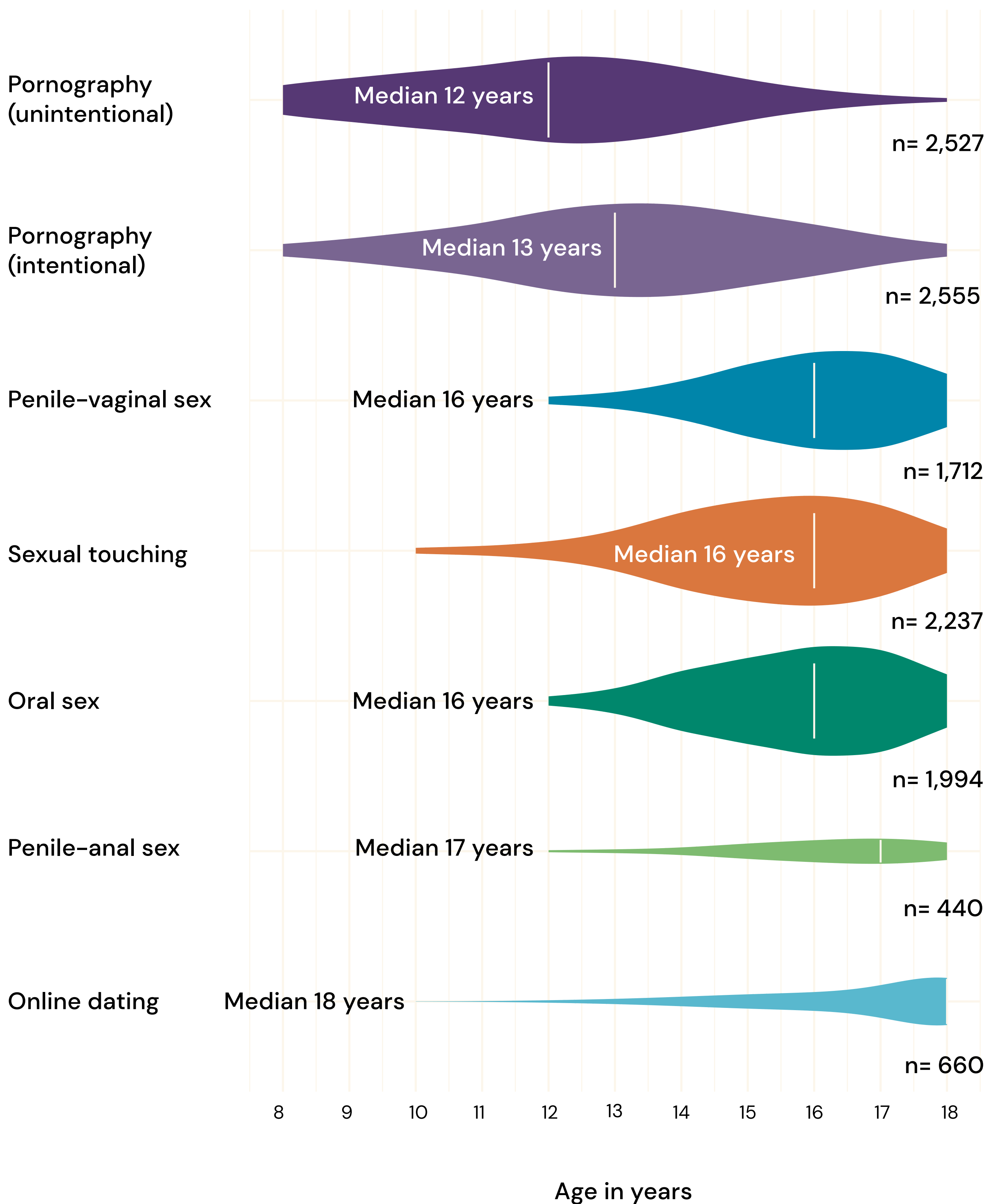
Table 5.1. Mean age of first experiences (in years)

Sexual experiences	Men M (SD)	Women M (SD)	Trans people M (SD)	Overall M (SD)
Unintentional pornography (n = 2,527)	11.5 (2.6)	11.6 (2.8)	11.1 (2.9)	**11.5 (2.8)**
Intentional pornography (n = 2,555)	12.6 (2.3)	13.2 (2.6)	13.0 (2.6)	**13.0 (2.5)**
Sexual touching (n = 2,371)	15.0 (2.7)	14.8 (2.6)	14.2 (3.3)	**14.8 (2.7)**
Oral sex (n = 2,049)	15.6 (2.2)	15.6 (1.9)	15.5 (2.1)	**15.6 (2.0)**
Penile–vaginal sex (n = 1,737)	15.9 (2.1)	15.8 (1.6)	16.1 (2.0)	**15.9 (1.8)**
Penile–anal sex (n = 456)	15.4 (3.1)	16.2 (1.8)	15.8 (2.1)	**15.9 (2.4)**
Online dating (n = 662)	16.5 (2.0)	16.7 (1.7)	17.4 (1.1)	**16.7 (1.8)**

Note: M = mean, SD = standard deviation. The SD describes the extent to which the data is spread out around the mean. A larger SD means the values are more spread out from the mean, while a smaller SD indicates that most values cluster closely around the mean. For example, the relatively large SD for penile–anal sex suggests a wider range of ages reported compared with other practices, which have smaller SD values.

2 The range of sexual practices young people had experienced increased with age (OR 1.71, 95% CI 1.61–1.81).

Figure 5.2. Violin plot displaying the distribution of first age of sexual practices



Note: The shape of the violin plot is a visual representation of the distribution and density of first age of each sexual practice. The more data points in a specific range, the larger the violin is for that range. The vertical line represents the median age of participants.

SEXUAL PRACTICES BEFORE 16 YEARS OF AGE

A substantial proportion of young people engaged in sexual practices before the age of 16:

- 54% (n = 2,395) had viewed pornography unintentionally
- 49% (n = 2,146) had viewed pornography unintentionally
- 28% (n = 1,238) had experienced sexual touching
- 19% (n = 837) had experienced oral sex
- 14% (n = 608) had experienced penile–vaginal sex
- 3.2% (n = 140) had experienced penile–anal sex
- 3.3% (n = 143) had used an online dating platform

Compared to young men, young women were less likely to report viewing pornography intentionally or engaging in penile–anal sex before the age of 16, but more likely to report sexual touching and penile–vaginal sex before 16. For all sexual practices except penile–vaginal sex, LGBQ+ young people were more likely than heterosexual young people to have experienced them before 16.[3]

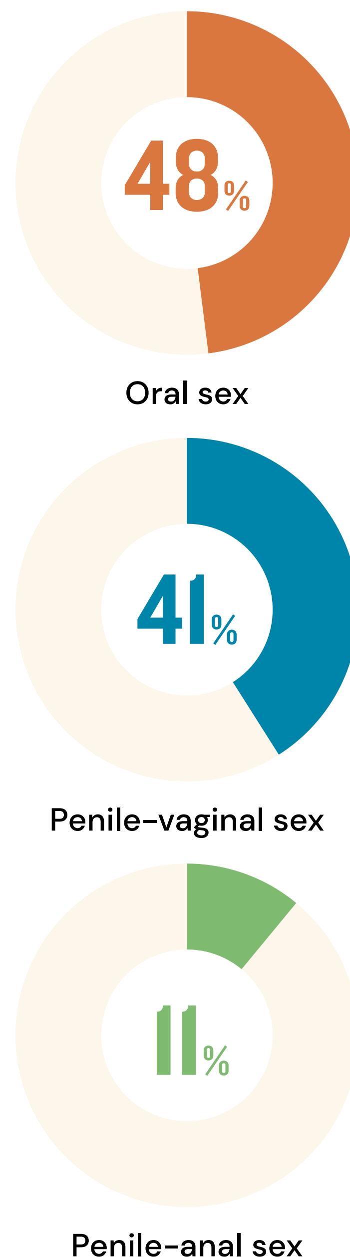
SEXUALLY ACTIVE YOUNG PEOPLE

For the purposes of this report, we define sexually active as having engaged in oral, penile–vaginal or penile–anal sex. We are aware that many young people, particularly LGBQ+ and trans young people, hold a more expansive definition of sexually active (Kauer et al., 2024) and do not consider these kinds of sex to be the indicator of 'real' sex. However, for analytical purposes, survey research relies on clear and consistent categories that allow us to examine patterns in the data. This definition of 'sexually active' is a useful indicator of a person who has participated in sexual practices and is considered sexually active.

SSASH 8 included 2,193 young people (50%) who were sexually active. Figure 5.3 shows the total percentage of young people who had engaged in oral, penile–vaginal or penile–anal sex.

Table 5.2 lists the frequency of young people's sexual practices by gender. Young women were more likely to report being sexually active than young men (54% compared to 42%). Young people who identified as bisexual were more likely to be sexually active than heterosexual young people (66% compared to 46%), while young people who were queer/questioning/ACE were less likely than heterosexual young people to be sexually active (43% compared to 46%).[4]

Figure 5.3. Percentage of young people who had experienced oral, penile-vaginal and/or penile–anal sex (n = 4,350)



3 Young women were less likely than men to report: viewing pornography intentionally before 16 (OR 0.53, 95% CI 0.46–0.60); experiencing penile–anal sex before 16 (OR 0.48, 95% CI 0.33–0.69), but more likely to report sexual touching (OR 1.39, 95% CI 1.19–1.62) and penile–vaginal sex (OR 1.80, 95% CI 1.47–2.22). LGBQ+ young people showed consistently higher odds across all sexual practices except for penile–vaginal sex, where no differences were observed.

4 Young women were more likely to report being sexually active than young men (OR 1.53, 95% CI 1.32–1.77). Young people who identified as pan- or bisexual were more likely to be sexually active than heterosexual young people (OR 1.73, 95% CI 1.46–2.05), while young people who were unsure of their sexuality or questioning were less likely to be sexually active (OR 0.68, 95% CI 0.55–0.83).

Table 5.2. Frequency of young people's sexual practices, by gender

Sexual experiences	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Kissing (n = 4,339)	914 (65%)	1,969 (75%)	261 (85%)	3,144 (72%)
Sexual touching (n = 4,260)	726 (53%)	1,608 (62%)	186 (63%)	2,520 (59%)
Oral sex (n = 4,351)	555 (40%)	1,393 (53%)	159 (52%)	2,107 (48%)
Penile–vaginal sex (n = 4,350)	437 (31%)	1,244 (47%)	93 (31%)	1,774 (41%)
Penile–anal sex (n = 4,347)	153 (11%)	279 (11%)	36 (12%)	468 (11%)

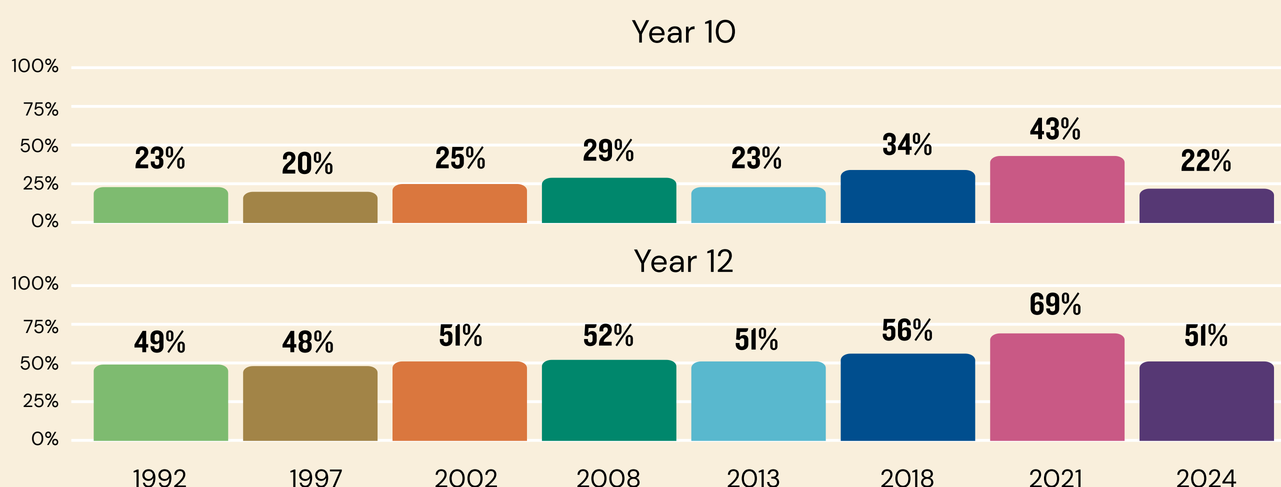
CHANGES OVER TIME: SEXUAL EXPERIENCES

The SSASH survey, beginning in 1992, has consistently asked students about their sexual experiences. In early iterations of the survey 'sexually active' was defined as having experienced penile–vaginal or penile–anal sex, so that is the point of comparison we use here to show change over time.

As shown in Figure 5.4, the proportion of students reporting they had experienced penile–vaginal or penile–anal sex has remained largely stable, with the exceptions of 2018 and 2021. It is likely that this reflects the change in recruitment method. In 2018 and 2021, data were collected solely through social media advertising. Advertisements for the survey may have been of more interest to people who were sexually active. This would have had a greater impact in 2021, as social media algorithms were more widely in place, meaning people were more likely to only see content based on their previous interests. The lower percentage of sexually active young people in 2024 likely reflects the mixed recruitment method.

As expected, sexual activity has consistently been higher among year 12 students than year 10 students. Among year 10 students, reported sexual activity ranged from 23% to 29%, with noticeable increases in 2018 and 2021 before declining again in 2024. Year 12 students reported higher levels overall, typically between 49% and 52%, again with elevated levels in 2018/2021 before returning to 51% in 2024. Taken together (excluding 2018/2021), these findings suggest a fairly stable pattern of around one in four year 10 students being sexually active and one in two Year 12 students.

Figure 5.4. Percentage of year 10 and year 12 students reporting penile-vaginal or penile–anal sex across the survey years



Note: Sample sizes by survey year: 1992 (n = 1,741); 1997 (n = 3,550); 2002 (n = 2,367); 2008 (n = 2,915); 2013 (n = 1,517); 2018 (n = 3,845); 2021 (n = 3,185); 2024 (n = 2,381)

MOST RECENT SEXUAL EXPERIENCE

To gain a picture of young people's sexual practices, we asked a series of questions about people's most recent consensual sexual experience. Young people were asked to respond to these questions by 'thinking about times that they wanted, desired and agreed to have sex'. There were 2,193 sexually active young people who participated in the survey. Up to 1,866 of these young people responded to the questions about their most recent sexual experience. The percentages listed below are based on the number of valid responses to each question.

Sexual practices

For most young people, their most recent sexual experience involved oral sex (85%, n = 1,588/1,866) and penile–vaginal sex (82%, n = 1,536/1,866), while 8.2% of young people (n = 153/1,866) reported having penile–anal sex.

Gender of most recent sexual partner

Most young people reported that their most recent sexual encounter was with someone of the opposite gender. Specifically, 92% of young women (n = 1,054) and 74% of young men (n = 331) indicated that their last sexual partner was of the opposite gender. Table 5.3 lists the gender of young people's most recent sexual partner by gender and sexual orientation.

Table 5.3. Gender of most recent sexual partner, by sexual orientation and gender (n = 1,712)

Gender of most recent partner	Heterosexual women n (%)	LGBQ+ women n (%)	Heterosexual men n (%)	LGBQ+ men n (%)	Trans people n (%)*
Man	576 (99.7%)	455 (84.4%)	2 (0.7%)	79 (47%)	70 (56.9%)
Woman	2 (0.3%)	65 (12.1%)	264 (97.8%)	61 (36.3%)	26 (21.1%)
Trans person	0 (0%)	19 (3.5%)	4 (1.5%)	28 (16.7%)	27 (22%)

* **Note:** 89% of trans young people identified as LGBQ+.

Relationship with most recent partner

Young people were generally in a committed relationship at the time of their most recent sexual encounter (n = 1,340, 78.7%). A further 13.6% (n = 231) reported last having sex with a friend or acquaintance that they knew without being in a steady relationship. There were 3.3% of young people (n = 57) who reported that their last sexual encounter was with someone they did not know or had just met (Table 5.4). There were no differences between gender, school type or sexual orientation on these measures.

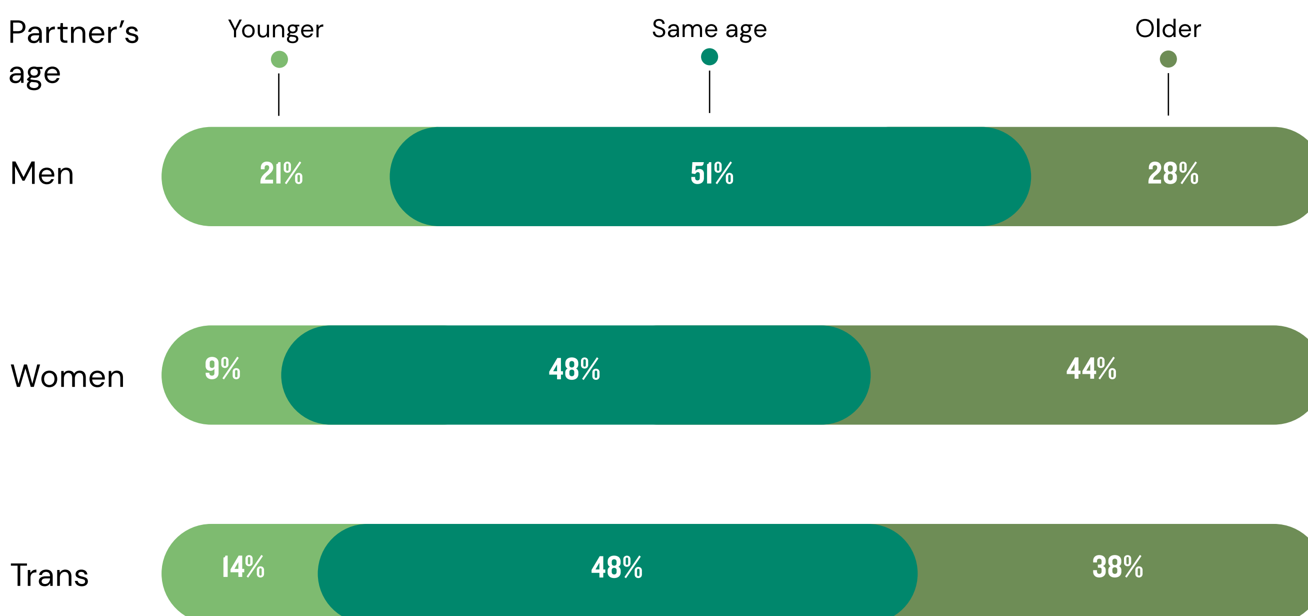
Table 5.4. Relationship with most recent sexual partner, by gender (n = 1,702)

Relationship	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
We were in a steady relationship	347 (78.5%)	889 (78.3%)	104 (83.9%)	1,340 (78.7%)
A friend or someone I knew but wasn't in a steady relationship with	59 (13.3%)	159 (14%)	13 (10.5%)	**231 (13.6%)**
We used to be in a steady relationship, but were not at that time	18 (4.1%)	50 (4.4%)	2 (1.6%)	**70 (4.1%)**
Someone I did not know/just met	16 (3.6%)	37 (3.3%)	4 (3.2%)	**57 (3.3%)**
Someone else	2 (0.5%)	1 (0.1%)	1 (0.8%)	**4 (0.2%)**

Age of most recent sexual partner

Participants' most recent sexual partners were generally either the same age or older, with less young people reporting partners who were younger (Figure 5.5). This was consistent for all age groups and genders (Table 5.5).

Figure 5.5. Age difference between participant and most recent sexual partner by age and gender of participant (n = 1,714)



Among 14- to 15-year-olds, 57% (n = 84) had a partner of the same age, while 40% (n = 59) reported an older partner aged 16 or 17 years.

Among 16- to 17-year-olds, 49% (n = 296) had a partner of the same age and 41% (n = 250) had an older partner. Within this group, a small number (n = 30) had a sexual partner aged 20 or older.

Among 18-year-olds, 47% (n = 450) reported their partner was the same age as them, while 27% had a younger partner and 38% (n = 359) had an older partner (14.5% has a partner aged 20 or older).

Compared to men, women were more likely to have an older partner.[5]

Table 5.5. Age difference between participant and most recent sexual partner, by age and gender of participant

Age of sexual partner, by age of participant	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
14–15 years (n = 93)				
Partner under 16	19 (86%)	47 (69%)	2 (67%)	68 (73%)
Partner 16–17	3 (14%)	21 (31%)	1 (33%)	25 (27%)
Aged 16–17 (n = 397)				
Partner under 16	19 (17%)	27 (10%)	1 (4.2%)	47 (12%)
Partner 16–17	78 (71%)	167 (63%)	16 (67%)	261 (66%)
Partner 18–19	8 (7.3%)	60 (23%)	6 (25%)	74 (19%)
Partner 20–24	3 (2.7%)	7 (2.7%)	1 (4.2%)	11 (2.8%)
Partner 25+	2 (1.8%)	2 (0.8%)	0 (0%)	4 (1%)
Aged 18 (n = 1,231)				
Partner under 16	7 (2.2%)	10 (1.2%)	5 (5%)	22 (1.8%)
Partner 16–17	118 (37%)	160 (20%)	30 (30%)	308 (25%)
Partner 18–19	159 (50%)	502 (62%)	57 (57%)	718 (58%)
Partner 20–24	21 (6.6%)	125 (15%)	6 (6%)	152 (12%)
Partner 25+	11 (3.5%)	18 (2.2%)	2 (2%)	31 (2.5%)

Sexual pleasure and feelings about most recent sexual experience

Sexual health discussions often focus on risk factors such as STI prevention, contraception and consent. While these are essential, a risk-focused framework overlooks positive dimensions of sexuality, including pleasure and emotional connection. It also does not

5 A logistic regression was performed to examine the association between gender and the likelihood of having a partner who is older (adjusted for age and sexual orientation). Compared to men, women had significantly higher odds of having an older partner (OR 2.02, 95% CI 1.59–2.59).

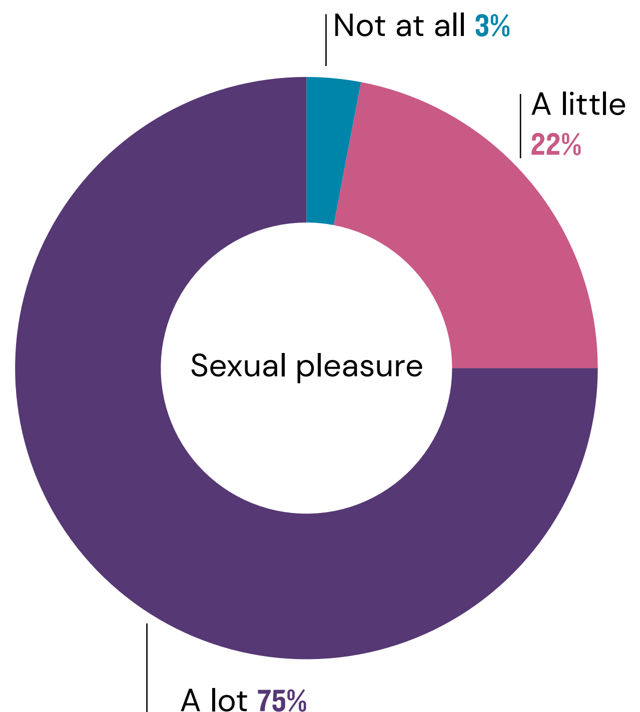
“RECOGNISING THE BREADTH OF YOUNG PEOPLE’S SEXUAL EXPERIENCES IS IMPORTANT, NOT ONLY FOR UNDERSTANDING SEXUAL WELLBEING, BUT ALSO FOR RESHAPING HEALTH NARRATIVES TOWARD MORE HOLISTIC AND AFFIRMING MODELS OF CARE.”

engage with young people’s subjective experience of sex such as whether they felt it was positive and how they felt afterward.

Recognising the breadth of young people’s sexual experiences is important, not only for understanding sexual wellbeing, but also for reshaping health narratives toward more holistic and affirming models of care. This approach also highlights the diversity of young people’s sexual experiences and affirms the value of pleasure in sexual health and wellbeing.

Most young people reported that they enjoyed their most recent sexual experience ‘a lot’ (n = 1,288, 75%; Figure 5.6).

Figure 5.6. **Percentage of young people reporting their enjoyment of their most recent sexual experience (n = 1,718)**



Young women were less likely than young men to report that they enjoyed their most recent sexual experience ‘a lot’. There were no other differences between gender, sexual orientation or age.[6] Table 5.6 lists how much young people enjoyed their most recent sexual experience, by gender.

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6 A multiple logistic regression analysis was used to explore associations between enjoyment of most recent sexual experience (‘a lot’ compared to ‘a little’ or ‘not at all’) and participants’ gender, sexual orientation and age, and the gender of their sexual partner. Young women (OR 0.49, 95% CI 0.32–0.72) had lower odds of enjoying their most recent sexual experience than young men. There were no other differences between gender, sexual orientation or age.

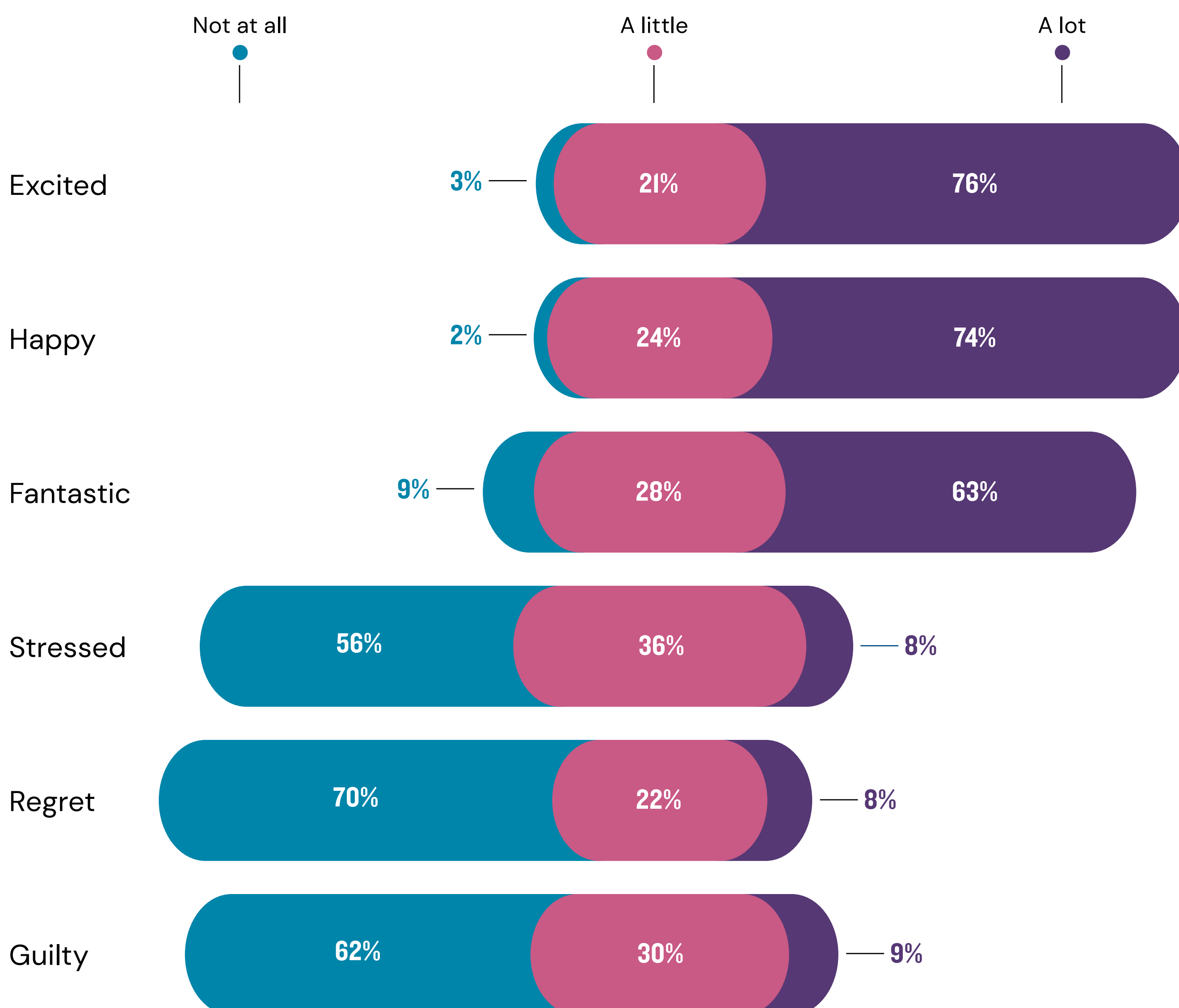
Table 5.6. Sexual enjoyment at most recent sexual experience, by gender (n = 1,718)

Enjoyed most recent sex	Men n (%)	Women n (%)	Trans n (%)	Overall n (%)
Not at all	5 (1.1%)	43 (3.8%)	5 (3.9%)	53 (3.1%)
A little	67 (14.9%)	277 (24.3%)	33 (26%)	377 (21.9%)
A lot	378 (84%)	821 (72%)	89 (70.1%)	1,288 (75%)

Young people were asked to what extent they felt excited, happy, fantastic, stressed, regretful and guilty about their most recent sexual experience (with the response options: 'not at all', 'a little', or 'a lot').

Overall, young people rated their most recent sexual experience positively: 76% (n = 1,301) reported feeling excited, 74% (n = 1,270) reported feeling happy, and 63% (n = 1,070) reported feeling fantastic. Negative feelings were less common: 8.8% (n = 150) reported feeling guilty, 8.4% (n = 143) reported feeling stressed, and 8% (n = 137) reported feeling regret. Figure 5.7 shows the mean ratings for these feelings for young people.

Figure 5.7. Young people's feelings about their most recent sexual experience (n = 1,721)



As can be seen in Table 5.7, more heterosexual men reported positive feelings than women, trans or LGBQ+ young people, although there were no differences for negative emotions or feeling happy.[7]

Table 5.7. Proportion of participants reporting high-intensity feelings ('a lot') at most recent sexual experience, by gender and sexual orientation (n = 1,721)

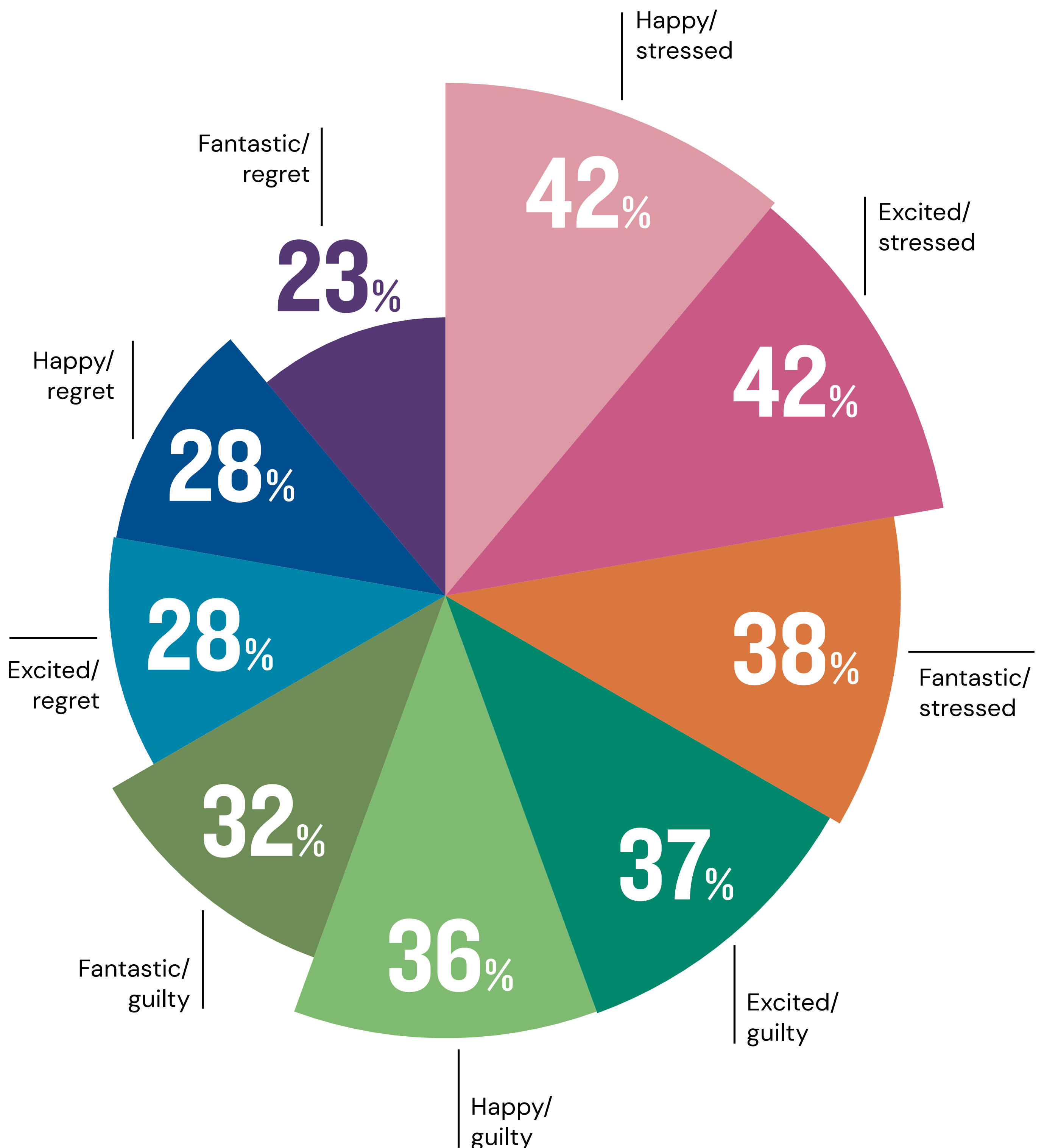
Feelings	Heterosexual women n (%)	LGBQ+ women n (%)	Heterosexual men n (%)	LGBQ+ men n (%)	Trans people n (%)	Overall n (%)
Excited	428 (74%)	382 (71%)	232 (85%)	146 (87%)	92 (72%)	**1,280 (76%)**
Happy	427 (75%)	375 (69%)	215 (80%)	138 (82%)	91 (72%)	**1,246 (74%)**
Fantastic	362 (63%)	311 (58%)	194 (72%)	113 (68%)	70 (56%)	**1,050 (63%)**
Stressed	32 (5.6%)	49 (9.1%)	27 (10%)	14 (8.3%)	16 (13%)	**138 (8.2%)**
Regret	47 (8.2%)	48 (8.9%)	16 (5.9%)	10 (6%)	14 (11%)	**135 (8.1%)**
Guilty	43 (7.5%)	58 (11%)	14 (5.2%)	10 (6%)	20 (16%)	**145 (8.7%)**

7 Logistic regression analyses confirmed that men had significantly higher odds of feeling excited (OR 2.30, 95% CI 1.71–3.12) and fantastic (OR 1.51, 95% CI 1.19–1.92) than women, but there were no differences for negative emotions or feeling happy.

Mixed emotions

Even though most participants leaned toward the positive, many young people reported both positive and negative feelings about their most recent sexual encounter. In combinations such as happy/stressed and excited/stressed, nearly half reported feeling 'a little' or 'a lot' of both emotions (happy/stressed: n = 715, 42%; excited/stressed: n = 707, 42%), reflecting both positive and challenging sentiments tied to their sexual experiences. Other combinations such as fantastic/guilty (n = 526, 32%) and excited/guilty (n = 617, 37%) also showed the extent to which sex can be emotionally complex for many young people (see Figure 5.8).

Figure 5.8. Percentage of 'mixed feelings' about most recent sexual experience (n = 1,721)



Worry about desirability

Young people were asked the extent to which they worried that they were not desirable to their partner at their most recent sexual encounter ('not at all', 'a little', or 'a lot'). This question was included as open text responses in the previous survey (SSASH 7) indicated that many young people reported that they experienced negative emotions after their most recent sexual encounter because they worried their partner did not find them desirable or attractive during the encounter. One in five young people (21%, n = 354) indicated they worried 'a lot' that their partner did not find them desirable, while 38.6% (n = 646) were not at all worried about this.

Gay and lesbian young people were more likely to worry about their desirability than heterosexual young people but there were no other differences (see Table 5.8).[8]

Table 5.8. Proportion of participants reporting worrying that they weren't desirable at most recent sexual experience, by gender and sexual orientation

Worried about desirability	Heterosexual women n (%)	LGBQ+ women n (%)	Heterosexual men n (%)	LGBQ+ men n (%)	Trans people n (%)	Overall n (%)
Not at all	247 (43.1%)	178 (33.3%)	130 (48.3%)	52 (31%)	39 (30.7%)	**646 (38.6%)**
A little	217 (37.9%)	217 (40.6%)	105 (39%)	77 (45.8%)	56 (44.1%)	**672 (40.2%)**
A lot	109 (19%)	140 (26.2%)	34 (12.6%)	39 (23.2%)	32 (25.2%)	**354 (21.2%)**

Feeling safe

Young people were asked to what extent they felt safe during their most recent sexual experience ('not at all', 'a little', or 'a lot'; see Table 5.9), and 85% (n = 1,464) indicated that they felt very safe. There were no gender differences in responses.

Table 5.9. Proportion of participants reporting feeling safe at most recent sexual experience, by gender (n = 1,713)

Felt safe	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Very	369 (83%)	991 (87%)	104 (83%)	**1,464 (85%)**
A little	70 (16%)	130 (11%)	19 (15%)	**219 (13%)**
Not at all	7 (1.6%)	21 (1.8%)	2 (1.6%)	**30 (1.8%)**

8 Gay and lesbian young people were more likely to worry about their desirability than heterosexual young people (OR 3.05, 95% CI 1.88–4.90).

NON-SEXUALLY ACTIVE YOUNG PEOPLE

There were 2,193 young people (50%) in this study who had not experienced oral, penile-vaginal or penile–anal sex. These young people were asked about their reasons for not having sex yet and what they wanted to know before having sex. They were also asked to respond to an open-ended question about their thoughts and feelings about sex.

The main reasons young people were not sexually active were: they did not have a partner (n = 1,258, 58%), they had not had the opportunity to have sex (n = 984, 45%), or they were not yet ready to have sex (n = 849, 39%). Reasons for not being sexually active are listed in Figure 5.9.

Women were more likely than men to report they were not sexually active because they did not feel ready, did not experience sexual urges, had not been in a relationship long enough, wanted to wait until marriage, or were concerned about STIs.[9]

LGBQ+ young people were more likely than their heterosexual peers to report not having sex due to feeling shy or embarrassed or lacking the opportunity to have sex, but were less likely to want to wait for marriage or report concerns about religion.[10]

Older adolescents were less likely than younger adolescents to say they were not ready for sex, to worry about parent disapproval or worry about STIs. They were also more likely to report lacking the opportunity, wanting to be in love, or not having a partner.[11]

Figure 5.9. Reasons that non–sexually active young people have not yet had sex (n = 2,178)

When asked what they wanted to know before having sex, over half wanted to know how to make sex enjoyable or pleasurable (n = 1,136, 53%) and how to talk about sex to a partner (n = 1,073, 50%). Young people also wanted to know how to have sex (n = 1,027, 48%) and what sex felt like (n = 985, 46%). Figure 5.10 lists the topics that young people wanted to know about before having sex.

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9 Women were significantly more likely than men to report not feeling ready (OR 2.03, 95% CI 1.67–2.48), not experiencing sexual urges (OR 1.88, 95% CI 1.45–2.47), not being in a relationship long enough (OR 1.43, 95% CI 1.15–1.78), wanting to wait until marriage (OR 1.63, 95% CI 1.26–2.12) or concerns about STIs (OR 1.61, 95% CI 1.19–2.19). Young women were less likely than men to believe that their partner was not ready (OR 0.43, 95% CI 0.26–0.71). Trans participants were more likely than men to report no sexual urges (OR 3.05, 95% CI 1.95–4.76).

10 LGBQ+ young people were more likely than heterosexual young people to report not having sex due to shyness/embarrassment (OR 1.95, 95% CI 1.59–2.40) or lacking the opportunity to have sex (OR 1.81, 95% CI 1.49–2.20) but were less likely to want to wait for marriage (OR 0.20, 95% CI 0.13–0.28) or report concerns about religion (OR 0.18, 95% CI 0.12–0.26).

11 Older adolescents were less likely to say they weren't ready (OR 0.87, 95% CI 0.82–0.93), worry about parent disapproval (OR 0.77, 95% CI 0.71–0.83), or worry about STIs (OR 0.83, 95% CI 0.75–0.91), while they were more likely to report lacking the opportunity (OR 1.17, 95% CI 1.10–1.25), wanting to be in love (OR 1.12, 95% CI 1.05–1.20), or not having a partner (OR 1.13, 95% CI 1.06–1.20).

Figure 5.9. Reasons that non-sexually active young people have not yet had sex (n = 2,178)

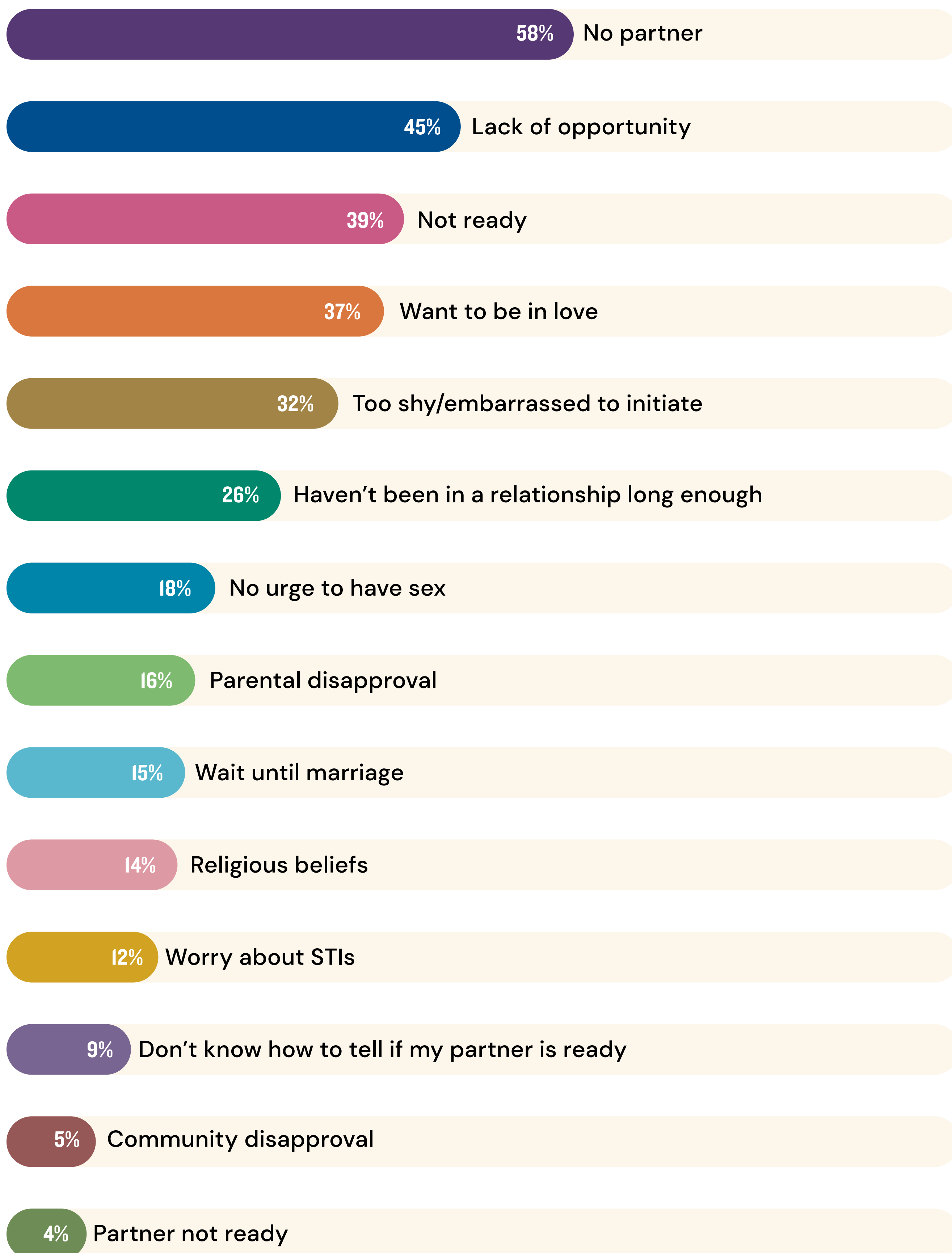


Figure 5.10. **Topics that non–sexually active young people wanted to know about before becoming sexually active (n = 2,127)**

Topic	%
Sexual pleasure	53%
How to talk to partner about sex	50%
How to have sex	48%
What sex feels like	46%
STI prevention	38%
How to get contraception	27%
How to use condoms	26%
Sexual consent	25%

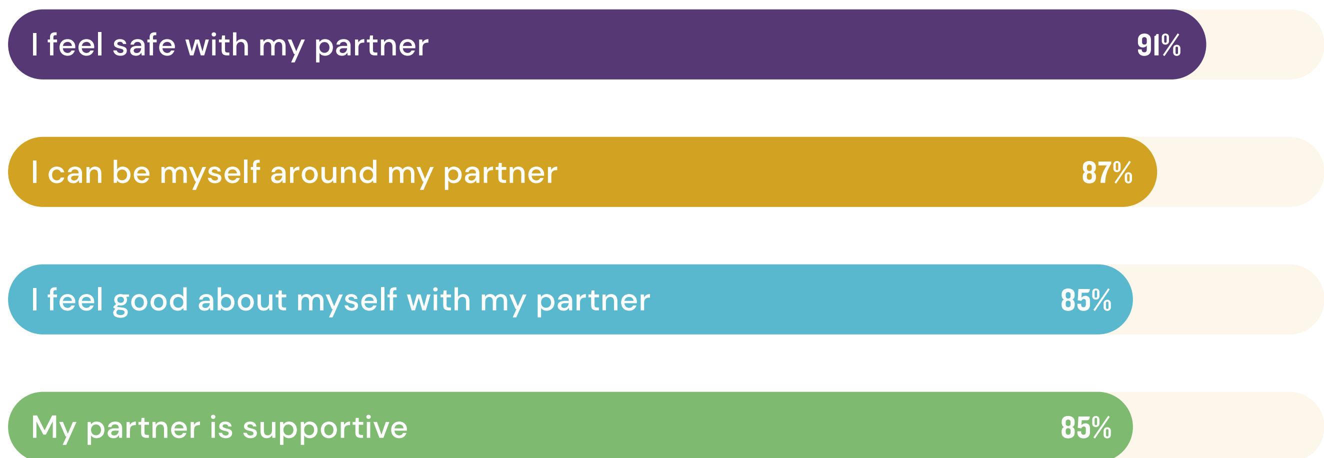
SEXUAL AND ROMANTIC RELATIONSHIPS

Of the entire sample, 61% of young people (n = 2,596) reported having been in a romantic relationship that lasted for at least 3 months. These relationships may or may not have involved sex.

We asked young people who had been in a relationship how they felt with their most recent partner. These questions aimed to explore aspects of wellbeing within relationships, including emotional safety, sense of self and positive connection. Participants were asked to rate their agreement on a 5-point scale (from strongly disagree to strongly agree) across four statements: feeling safe and comfortable with their partner, being able to be themselves, having a supportive partner, and feeling good around their partner.

Most young people reported high rates of agreement across these statements, reflecting generally positive experiences within their most recent relationship, as illustrated in Figure 5.11.

Figure 5.11. Agreement with relationship wellbeing statements among young people who had experienced a relationship of 3 months or more (n = 2,588)



LGBQ+ young people were significantly less likely than heterosexual participants to rate their most recent relationship in positive terms, including feeling good about themselves, feeling safe with their partner and feeling supported by their partner.[12]

There were no other significant differences with respect to gender or sexuality. Agreement with these four relationship wellbeing statements is listed in Table 5.10 by gender and sexual orientation.

Table 5.10. Relationship wellbeing statements among young people, by gender and sexual orientation (n = 2,588)

Relationship statements	Heterosexual women n (%)	LGBQ+ women n (%)	Heterosexual men n (%)	LGBQ+ men n (%)	Trans people n (%)	Overall n (%)
My partner makes me feel safe (agree/ strongly agree)	767 (93%)	688 (88%)	439 (95%)	215 (88%)	210 (91%)	2,319 (91%)
I can be myself with my partner (agree/ strongly agree)	734 (90%)	647 (83%)	416 (90%)	204 (84%)	200 (87%)	2,201 (87%)
My partner supports me (agree/strongly agree)	720 (88%)	623 (80%)	400 (87%)	205 (84%)	194 (84%)	2,142 (84%)
I feel good about myself with my partner (agree/ strongly agree)	713 (88%)	620 (80%)	415 (90%)	202 (83%)	195 (84%)	2,145 (85%)

12 Multiple logistic regression analyses showed that LGBQ+ young people were significantly less likely than heterosexual young people to feel good about themselves when with their most recent partner (OR 0.94, 95% CI 0.91–0.97), to feel safe around their partner (OR 0.96, 95% CI 0.93–0.98) and to feel supported by their partner (OR 0.95, 95% CI 0.92–0.98).

BELIEFS ABOUT GENDER ROLES IN RELATIONSHIPS

We asked participants about their attitudes toward gender roles within opposite-sex/heterosexual relationships (see Table 5.11). The purpose of these questions was to better understand the gendered sexual cultures guiding young people's expectations about relationships.

Participants were asked to respond to two attitude statements using a 5-point scale (from strongly disagree to strongly agree): 'Women prefer men to be in charge' and 'Men should make the first move'. One further statement was presented to young people who were sexually active: 'I wait for my partner to initiate sex'.

One in three (n = 1,281, 32%) believed that women prefer men to be in charge of relationships while less than one in five (17%, n = 685) believed that men should make the first move when having sex. Young women were more likely than young men to agree that men should make the first move during sex,[13] but there were no differences by gender in agreement that men should be in charge in a relationship.

Of sexually active young people, one in four (25%, n = 498) indicated they wait for their partner to initiate sex (n = 498, 25%). Young women were more likely than young men to agree with this statement (27% compared to 22%), but this difference was not statistically significant.[14]

LGBQ+ young people less likely than heterosexual young people to agree that women want men to take charge of relationships and less likely to believe than men should make the first move.[15]

Table 5.11. Young people's beliefs about gender roles within relationships, by gender

Belief statements	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Women prefer men to be in charge (n = 4,017)	463 (36%)	790 (32%)	28 (10%)	**1,281 (32%)**
Men should make the first move (n = 4,014)	207 (16%)	471 (19%)	7 (2.5%)	**685 (17%)**
I wait for my partner to initiate sex* (n = 1,954)	119 (22%)	343 (27%)	36 (26%)	**498 (25%)**

Note: The percentages are of young people who agreed or strongly agreed with each statement.
* Only sexually active young people were shown this statement.

13 Young women were more likely than young men to agree that men should make the first move during sex (OR 1.63, 95% CI 1.35–1.97).

14 Young women were more likely than young men to agree that they wait for their partner to initiate sex, but this difference was not statistically significant (OR 1.28, 95% CI 1.01–1.63, p = .047).

15 LGBQ+ young people less likely than heterosexual young people to agree that women want men to take charge of relationships (OR 0.27, 95% CI 0.23–0.32), and less likely to believe than men should make the first move (OR 0.25, 95% CI 0.20–0.31).

6. CONDOM USE, CONTRACEPTION AND STI PREVENTION

Sexual decision-making involves a complex interplay between knowledge, access to safe-sex and contraceptive materials, relationships and context. This chapter examines how young people engage with condoms, contraception, STI prevention, and strategies to avoid unplanned pregnancy in their sexual relationships. A series of questions was designed based on previous SSASH findings that show young people's attitudes toward condoms are shaped by their relationships, perceived risks, and ideas about trust, care and intimacy (Power, Kauer, et al., 2024).

BELIEFS ABOUT CONDOM USE

Young people were asked to rate (using a 5-point scale from: strongly disagree to strongly agree) how much they agreed with five statements about condom use (see Figure 6.1).

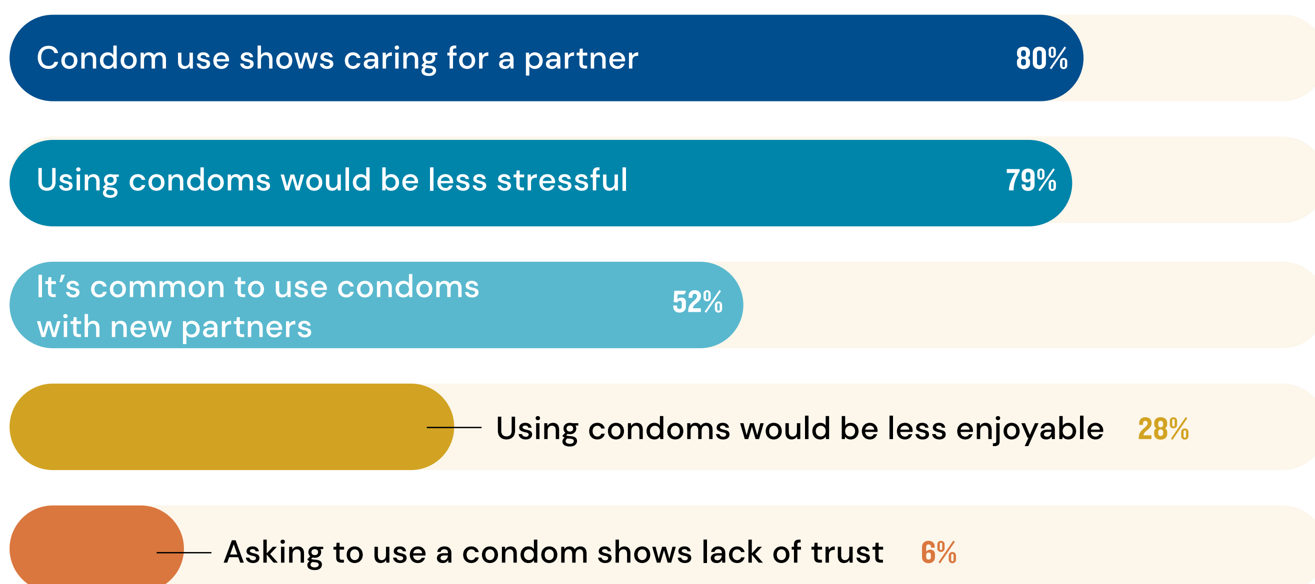
Responses, on the whole, showed that young people have a positive attitude toward condoms. Most young people agreed that using condoms shows care for a partner (n = 3,513, 80%) and few agreed that asking someone to use a condom would suggest a lack of trust (n = 266, 6.1%).

Most young people (n = 3,452, 79%) also agreed that using condoms when having sex would be less stressful than not using a condom, while fewer than one in three believed that using condoms would make sex less enjoyable (n = 1,224, 28%).

Despite positive attitudes toward condoms, only half (n = 2,283, 52%) believed that using condoms with new partners was common among people their age.

Young people who agreed that 'using condoms shows you care about your partner' were more likely to consistently use condoms (95% compared to 73% who did not agree) as were young people who agreed that 'using condoms would be less stressful' (93% compared to 71% who did not agree). In contrast, those who agreed that 'using condoms is less enjoyable' were less likely to

Figure 6.1. Percentage who agreed with condom belief statements (n = 4,366)



always use a condom (18% compared to 54% who did not agree).[16]

PATTERNS OF CONDOM USE

Condom use was relatively common among young people who had engaged in penile–vaginal sex or penile–anal sex. A quarter (n = 428, 26%) reported that they always used condoms and 31% (n = 511) often used condoms. Only 11% (n = 176) reported never using condoms (see Figure 6.2).

At their most recent sexual experience, 80% (n = 1,127) reported that a condom was available at this time, although only 51% (n = 732) used one (see Figure 6.3).

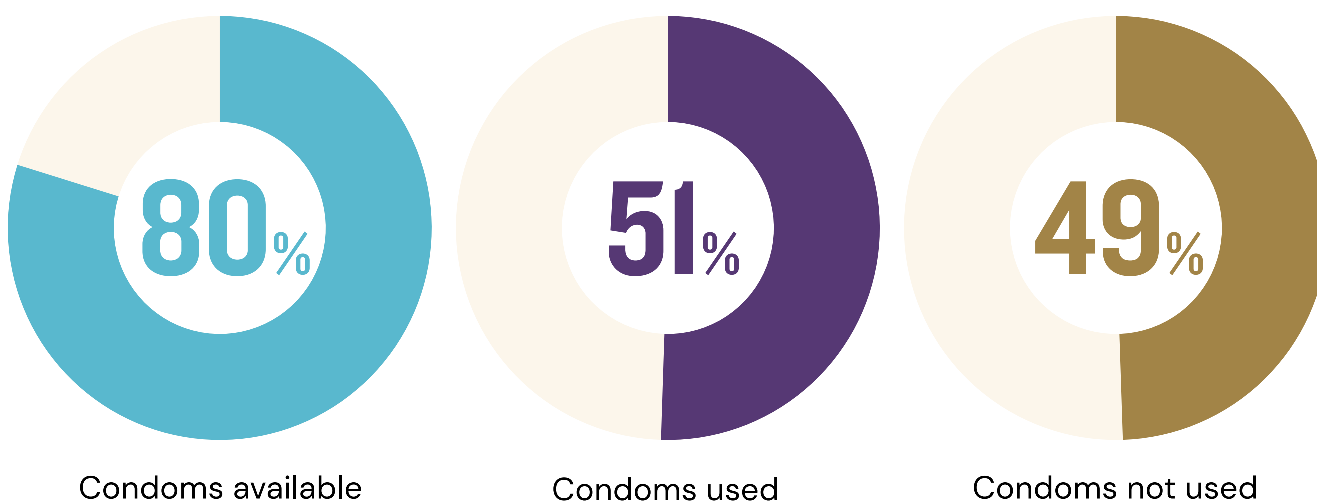
Condom use and availability did not differ according to gender or sexual orientation, or between major cities and regional/remote areas.

Condom use during penile-vaginal sex significantly decreased for young people who were using the oral contraceptive pill or long-acting reversible contraception (LARC).

Young people who were in a steady relationship were just as likely to use condoms as those who were not. However, condoms were more likely to be available if the young person was in a steady relationship.[17] Condom use patterns are presented in Table 6.1 by gender.

Figure 6.2. Frequency of condom use (n = 1,642)

Figure 6.3. Condom availability and use during most recent sexual experience (n = 1,449)



16 Young people who agreed that 'using condoms shows you care about your partner' (OR 1.13, 95% CI 1.07–1.19) and that 'using condoms would be less stressful' (OR 1.12, 95% CI 1.06–1.18) were more likely to 'always' use a condom, compared to young people who did not consistently use a condom (either using a condom 'often', 'occasionally' or 'never'). Young people who agreed that 'using condoms is less enjoyable' were less likely to consistently use a condom (OR 0.78, 95% CI 0.74–0.81).

17 Logistic regression models explored patterns in condom use among young people, using gender, sexual orientation, relationship status, rurality, and contraception use as predictors. Condom use during penile-vaginal sex significantly decreased for young people who were using the oral contraceptive pill or LARC (OR 0.29, 95% CI 0.23–0.36). Young people in a steady relationship were more likely to report a condom was available at their most recent sexual encounter (OR 1.72, 95% CI 1.27–2.32).

Table 6.1. Condom use patterns among young people, by gender

Condom use and access	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Frequency of condom use (n = 1,642)				
Never	57 (13.5%)	113 (10%)	6 (6.5%)	**176 (10.7%)**
Occasionally	120 (28.5%)	378 (33.5%)	29 (31.2%)	**527 (32.1%)**
Often	125 (29.7%)	354 (31.4%)	32 (34.4%)	**511 (31.1%)**
Always	119 (28.3%)	283 (25.1%)	26 (28%)	**428 (26.1%)**
Condom available at last sexual experience (n = 1,412)				
	302 (81.8%)	761 (78.4%)	64 (88.9%)	**1,127 (79.8%)**
Condom used at last sexual experience (n = 1,449)				
	208 (55.9%)	482 (48%)	42 (57.5%)	**732 (50.5%)**
Condoms not used at last sexual experience (n = 1,449)				
	164 (44.1%)	522 (52%)	31 (42.5%)	**717 (49.5%)**

REASONS FOR NOT USING CONDOMS

Young people who did not use a condom at their most recent sexual experience were given a list of reasons that might reflect why and asked to indicate if any of these apply. They were also able to provide additional reasons in their own words. Figure 6.4 shows the percentage of young people who selected each reason.

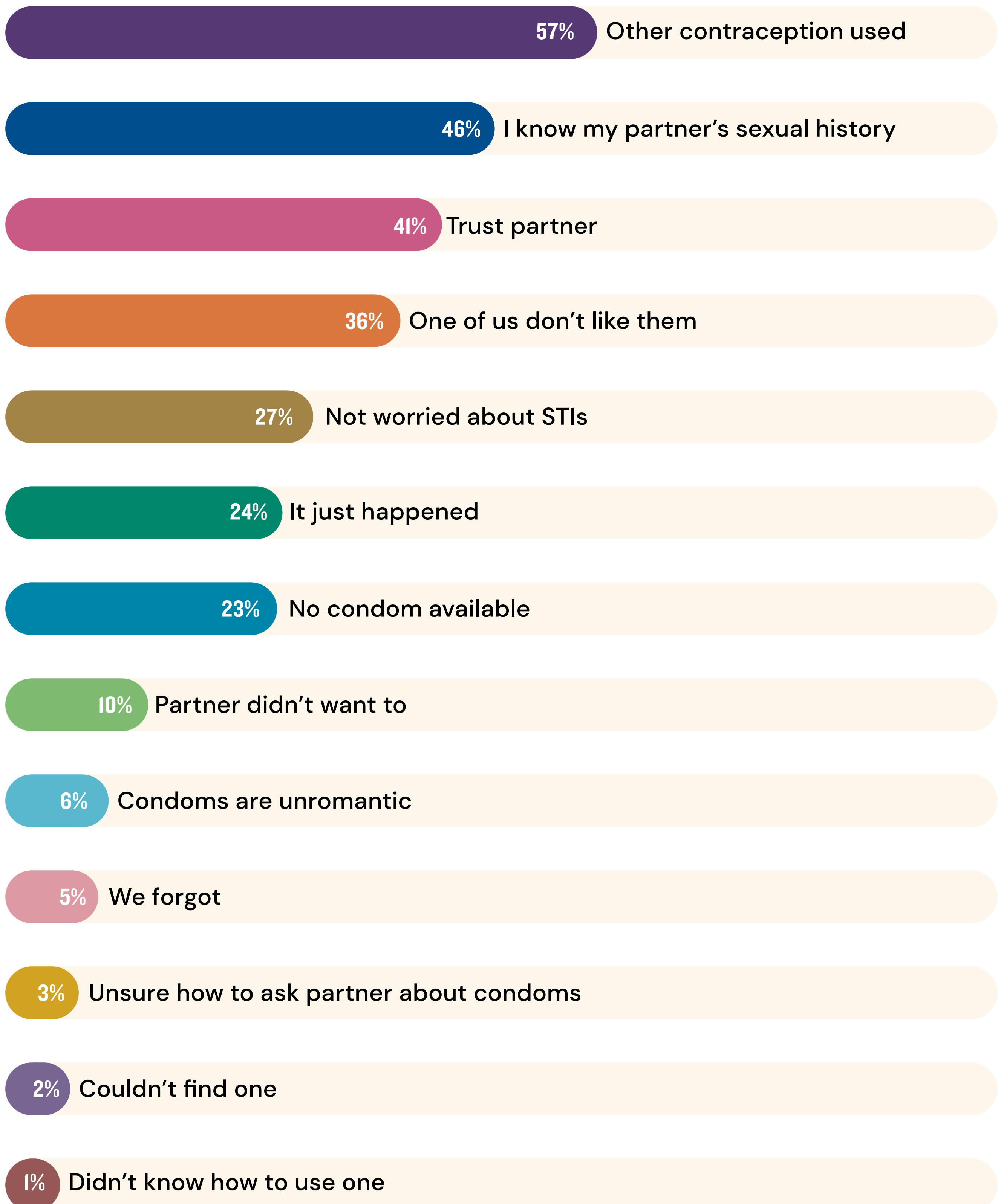
Among young people who did not use a condom, the most common reasons given were about feeling protected by using another form of contraception (n = 409, 57%), knowing their partner's sexual history (n = 327, 46%), trusting their partner (n = 292, 41%), or having low concern about STIs (n = 191, 27%).

Some young people were unprepared for their sexual encounter, indicating that 'it just happened' (n = 170, 24%) or they did not have a condom available at the time (n = 164, 23%).

Preferences were another factor involved in young people's decision not to use a condom, specifically not liking condoms (n = 260, 36%) or their partner not wanting to use one (n = 71, 9.9%).

Less common were emotional or knowledge-based barriers, namely feeling unsure how to ask their partner (n = 21, 2.9%), not knowing where to find condoms (n = 12, 1.7%), or not knowing how to use one (n = 7, 1%).

Figure 6.4. Young people's reasons for not using condoms at most recent sexual encounter (n = 716)



Whether or not someone was in a steady relationship with their sexual partner affected their reasons for not using a condom. Young people who were not in a steady relationship with their most recent sexual partner were more likely than young people in a steady relationship to report that they:

did not have a condom available, forgot to use one, or that sex 'just happened'.[18]

Young people who were in a steady relationship were more likely to report not using a condom because they were using another form of contraception, were not worried about STIs, trusted their partner or knew their partner's sexual history.[19] Table 6.2 lists the reasons young people gave for not using a condom during their most recent sexual encounter, grouped by whether or not they were in a steady relationship.

Table 6.2. Reasons for not using a condom at most recent sexual encounter by relationship status (n = 716)

Reasons for not using condoms	Steady partner n (%)	Other partner n (%)	Overall n (%)
Other contraception used	335 (61.4%)	74 (44.3%)	**409 (57.4%)**
I know my partner's sexual history	273 (50%)	54 (32.3%)	**327 (45.9%)**
I trust my partner	240 (44%)	51 (30.5%)	**291 (40.8%)**
One of us doesn't like them	214 (39.2%)	45 (26.9%)	**259 (36.3%)**
Not worried about STIs	162 (29.7%)	28 (16.8%)	**190 (26.6%)**
It just happened	97 (17.8%)	72 (43.1%)	**169 (23.7%)**
No condom available	110 (20.1%)	53 (31.7%)	**163 (22.9%)**
Partner did not want to use one	50 (9.2%)	20 (12%)	**70 (9.8%)**
Condoms are unromantic	27 (4.9%)	18 (10.8%)	**45 (6.3%)**
We forgot	18 (3.3%)	17 (10.2%)	**35 (4.9%)**
Didn't know how to ask partner to use one	10 (1.8%)	10 (6%)	**20 (2.8%)**
Couldn't find one	10 (1.8%)	2 (1.2%)	**12 (1.7%)**
Didn't know how to use one	3 (0.5%)	4 (2.4%)	**7 (1%)**

18 Logistic analysis found that young people who were not in a steady relationship were more likely than young people in a steady relationship to say they: did not have a condom available (OR 1.91, 95% CI 1.28–2.84), forgot to use a condom (OR 3.58, 95% CI 1.73–7.42), or sex 'just happened' (OR 3.60, 95% CI 2.43–5.35).

19 Young people in a steady relationship were more likely (than those not in a steady relationship) to report that: they were using another form of contraception (OR 2.04, 95% CI 1.41–2.94); they were not worried about STIs (OR 2.17, 95% CI 1.39–3.57); they trusted their partner (OR 1.89, 95% CI 1.28–2.78); or they knew their partner's sexual history (OR 2.13, 95% CI 1.47–3.13).

Fifty-five young people shared open-text responses to describe their reasons for not using a condom at their most recent sexual encounter. Responses often reflected the reasons mentioned above, particularly knowing their partner's sexual history. Other issues mentioned included discomfort, poor fit and allergies. Figure 6.5 shows some of the words young people used to describe why they did not use condoms during their most recent sexual encounter.

Figure 6.5. Words young people used to describe why they did not use a condom during their most recent sexual experience (n = 55).

medical illness intimate relationship
rod erection strap contraception finish period
iud lesbian size hormones painful left
infertile vagina pregnant breaking
risks dildos
free STI climax
allergic partner feel fit
latex women
hard pill tested female
girlfriend money penis blockers drunk individual
raw
foreskin hurt wrong easier gentile
textured worried negative

Note: This word cloud visualises the words mentioned most often in the open text responses, with larger words appearing more frequently in young people's responses.

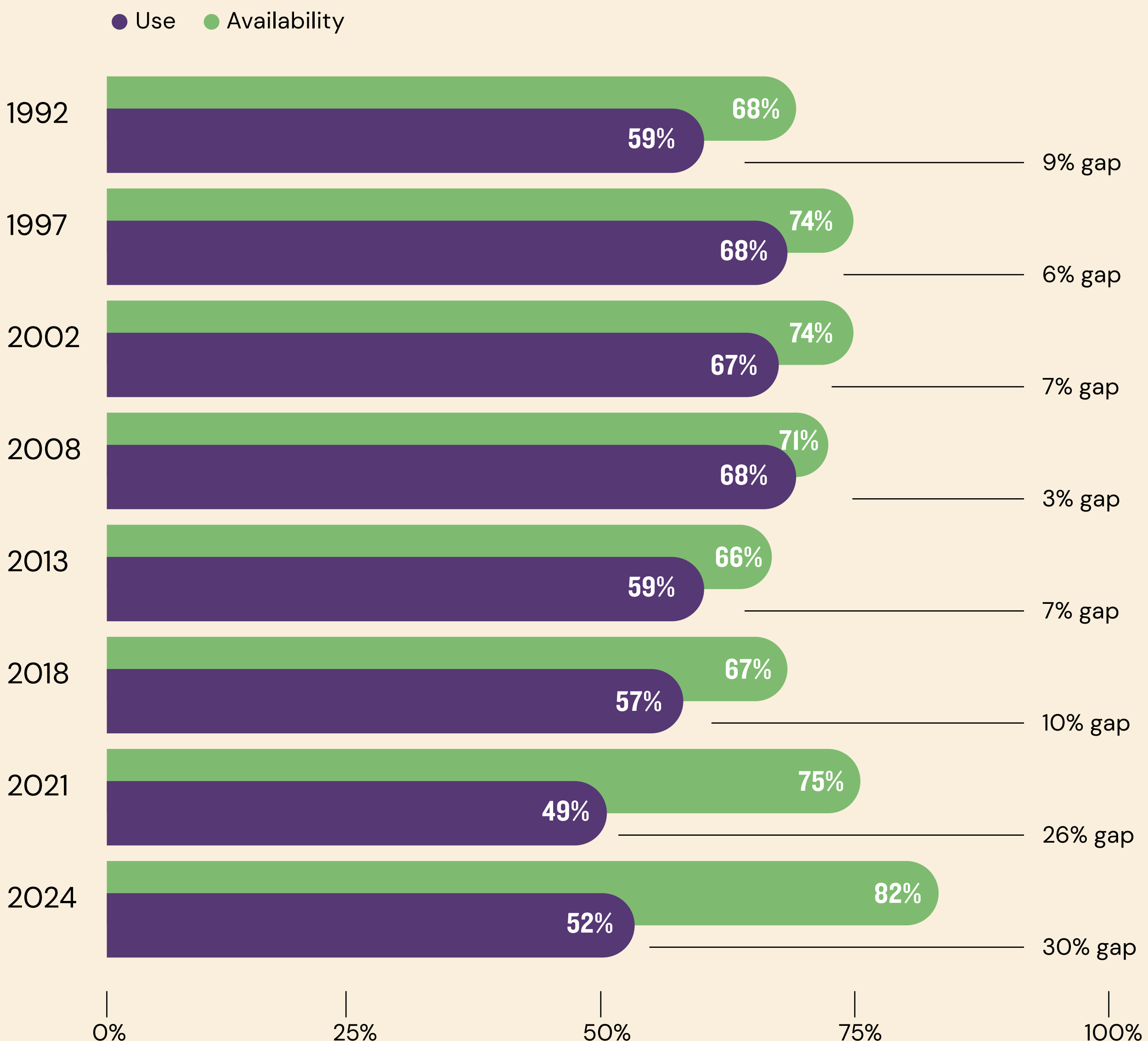
CHANGES OVER TIME: CONDOM AVAILABILITY AND USE

Since 1992, the SSASH survey has asked sexually active young people if they had a condom available at their most recent sexual encounter and whether a condom was used. Young people consistently report a gap between condom availability and use from 1992 to 2024. As shown in Figure 6.6, this gap has widened in recent years. Between 1992 and 2018, the gap between availability and use was 10% or under. This pattern changed substantially in 2021 and 2024, when availability rose sharply while use declined or remained comparatively low.

While availability has increased substantially in recent years with 82% of young people reporting access to condoms in 2024; use has decreased with 2021 and 2024 reporting the lowest rates of condom use (49% and 52%).

This suggests that cultural attitudes toward condom use may be changing. This may relate to increasing availability and reliance on LARC or an overall decrease in the visibility of condoms in recent years as HIV-prevention has increasingly focused on biomedical prevention options (Power, Kauer, et al., 2024).

Figure 6.6. Reported condom availability, use, and the gap between them among sexually active year 10 and year 12 students



Note: Sample sizes by survey year: 1992 (n = 599); 1997 (n = 1,172); 2002 (n = 857); 2008 (n = 934); 2013 (n = 510); 2018 (n = 1,818); 2021 (n = 1,792); 2024 (n = 822)

STI PREVENTION PRACTICES

Sexually active participants were asked whether they took precautions to prevent STIs during their most recent encounter. Less than half (n = 694, 42%) reported that they used some form of STI prevention: condoms, PrEP or post-exposure prophylaxis (PEP),[20] or dental dams. Condoms were the most common method of STI prevention used (n = 688, 42%), while 15% (n = 250) reported that they and their partner had tested for STIs. There were seven young people (0.4%) who said they had used PrEP or PEP for HIV prevention. There were three young people (0.2%) who said they used dental dams.

In open text responses, four young people described prioritising hygiene (although it was not necessarily clear how they applied this to STI prevention) and some noted it was a first sexual experience for both them and their partner.

Notably, 41% (n = 666) said that neither partner took any precautions. There were no differences in age, gender, sexual orientation, relationship status or whether they knew that HIV could be treated with PEP. Table 6.3 lists the use of STI prevention by young people by gender.

"LESS THAN HALF OF SEXUALLY ACTIVE PARTICIPANTS REPORTED USING STI-PREVENTION STRATEGIES — MOSTLY CONDOMS — HIGHLIGHTING SUBSTANTIAL GAPS IN PROTECTIVE PRACTICES."

Table 6.3. Use of STI prevention during most recent sexual encounter, by gender (n = 1,643)

STI prevention used	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Any STI prevention	194 (46.1%)	458 (41.7%)	42 (33.9%)	694 (42.2%)
Condoms	191 (45.4%)	456 (41.5%)	41 (33.1%)	688 (41.9%)
Both partners tested for STIs	48 (11.4%)	176 (16%)	26 (21%)	250 (15.2%)
PrEP or PEP	5 (1.2%)	2 (0.2%)	0 (0%)	7 (0.4%)
Dental dam	0 (0%)	2 (0.2%)	1 (0.8%)	3 (0.2%)
None by either partner	165 (39.2%)	448 (40.8%)	53 (42.7%)	666 (40.5%)

*Pre-exposure prophylaxis (PrEP) or Post-exposure prophylaxis (PEP).

20 Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are antiviral medications that can be taken before or soon after sex to prevent contracting HIV.

STI SYMPTOMS AND DIAGNOSES

Few young people in this study (n = 49; 1.1%) had ever received a diagnosis of an STI, including HIV or hepatitis. Overall, 37 (0.8%) indicated that they had been diagnosed with an STI including HIV or hepatitis, four (<0.1%) with hepatitis and four (<0.1%) with HIV (four did not report their diagnosis).

In total, 454 (11%) reported ever experiencing symptoms that they thought could be an STI including HIV or hepatitis: 281 (6.6%) within the past 12 months and 173 (4.1%) more than a year ago. LGBQ+ young people were more likely to report experiencing STI symptoms than heterosexual young people.[21]

CONTRACEPTIVE USE

The majority of young people who had engaged in penile-vaginal sex used some form of evidence-based contraception (those known to effectively prevent pregnancy: condoms, the oral contraceptive pill or LARC) during their most recent sexual experience (n = 1,176, 83%). Half (n = 715, 51%) used condoms, while 35% (n = 494) used the oral contraceptive pill, and 17% (n = 241) used LARC. There were 4.7% (n = 66) who used emergency contraception. Few young people reported that neither they nor their partner used contraception (n = 69, 4.9%). No differences in the use of evidence-based contraception were found between genders, sexual orientations, age or area of residence.

One in 10 young people reported using withdrawal (removing the penis before ejaculation) as their only form of contraception (n = 143, 10%), despite its limited effectiveness in preventing pregnancy and lack of protection against STIs. Those who used withdrawal were less likely to use condoms or LARC.[22] Just over one in 10 young people (14%, n = 199) reported that they waited for a safe time in the menstrual cycle (the rhythm method) to prevent pregnancy. Table 6.4 lists the frequency of young people using contraception by gender.

Table 6.4. Use of contraception during most recent sexual experience, by gender (n = 1,412)

Contraception used	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Evidence-based contraception*	274 (82.5%)	836 (82.9%)	66 (91.7%)	**1,176 (83.3%)**
Condoms	195 (58.7%)	481 (47.7%)	39 (54.2%)	**715 (50.6%)**
Oral contraceptive pill	102 (30.7%)	369 (36.6%)	23 (31.9%)	**494 (35%)**
Withdrawal	30 (9.0%)	110 (10.9%)	3 (4.2%)	**143 (10.1%)**
LARC	40 (12%)	185 (18.4%)	16 (22.2%)	**241 (17.1%)**
Rhythm method	46 (13.9%)	137 (13.6%)	16 (22.2%)	**199 (14.1%)**
Emergency contraception	15 (4.5%)	49 (4.9%)	2 (2.8%)	**66 (4.7%)**
None by either partner	19 (5.7%)	47 (4.7%)	3 (4.2%)	**69 (4.9%)**

* Refers to condoms, oral contraception or LARC.

21 LGBQ+ young people were more likely to report experiencing STI symptoms than heterosexual young people (OR 1.48, 95% CI 1.20–1.83). Young people were more likely to report STI symptoms as they got older (OR 1.53, 95% CI 1.38–1.70).

22 Logistic regression analysis showed that those who used withdrawal to prevent pregnancy were less likely to use condoms (OR 0.39, 95% CI 0.30–0.51) or LARC (OR 0.38, 95% CI 0.26–0.55).

PREGNANCY

There were 110 young people in this survey who reported they or their sexual partner had ever been pregnant, with 15 who had carried to term.

Most of the young people who reported a pregnancy were women (n = 85, 77%), heterosexual (n = 56, 52%) or bisexual (n = 37, 34%) and were 18 years of age (n = 67, 61%). Of the 15 pregnancies carried to term, seven were among 18-year-olds, eight were women and 10 were reported by heterosexual young people.

KNOWLEDGE ABOUT HIV AND OTHER STIS

When the SSASH study was first developed in 1992, one of its primary aims was to assess the extent to which young people knew about HIV and other STIs, including symptoms, treatment options and prevention methods. In each iteration of the survey, we have assessed young people's knowledge of these issues to monitor change over time. However, change over time is not necessarily an indicator of overall improvement or reduction in young people's sexual health knowledge. More commonly it reflects broader change. For example, we previously asked young people if they believed HIV could be transmitted via mosquitoes. In the early 1990s there were concerns that this could happen and busting this myth was an important part of HIV education. By the 2000s, it was so well understood that mosquitoes cannot transmit HIV that this was no longer part of HIV education or health promotion content delivered to young people. Subsequently, we found a decrease in the number of young people who correctly knew the answer to these questions between 2001 and 2018. We have now removed this question as we were concerned that it could be confusing for study participants who may never have considered a connection between mosquitoes and HIV. Here we report young people's responses to knowledge about HIV and STIs and reflect on how this has changed over time.

Young people responded to 15 questions about: STI transmission and symptoms; prevention and protection; and treatment and management. Response options were 'true', 'false' or 'unsure'. Any 'unsure' answers were included with the incorrect answers.

Knowledge about STI symptoms and transmission was high, with over 80% understanding that STIs can be asymptomatic and that young people are at risk of STIs. Young people also had good knowledge about STI prevention, including the effectiveness of condoms for preventing HIV and other STIs. Young people were less certain about the

potential long-term impact of STIs, with just over half (56%) indicating they knew untreated chlamydia could cause infertility.

On average, young women had better knowledge about HIV and other STIs overall than men (with 69% of correct responses compared to 63%), as did LGBQ+ young people (73%) compared to heterosexual young people (65%) and young people living in regional or remote areas compared to major cities (71% compared to 68).[23] Knowledge also improved with age (14 to 15 years: 58%; 16 to 17 years: 66%; 18 years: 73%.[24]

The frequency of correct answers for each of the knowledge subscales is presented in Table 6.5.

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23 Multiple linear regression analysis revealed that women were more likely to have better overall knowledge than men (ß 3.1, 95% CI 1.7–4.4), LGBQ+ young people more likely to have better knowledge than heterosexual young people (ß 6.2, 95% CI 4.8–7.5) and that young people living in regional or remote areas were more likely to have better knowledge than young people living in greater capital cities (ß 2.6, 95% CI 1.2–4.0).

24 Sexual health was higher among older participants (ß 3.8, 95% CI 3.3–4.3).

Table 6.5. **Frequency of correct responses for the STI and sexual health knowledge questions (n = 4,396)**

Knowledge items	Men	Women	Trans people	Overall
Symptoms and transmission subscale				
You can catch an STI from someone who doesn't have signs or symptoms of an STI (true)	1,208 (85%)	2,331 (87%)	281 (91%)	3,820 (87%)
A person who has an STI will always experience symptoms (false)	1,120 (79%)	2,188 (82%)	268 (87%)	3,576 (81%)
In Australia, almost no young people get STIs (false)	1,150 (81%)	2,270 (85%)	258 (84%)	3,678 (84%)
Chlamydia only affects women (false)	1,009 (71%)	2,169 (81%)	263 (85%)	3,441 (78%)
Although rare, you can get HIV or hepatitis C from a tattoo or body piercing (true)	824 (58%)	1,681 (63%)	198 (64%)	2,703 (61%)
HIV can be spread through coughing or sneezing near other people (false)	843 (59%)	1,521 (57%)	198 (64%)	2,562 (58%)
Mean percentage of correct answers	72%	76%	79%	75%
Prevention and protection subscale				
Using a condom during vaginal or anal sex helps reduce the spread of STIs (true)	1,303 (92%)	2,506 (94%)	302 (98%)	4,111 (94%)
The contraceptive pill protects a person from HIV (false)	997 (70%)	2,139 (80%)	255 (83%)	3,391 (77%)
Condoms used during vaginal or anal sex help protect people from getting HIV (true)	1,204 (85%)	2,276 (85%)	279 (91%)	3,759 (86%)
HPV and hepatitis B can be prevented by vaccination (true)	802 (56%)	1,734 (65%)	209 (68%)	2,745 (62%)
Mean percentage of correct answers	76%	81%	85%	80%
Treatment and management subscale				
If left untreated, chlamydia can lead to infertility in women (true)	733 (52%)	1,569 (59%)	175 (57%)	2,477 (56%)
Once a person has caught genital herpes, they will always have the virus (true)	548 (39%)	1,243 (47%)	139 (45%)	1,930 (44%)
HIV cannot be cured but treatment now prevents people passing HIV to others through sex (true)	769 (54%)	1,533 (58%)	214 (69%)	2,516 (57%)
Human papillomavirus (HPV), also known as genital warts, can lead to cancer (true)	413 (29%)	806 (30%)	94 (31%)	1,313 (30%)
Gonorrhoea, chlamydia and syphilis can all be treated with medicine (true)	859 (60%)	1,800 (68%)	240 (78%)	2,899 (66%)
Mean percentage of correct answers	47%	52%	56%	51%

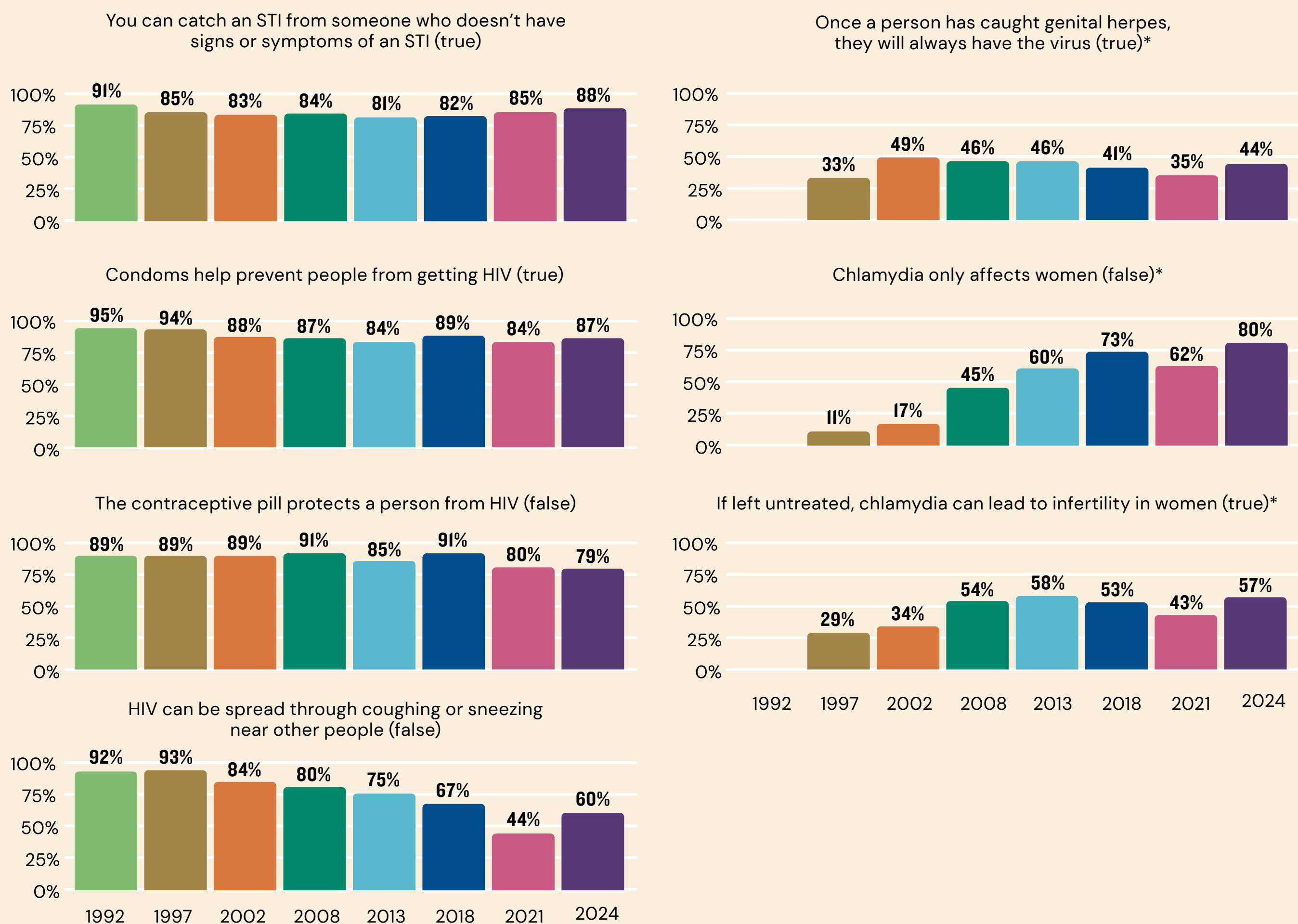
CHANGES OVER TIME: HIV AND STI KNOWLEDGE

The SSASH surveys have included five core knowledge questions since 1992, with two additional items introduced in 1997. These questions have been retained across survey waves, with only minor wording updates to ensure the terminology remains current. Figure 6.7 presents trends in STI knowledge across survey waves.

Overall, responses reflect sustained investment in STI and HIV education since the 1990s. Most young people correctly identified that condoms protect against HIV, that STIs can be transmitted by someone who appears healthy, and that the contraceptive pill does not protect against HIV, with rates of correct responses remaining high since 1992. However, correct responses to the item assessing whether HIV can be spread through coughing or sneezing have steadily declined. This pattern may reflect a change in emphasis in HIV education and the possibility that educators take it as given that young people understand HIV is not a respiratory illness (something that needed to be directly addressed in 1992 when basic knowledge was limited and fear of HIV was very high).

Knowledge about other STIs has improved substantially over time, including increased awareness that chlamydia can affect people of all genders and that untreated, it can lead to infertility. In contrast, understanding of the persistent, lifelong nature of genital herpes remains comparatively low.

Figure 6.7. Mean percentage of correctly answered STI and HIV knowledge questions across the survey years for year 10 and year 12 students



Note: Data are from year 10 and year 12 students only. Sample sizes by survey year: 1992 (n = 1,741); 1997 (n = 3,550); 2002 (n = 2,387); 2008 (n = 2,913); 2013 (n = 1,517); 2018 (n = 3,935); 2021 (n = 3,187); 2024 (n = 2,381)

*These questions were not asked in 1992.

7. ACCESS TO SEXUAL HEALTH CARE AND STI SCREENING

In this chapter, we examine young people's experiences with the health care system, including their unmet health care needs and the barriers they encounter when seeking information or care.

UNDERSTANDING OF ACCESS TO CARE

Young people were asked a series of questions designed to assess whether they understood how to access clinical services for sexual health (see Table 7.1).

Overall, young people's understanding of how to access services was good, but there were some gaps. Most young people (59%) understood that young people can access free sexual health services. However, 41% is a sizable minority of young people who do not know they can access free services if they need them. A similar number of young people were also unaware that they could get their own Medicare card before 18 (44%), while 68% wrongly believed their parents could access their Medicare records until they turn 18. While needing to ask a parent for their Medicare card or worrying that a parent might see their health care use is not a barrier for all young people, it is likely to be a significant barrier for many young people who need to access sexual health services. As we discuss later in this chapter, fear of parents finding out is a common reason why young people do not seek sexual health care services or STI screening.

Table 7.1. Frequency of correct responses about access to care (n = 4,396)

Access to care scale	Men	Women	Trans people	Overall
There are free sexual health clinics that young people can access without a Medicare card (true)	856 (60%)	1,550 (58%)	167 (54%)	2,573 (59%)
You can ask a doctor for a STI test even if you don't have symptoms (true)	1,250 (88%)	2,386 (89%)	277 (90%)	3,913 (89%)
You need to be 18 to get your own Medicare card (false)	742 (52%)	1,518 (57%)	191 (62%)	2,451 (56%)
Until you turn 18, your parents can access your Medicare records (false)	334 (23%)	951 (36%)	127 (41%)	1,412 (32%)
Mean percentage of correct answers	56%	60%	62%	59%

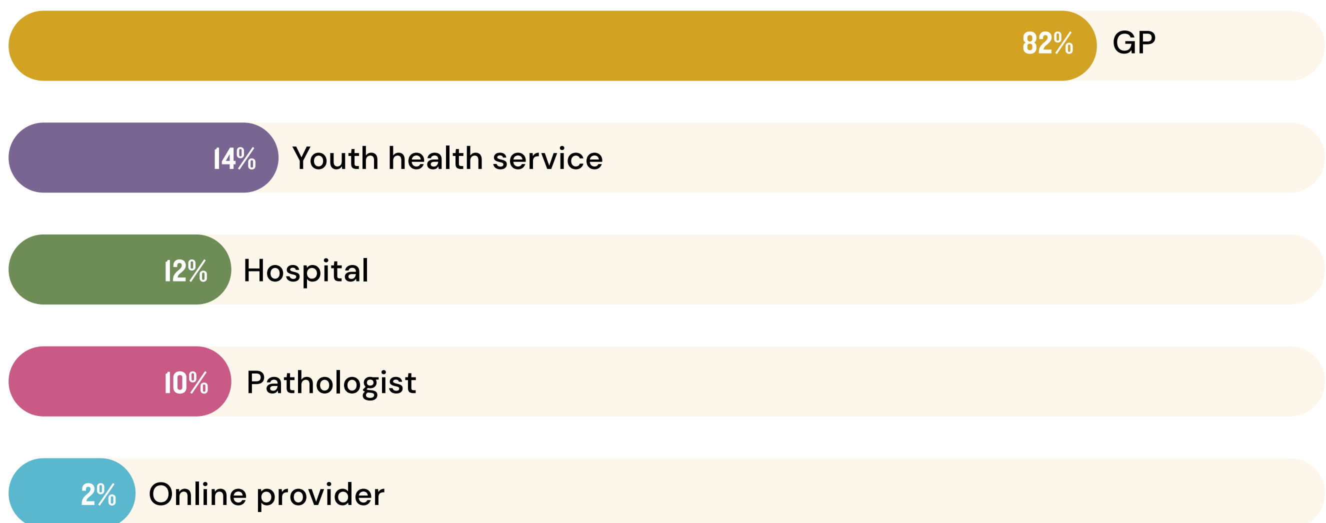
EXPERIENCE WITH STI SCREENING

Twelve per cent of young people (n = 512) reported that they had been screened for STIs.

Compared to young men, young women were more likely to have been screened. Young people living in regional or remote areas were more likely than those in major cities to have been screened. STI screening also increased with age, with 25 young people aged 14 to 15 (3.2%) having screened, 45 16-year-olds (7.3%), 72 17-year-olds (11%), and 370 18-year-olds (16%).[25]

Most young people sought STI screening with a GP (n = 418, 82%), and some young people attended youth health clinics (n = 71, 14%) or hospitals (n = 61, 12%). Figure 7.1 shows the percentage of young people who attended services for STI testing.

Figure 7.1. Percentage of young people who attended services for STI testing (n = 507)

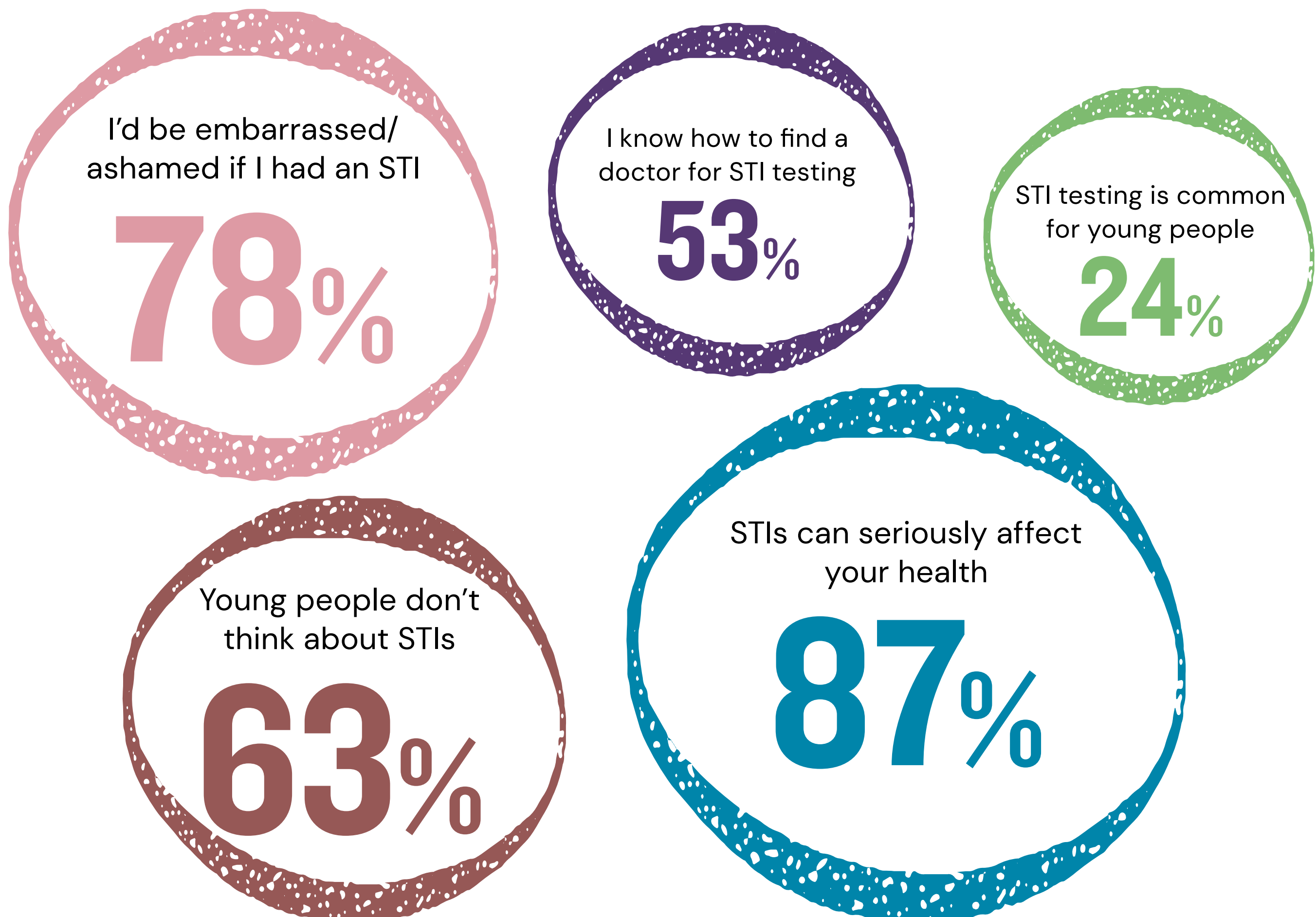


25 Compared to young men, young women (OR 2.09, 95% CI 1.64–2.68) were more likely to have been screened for STIs. Young people living in regional or remote areas were more likely than those in major cities to have been screened (OR 1.43, 95% CI 1.16–1.76). STI testing also increased with age (OR 1.61, 95% CI 1.45–1.78).

ATTITUDES TO STIS AND STI SCREENING

Although most young people believed that STIs could seriously affect their health (n = 3,803, 87%), there was a general sense of stigma and low awareness when it came to STI testing that potentially could be a barrier to screening. Most young people believed that having an STI would be embarrassing or shameful (n = 3,409, 78%), that STI testing was uncommon among young people (n = 3,299, 76%), and that young people do not think about STIs (n = 2,736, 63%). Just over half (n = 2,313, 53%) indicated they knew where to find a doctor for STI testing. Figure 7.2 shows the percentage of young people who agreed or strongly agreed with each statement.

Figure 7.2. Young people's beliefs about STIs (n = 4,380)



Note: The percentages are of young people who agreed or strongly agreed with the statements about STIs.

TALKING TO SEXUAL HEALTH CARE PROVIDERS

This section explores young people's experiences discussing sex and relationships with GPs and other health care providers. Young people were asked a series of questions about their confidence seeking help from GPs and whether they have ever spoken to a GP about sex and relationships.

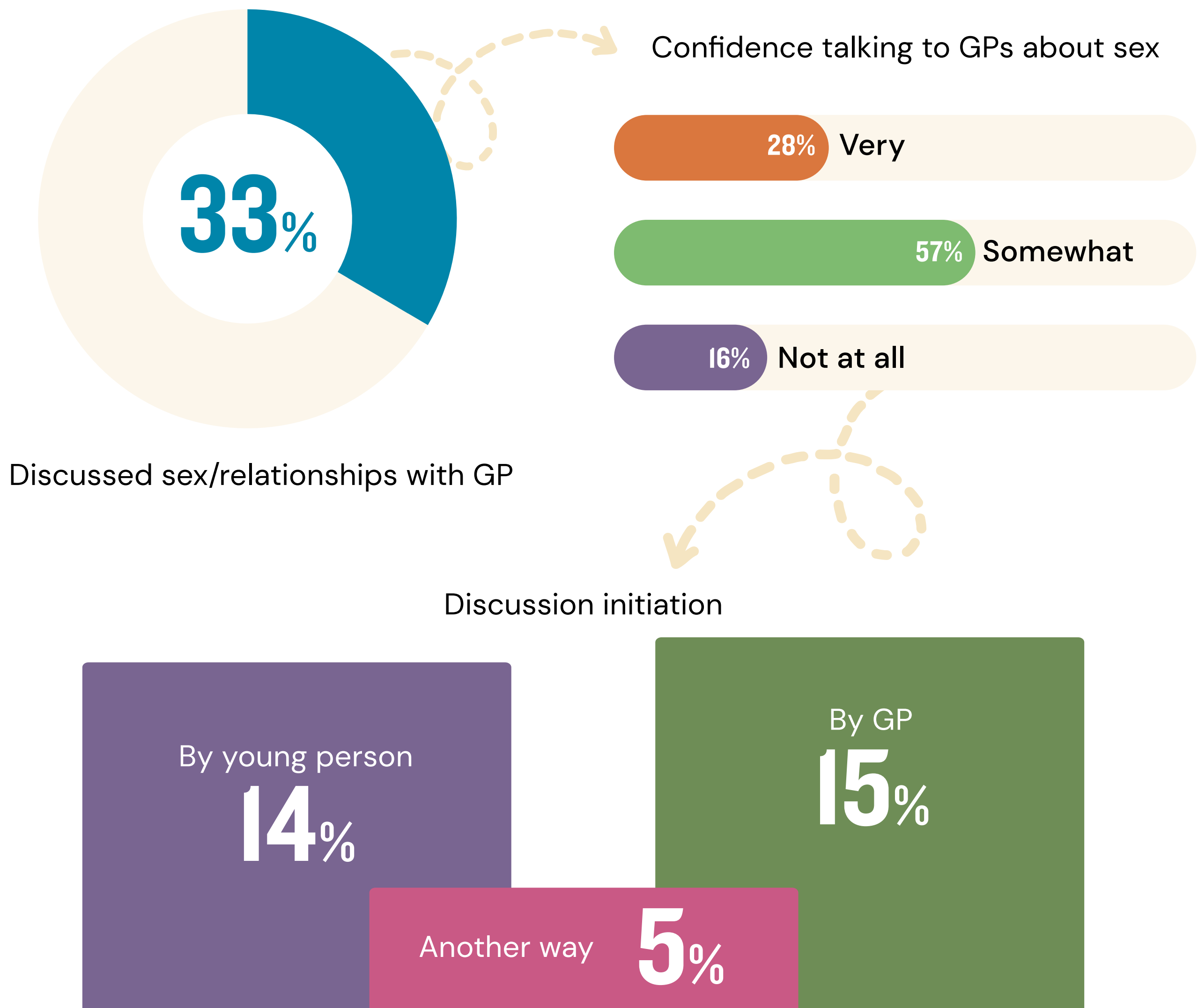
Overall, 1,404 (33%) young people had spoken to a GP or other health care provider about sex or relationships. Most of these conversations were initiated by the young person (n = 712, 17%). A further 15% (n = 648) indicated that their GP initiated the conversation and 5.1% (n = 214) reported that the conversation was initiated some other way, with text responses suggesting that this was mostly about discussing the use of contraception to help with menstrual issues or acne.

Most young people (n = 2,325, 57%) reported they were somewhat confident approaching a GP or other health care provider about sex and relationships and 28% (n = 1,130) reported that they were very confident. There were, however, 16% (n = 645) who said they were not at all confident talking

to a GP about sex and relationships.

When asked who the top three people that they would like to talk to about sex and relationships, 41% (n = 1,733) selected GPs as one of their top three choices. Figure 7.3 illustrates young people's engagement and confidence with GPs.

Figure 7.3. Young people's engagement and confidence speaking to GPs about sex and relationships



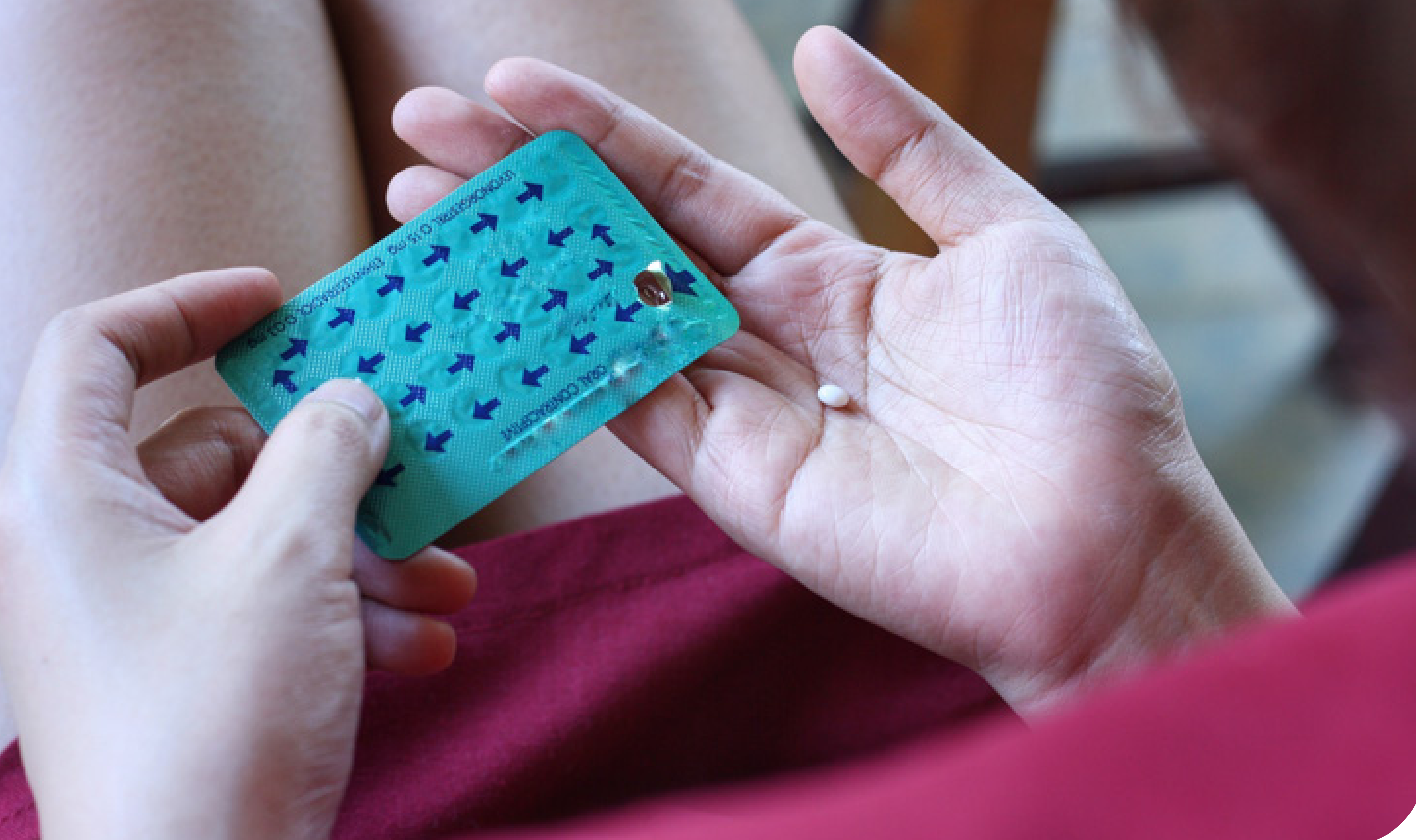
Young people's engagement and confidence with GPs differed across genders. Young women and trans young people were more likely than young men to have talked to GPs about sex and relationships and young women were more likely to have initiated conversations with GPs.[26] There were no differences between genders in confidence talking to GPs.

Young women or trans young people were more likely than men to report that GPs had initiated conversations about sex and relationships with them.[27] Table 7.2 lists young people's engagement and confidence with GPs by gender.

Bisexual young people were more likely than heterosexual young people to have talked to a GP

26 Young people's engagement with GPs differed across genders. Young women (OR 3.29, 95% CI 2.77–3.92) and trans young people (OR 3.15, 95% CI 2.33–4.27) were more likely than young men to have talked to GPs about sex and relationships. Young women were more likely to have initiated conversations with GPs (OR 1.99, 95% CI 1.59–2.51).

27 Young women (OR 2.20, 95% CI 1.77–2.75) and trans young people (OR 2.06, 95% CI 1.42–2.97) were more likely than men to report that GPs initiated conversations about sex and relationships with them.



about sex and relationships and to have initiated the discussion with a GP.[28]

Young people who lived in regional or remote areas were more likely than young people living in major cities to have had discussions with GPs about sex and relationships and to have had GPs initiate these discussions.[29]

Table 7.2. Young people's engagement and confidence with GPs, by gender

GP engagement	Men	Women	Trans people	Overall
Confidence with GPs (n = 4,100)				
Not at all	230 (18%)	367 (15%)	48 (17%)	645 (16%)
Somewhat	711 (54%)	1,461 (59%)	153 (53%)	2,325 (57%)
Very	373 (28%)	668 (27%)	89 (31%)	1,130 (28%)
Ever spoken to a GP about sex and relationships (n = 4,195)	225 (17%)	1,049 (41%)	130 (45%)	1,404 (33%)
Initiated conversation (n = 4,212)	111 (8.1%)	432 (17%)	52 (18%)	595 (14%)
GP initiated conversation (n = 4,195)	118 (8.7%)	472 (19%)	58 (20%)	648 (15%)
Conversation initiated some other way (n = 4,195)	31 (2.3%)	153 (6%)	30 (10%)	214 (5.1%)
GPs as one of top three choices (n = 4,205)	644 (47%)	980 (38%)	109 (38%)	1,733 (41%)

28 Bisexual young people were more likely than heterosexual young people to have talked to a GP about sex and relationships (OR 1.61, 95% CI 1.36–1.90) and to have initiated the discussion with GPs (OR 1.44, 95% CI 1.16–1.79).

29 Young people who lived in regional or remote areas were more likely than young people living in major cities to have had discussions with GPs about sex and relationships (OR 1.56, 95% CI 1.33–1.83), and to have had GPs initiate these discussions (OR 1.46, 95% CI 1.21–1.76).

UNMET SEXUAL HEALTH CARE NEEDS

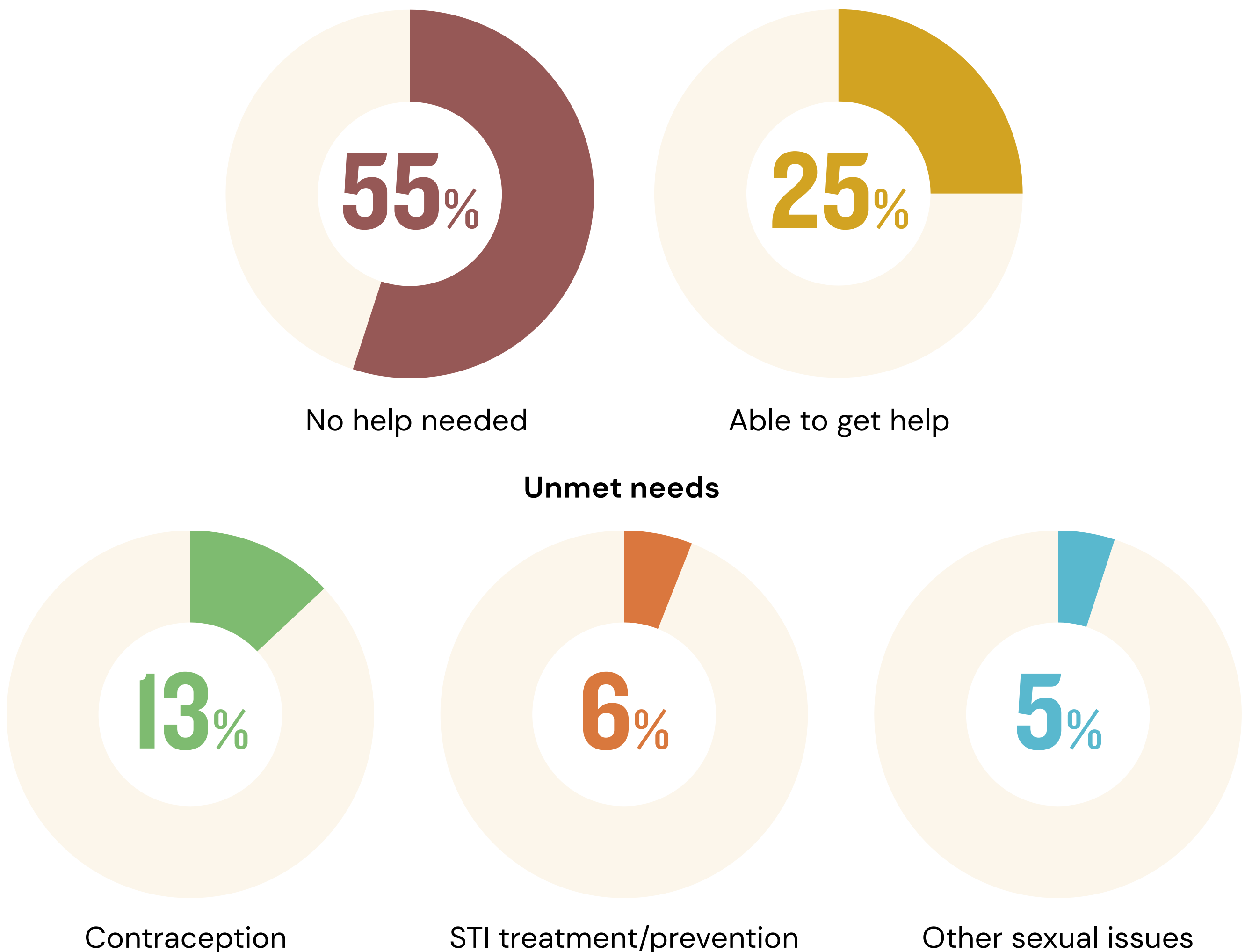
Young people were asked about their unmet sexual health needs by asking if they had ever needed help for sexual issues but were unable to get it (see Figure 7.4).

There were 19% of young people (n = 748) who indicated they had unmet needs. In most cases this was related to being unable to get help with contraception (n = 486, 13%) or STI prevention or treatment (n = 225, 5.8%), while 4.9% (n = 190) indicated that they could not get help for another sexual health issue (see Figure 7.4).

Young women were more likely to report unmet needs than young men, while bisexual young people were more likely to report unmet needs than heterosexual young people.[30]

"THE PREVALENCE OF UNMET SEXUAL HEALTH NEEDS HIGHLIGHTS PERSISTENT GAPS IN ACCESS TO CONTRACEPTION AND STI CARE."

Figure 7.4. Young people's experiences of unmet needs (n = 3,887)



30 Young women (OR 1.94, 95% CI 1.59–2.39) were more likely to report unmet needs than young men, while bisexual young people were more likely to report unmet needs than heterosexual young people (OR 1.38, 95% CI 1.13–1.68).

Table 7.3. Frequency of met and unmet needs, by gender (n = 3,887)

Sexual issues	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Unmet needs				
STI prevention, testing or treatment	67 (5.5%)	133 (5.5%)	25 (9.1%)	**225 (5.8%)**
Contraception	51 (4.2%)	396 (17%)	39 (14%)	**486 (13%)**
Other sexual health issue	52 (4.3%)	113 (4.7%)	25 (9.1%)	**190 (4.9%)**
Total unmet needs	146 (12%)	538 (22%)	64 (23%)	**748 (19%)**
Always got the help needed	312 (26%)	611 (25%)	68 (25%)	**991 (25%)**
Never needed help for sexual health	757 (62%)	1,248 (52%)	143 (52%)	**2,148 (55%)**

Young people who had other unmet needs indicated that these issues included periods and period pain, sexual health and functioning, pain or discomfort, infections, questions about reproductive health, LGBTQI+ health, or issues related to sexual assault. Figure 7.5 lists some of the words young people used to describe the issues they were unable to get help for.

Figure 7.5. Other unmet sexual health needs reported by young people (n = 115)

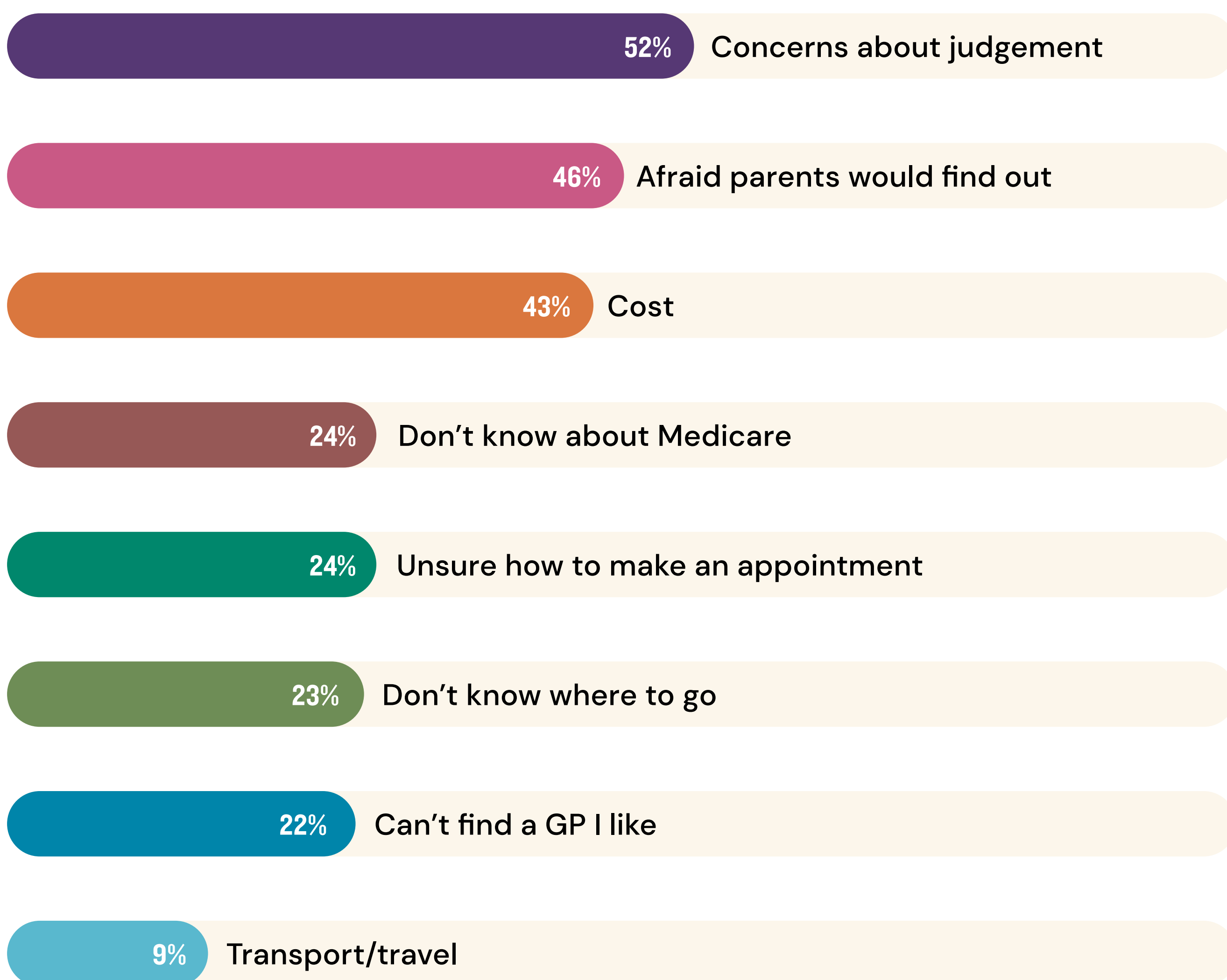
Note: This word cloud visualises the words mentioned most often in the open text responses, with larger words appearing more frequently in young people's responses.

BARRIERS TO SEXUAL HEALTH CARE

Among those who indicated they had unmet sexual health care needs, emotional and social barriers were the most commonly cited reasons for this. These included being afraid that parents would find out (n = 337, 46%), being worried or embarrassed about judgement (n = 385, 52%) and not finding a GP that they felt comfortable with (n = 162, 22%). Embarrassment or fear of judgement was more likely to be a barrier for LGBQ+ young people compared to heterosexual young people.[31]

Young people with unmet needs also reported practical barriers to sexual health care (see Figure 7.6). Almost half of the young people reported that the cost of services was a barrier (n = 314, 43%), either because they did not know how to pay or could not afford it. One in four young people indicated that they did not know how to make an appointment (n = 174, 24%), did not know how to use Medicare (n = 180, 24%), or did not know where to go to seek sexual health care (n = 173, 23%). Fewer (n = 65, 8.8%) reported that travel to health care services was a barrier.

Figure 7.6. Barriers to sexual health care among those with unmet needs (n = 737)



31 Embarrassment or fear of judgement was a more commonly cited barrier to sexual health care for LGBQ+ young people compared to heterosexual young people (OR 1.89, 95% CI 1.38–2.59).

8. DIGITAL SEXUAL EXPERIENCES

Digital technologies are now embedded in many aspects of young people's relationships and sexual experiences in a range of ways. The internet is a key source of information about sexual health and provides opportunities for young people to seek relationship advice or hear stories about other people's experiences (Power, James, et al., 2024). It is also a space where people connect with others sexually or explore sexual interests. We know that online spaces can also be sites of harm, including sexual harassment and image-based sexual abuse. However, to ensure messages about safety and harm minimisation are effective and appropriately targeted, we need to understand these risks in the context of young people's broader online engagement.

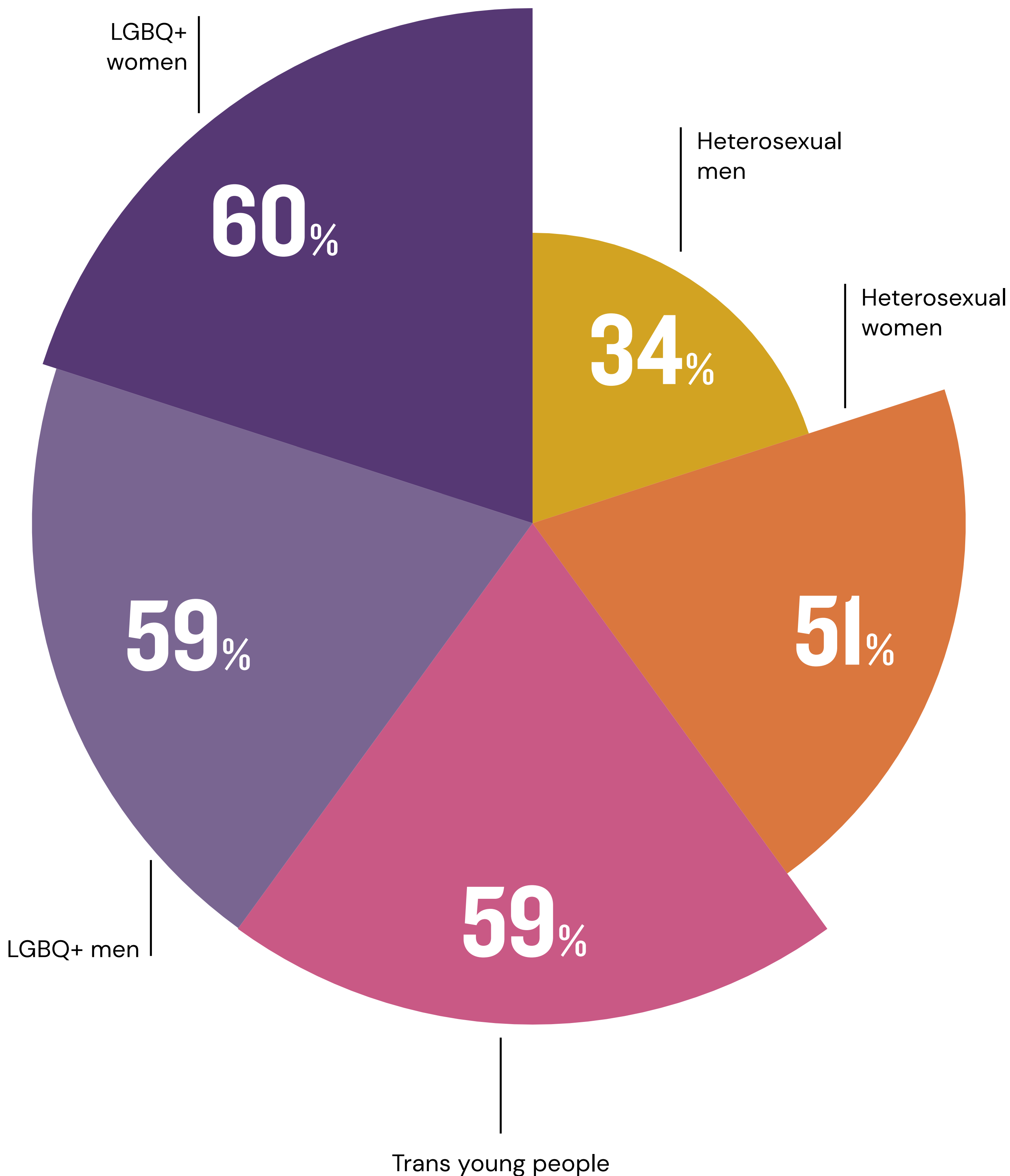
SEXTING

Sexting, defined in the SSASH 8 survey as 'sending or receiving nude photos or sexual images via mobile phone', was common among survey participants, with half (n = 1,977, 50%) reporting that they have shared a sexual image of themselves at least once (see Figure 8.1). Young women were more likely than young men to have shared images of themselves,[32] and bisexual young people were more likely to have sent images than heterosexual young people.[33]

32 Young women were more likely than young men to have shared images of themselves (OR 1.59, 95% CI 1.37–1.84).

33 Bisexual young people were more likely to have sent images than heterosexual young people (OR 2.32, 95% CI 1.95–2.76).

Figure 8.1. **Percentage of young people who sent nude or sexual images of themselves, by gender and sexuality (n = 3,921)**



We asked young people how frequently they send nude or sexual images of themselves to another person and, for most, it was infrequent or not at all.

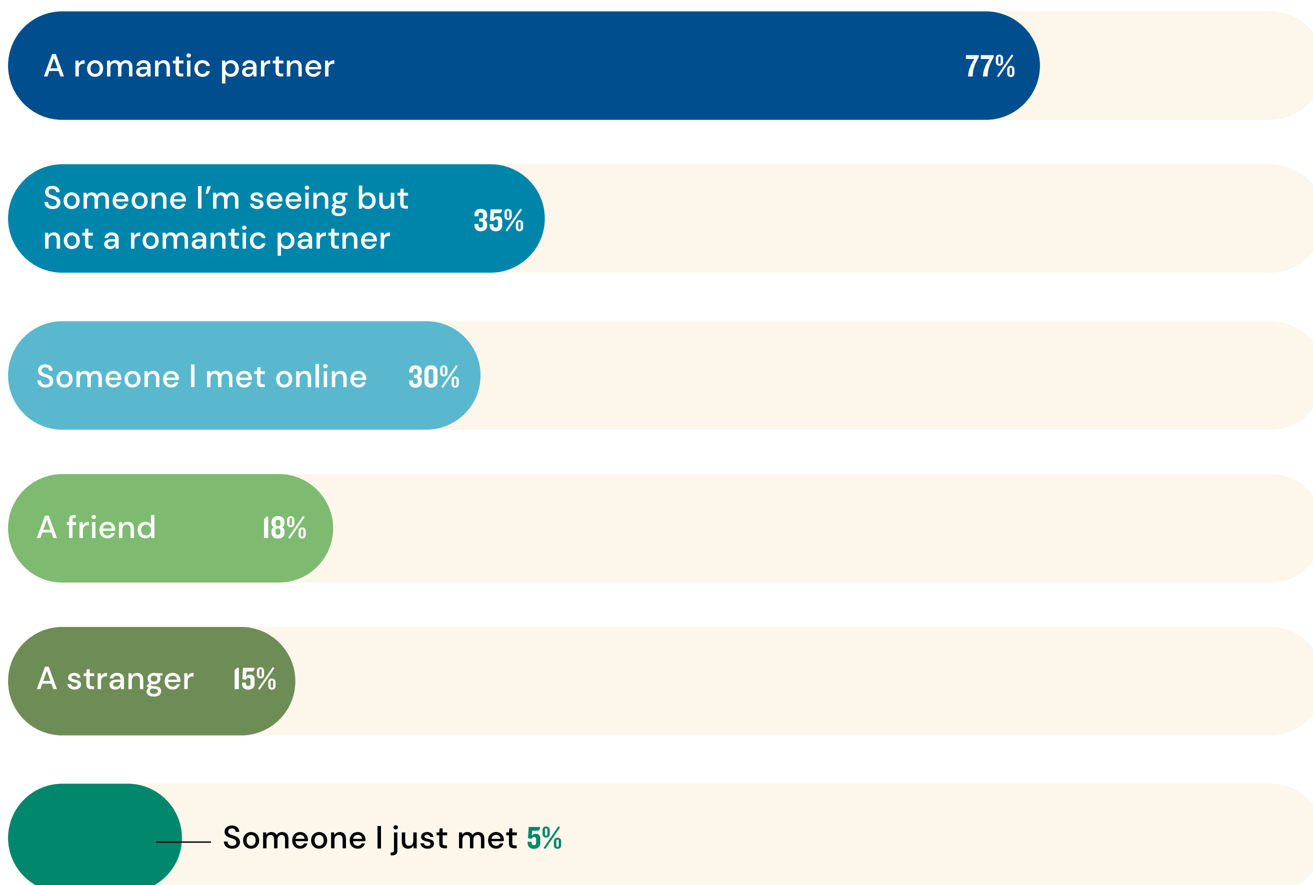
One in five young people (n = 743, 20%) indicated more frequent use, sending images of themselves more than once a month (see Table 8.1).

Table 8.1. **Proportion of participants reporting sending nude or sexual images of themselves in the past 12 months, by gender and sexual orientation (n = 3,838)**

Frequency	Heterosexual women n (%)	LGBQ+ women n (%)	Heterosexual men n (%)	LGBQ+ men n (%)	Trans people n (%)	Overall n (%)
Never	603 (50.8%)	429 (40.6%)	588 (66.8%)	144 (42.2%)	114 (42.1%)	1,878 (50.3%)
Not in the past 12 months	99 (8.3%)	135 (12.8%)	49 (5.6%)	34 (10%)	34 (12.5%)	**351 (9.4%)**
Once or twice	156 (13.1%)	133 (12.6%)	83 (9.4%)	54 (15.8%)	42 (15.5%)	**468 (12.5%)**
Less than once a month	111 (9.3%)	124 (11.7%)	54 (6.1%)	35 (10.3%)	24 (8.9%)	**348 (9.3%)**
One to three times a month	122 (10.3%)	138 (13.1%)	62 (7%)	38 (11.1%)	35 (12.9%)	**395 (10.6%)**
Weekly or more	97 (8.2%)	97 (9.2%)	44 (5%)	36 (10.6%)	22 (8.1%)	**296 (7.9%)**

Of those who had shared nude or sexual images, most had sent these to someone they were in a relationship with (n = 1,503, 77%), or someone they were seeing but not in a relationship with (n = 689, 35%). Figure 8.2 shows whom young people were sharing their nude or sexual images with.

Figure 8.2. **Whom young people shared their nude or sexual images with (n = 1,960)**

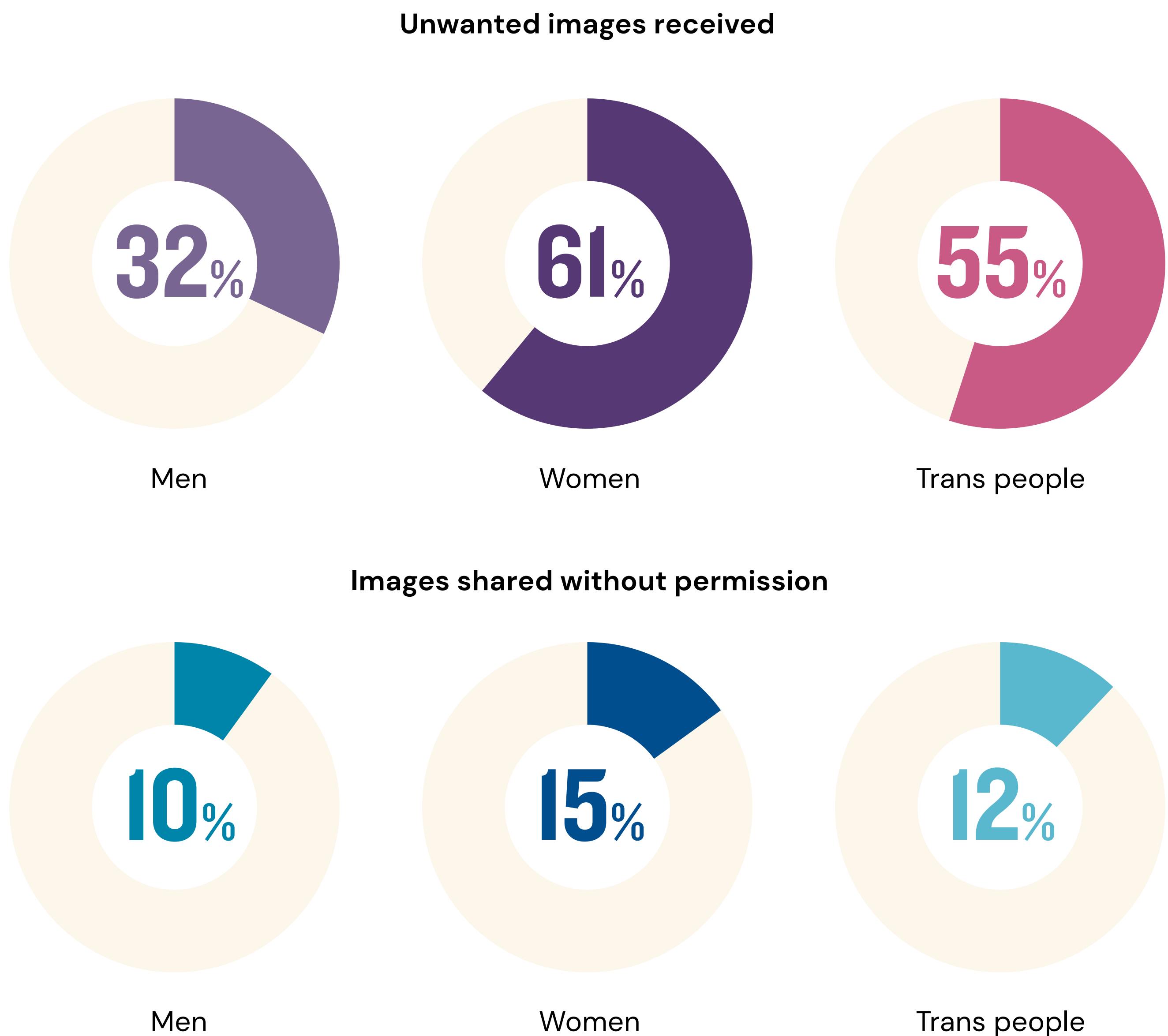


Non-consensual sexting

Many young people had received nude or sexual photos that they did not want or agree to receive (n = 2,020, 51%). One in eight young people (n = 490, 13%) also had nudes or sexual images of themselves shared without their permission. As shown in Figure 8.3, young women and trans young people were more likely than young men to have received unwanted images, and to have had their images shared non-consensually.[34]

To understand attitudes toward image-based abuse, young people were asked whether they believed a woman bears any responsibility if her partner shares a nude image of her without permission. Most young people did not agree with this (n = 3,185, 79%). A minority agreed (n = 541, 13%) or were unsure (n = 289, 7.2%).

Figure 8.3. Young people's experiences of unwanted sharing of sexual images (n = 3,680)



34 Compared to young men, young women (OR 3.23, 95% CI 2.79–3.75) and trans young people (OR 2.12, 95% CI 1.60–2.82) were more likely to have received unwanted sexual images. Women were also more likely than men to have had their sexual images shared without their permission (OR 1.81, 95% CI 1.44–2.29).

ONLINE DATING

Dating apps have become a common way for people to meet partners since their emergence in the early 2010s, and their use has expanded across both younger and older adults. There is limited population-level data on dating app use among people under 18 (e.g. Teunissen et al., 2024). SSASH 8 contributes new information about young people under 18 by including questions on dating app use for the first time. Figure 8.4 highlights some of the online dating practices reported by young people in the survey.Use of dating apps were not common among young people in this survey, with 17% (n = 688) reporting using them. On average, the age at which young people first started using dating apps was 16.7 years (SD = 1.76).

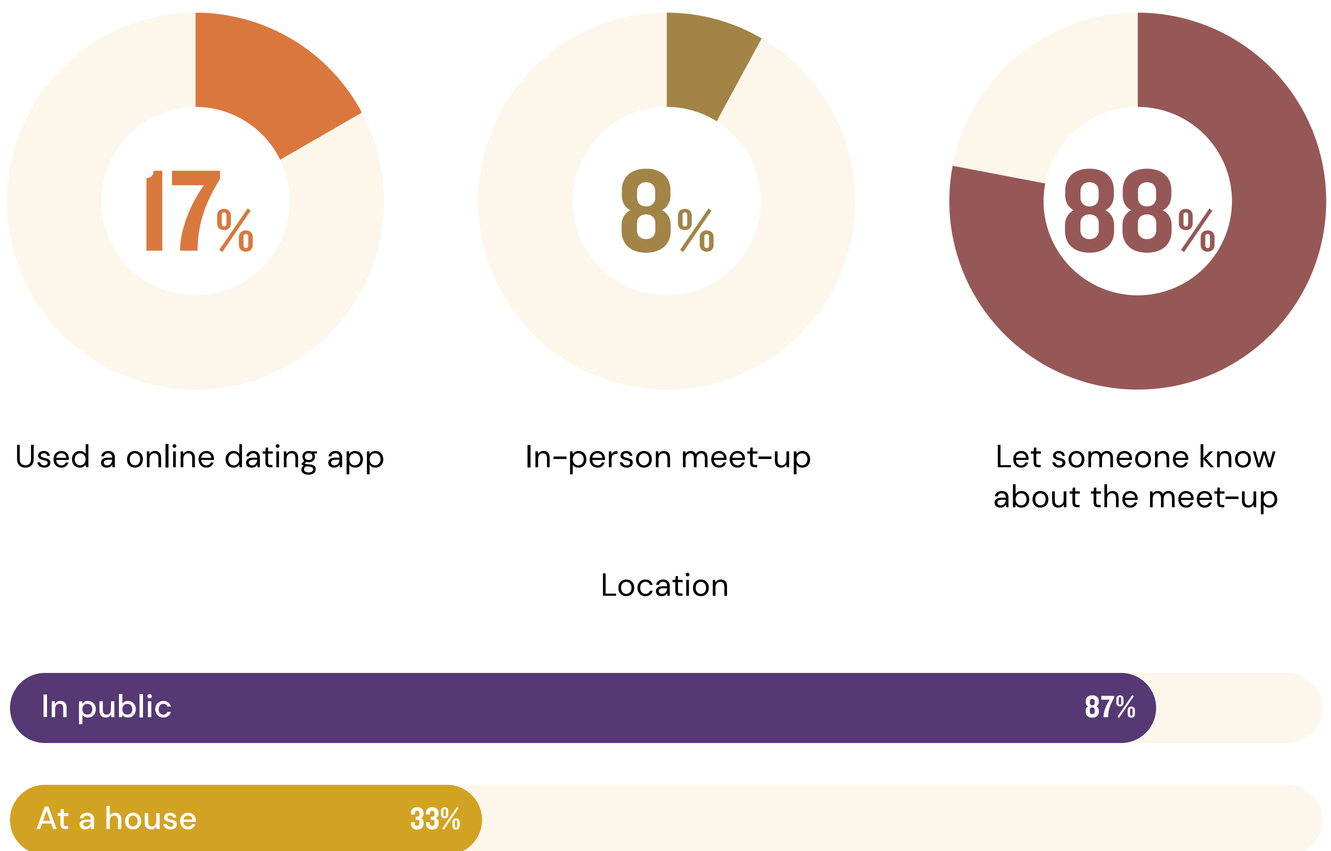
Meeting someone in person after first connecting online through a dating app was even less common, with 8.2% (n = 332) saying they had done this and 4.6% (n = 184) meeting up with someone from an online dating app more than once.

Of the 332 young people who had met someone from a dating app in real life, most met up in a public location (n = 286, 87%): either an open public place such as a park or a beach (n = 208, 63%) or a public building such as a cafe, restaurant or other place with people around (n = 156, 47%). One in three (n = 108, 33%) met up at someone's house, either their own home (n = 56, 17%) or the home of the person they met online (n = 73, 22%).

Most young people had informed someone about the meet-up before meeting in person for the first time (n = 291, 88%). Only 39 (12%) had never told anyone. Forty-six (14%) sometimes told someone. However, most young people told a friend or a sibling (n = 241, 73%) and a quarter told a parent (n = 91, 28%).

LGBQ+ young people were more likely to have used dating apps, and met up with a someone in real life, than heterosexual people.[35]

Figure 8.4. Young people's online dating practices



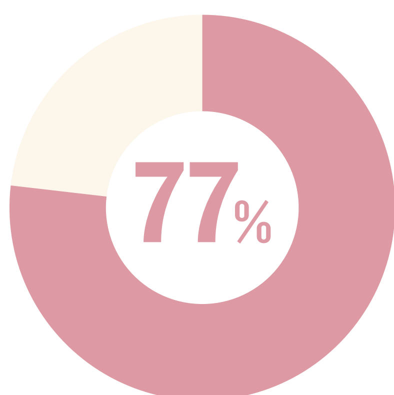
35 Compared to heterosexual young people, gay or lesbian young people (OR 2.23, 95% CI 1.63–3.04) and bisexual young people (OR 1.78, 95% CI 1.45–2.19) were more likely to have ever used dating apps and were also more likely to have then meet up in real life (gay/lesbian: OR 2.08, 95% CI 1.36–3.12; bisexual: OR 1.98, 95% CI 1.51–2.60).

PORNOGRAPHY

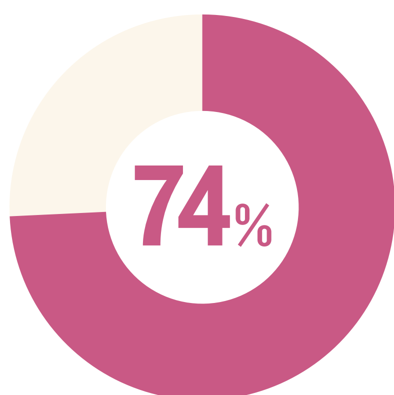
Pornography is widely accessible online, and many young people encounter it both unintentionally and deliberately. Unintentional viewing may occur when young people encounter pornography without actively seeking it out, for example through pop-up advertisements, links shared by peers, or content that appears in social media feeds or group chats. Deliberate viewing, by contrast, involves actively searching for or choosing to watch pornography.

Understanding young people's experiences with pornography is important for interpreting how pornography features in their sexual learning, shapes their expectations, and relates to sexual development and wellbeing. This section examines young people's patterns of engagement with pornography, motivations for viewing, attitudes and concerns. Figure 8.5 shows the percentage of young people who had viewed pornography either intentionally or unintentionally.

Figure 8.5. Percentage of young people who had viewed pornography (n = 3,752)



Unintentional exposure to pornography



Intentional use of pornography

Unintentional exposure to pornography

Three in four young people had accidentally or unintentionally viewed pornography (n = 2,955, 77%; see Figure 8.5). There were no differences by gender. However, LGBQ+ young people were more likely to have unintentionally viewed pornography than heterosexual young people.[36]

The age young people reported that this first occurred was, on average, 11.5 years (SD = 2.8).

Intentional viewing of pornography

The majority of young people (n = 2,815, 74%) indicated they had deliberately sought out pornography at least once. The average age young people reported that they first sought out pornography was 13.0 (SD = 2.5) years.

Young women were less likely to report that they had intentionally viewed pornography than young men, and LGBQ+ young people were more likely to intentionally watch pornography than heterosexual young people.[37]

Young men were more likely to intentionally view pornography at an earlier age than young women.[38]

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36 LGBQ+ young people were more likely to have unintentionally viewed pornography than heterosexual young people (OR 1.81, 95% CI 1.53–2.16). Linear regression analysis revealed no significant differences in the age of first unintentional pornography exposure by gender.

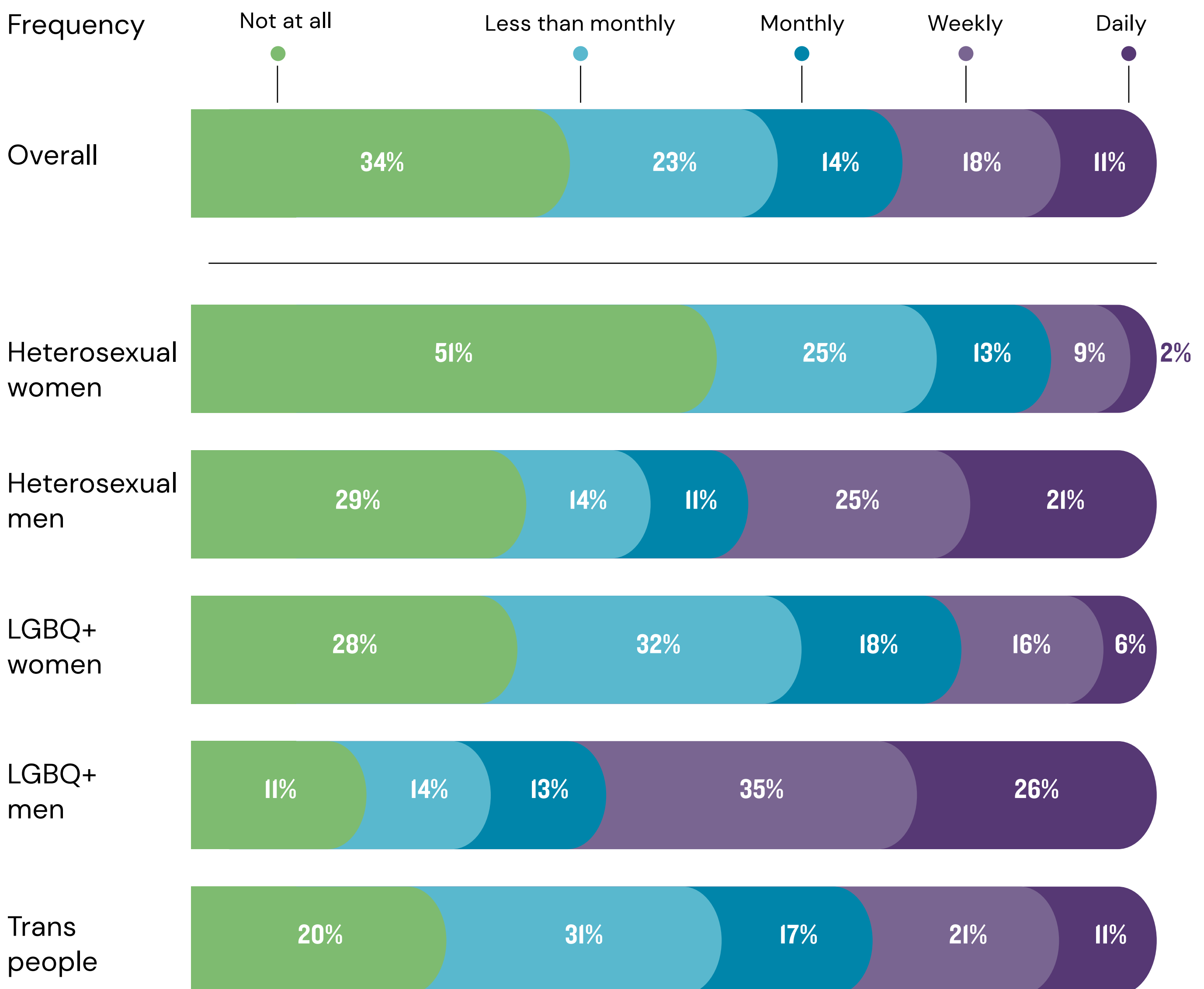
37 Young women (OR 0.40, 95% CI 0.33–0.48) were less likely to have intentionally viewed pornography than young men and LGBQ+ young people were more likely to have intentionally watched pornography than heterosexual young people (OR 3.11, 95% CI 2.59–3.74).

38 A linear regression analysis of intentional pornography viewing revealed that young men were more likely to begin viewing pornography intentionally at a younger age than women (ß -0.70, 95% CI -0.92 to -0.48). There were no differences between sexual orientations.

Frequency of pornography viewing

Overall, most young people intentionally viewed pornography either not at all (n = 1,277, 34%) or less than monthly (n = 881, 23%). Some young people reported more frequent use, with 18% (n = 670) viewing pornography weekly and 11% (n = 408) daily. Figure 8.6 reports frequency of pornography use by gender and sexuality.

Figure 8.6. Percentage of young people who intentionally viewed pornography (n = 3,673)



Young people were more likely to intentionally watch pornography as they got older. For instance, only 24% of 18-year-olds (n = 482) reported no use in the past year compared to 58% of 14-year-olds (n = 144). Weekly or daily use became increasingly common with age, rising from 23% (n = 58) at 14 years of age to 33% (n = 668) at 18 years of age. LGBQ+ young people viewed pornography more frequently than heterosexual young people. Young men intentionally viewed pornography more frequently than young women or trans young people.[39] Table 8.2 lists the frequency of pornography viewing.

39 To examine factors that might influence the frequency of intentionally watching pornography, an ordinal logistic regression was used. Intentional pornography use increased with age (OR 1.32, 95% CI 1.25–1.38). LGBQ+ young people watched pornography more frequently than heterosexual young people (OR 1.98, 95% CI 1.74–2.25). Young men watched pornography more frequently than young women (OR 0.22, 95% CI 0.19–0.26) or trans young people (OR 0.33, 95% CI 0.26–0.43).

“PORNOGRAPHY WAS COMMONLY ENCOUNTERED FROM EARLY ADOLESCENCE WITH YOUNG PEOPLE EXPRESSING MIXED FEELINGS RANGING FROM ENJOYMENT TO DISCOMFORT.”

Table 8.2. Frequency of intentional pornography use, by age group (n = 3,765)

Participant characteristics	Not in the past year n (%)	Less than monthly n (%)	Monthly n (%)	Weekly n (%)	Daily n (%)
Gender and sexual orientation					
Heterosexual women	599 (51%)	287 (25%)	148 (13%)	100 (8.5%)	36 (3.1%)
LGBQ+ women	289 (28%)	330 (32%)	190 (18%)	172 (16%)	66 (6.3%)
Heterosexual men	242 (29%)	115 (14%)	90 (11%)	211 (25%)	177 (21%)
LGBQ+ men	39 (11%)	50 (14%)	45 (13%)	121 (35%)	91 (26%)
Trans people	54 (20%)	85 (31%)	46 (17%)	59 (21%)	31 (11%)
Age groups					
14–15 years	324 (51%)	97 (15%)	61 (9.6%)	93 (15%)	61 (9.6%)
16–17 years	471 (42%)	235 (21%)	153 (14%)	171 (15%)	85 (7.6%)
18 years	482 (24%)	549 (27%)	315 (16%)	406 (20%)	262 (13%)
Total	**1,277 (29%)**	**881 (20%)**	**529 (12%)**	**670 (15.2%)**	**408 (9.3%)**

Attitudes to pornography

Young people who had viewed pornography were asked to rate five statements about pornography from strongly agree to strongly disagree. Many young people agreed or strongly agreed that pornography was enjoyable (n = 1,655, 59%) and there were no differences in gender, with young women equally likely to report enjoying pornography as young men. Many young people also reported that pornography taught them something that they had not learnt elsewhere (n = 1,786, 65%). However, a majority of young people also reported that pornography could make them uncomfortable (n = 2,354, 86%).

A quarter (n = 726, 26%) reported that pornography was hard to stop watching, suggesting that, for some, pornography was compulsive or problematic. Young men were more likely to find it hard to stop watching pornography than young women, and heterosexual young people found it harder to stop watching than those identifying as LGBQ+.[40] The more frequently young people viewed pornography, the more likely they were to agree that pornography is hard to stop watching.[41]

Just over one in four agreed that it was easy to speak with their friends about viewing pornography (n = 730, 27%), while the majority disagreed or were ambivalent about this.

Table 8.3 lists the frequency of agree/strongly agree responses for these questions by gender and sexuality.

Table 8.3. Agreement with statements about pornography among young people, by gender (n = 2,795)

Statements	Heterosexual women n (%)	LGBQ+ women n (%)	Heterosexual men n (%)	LGBQ+ men n (%)	Trans people n (%)	Overall n (%)
Pornography taught me something	450 (65.9%)	544 (62.2%)	418 (66.2%)	218 (68.1%)	156 (65.8%)	1,786 (65.1%)
It's hard to stop watching pornography	133 (19.4%)	150 (17.2%)	283 (45.1%)	106 (33%)	41 (17.2%)	713 (26%)
Watching pornography is enjoyable	358 (52.3%)	472 (54.1%)	415 (66.1%)	241 (76.3%)	143 (60.1%)	1,629 (59.5%)
It's easy to talk to friends about pornography	159 (23.3%)	204 (23.5%)	206 (32.6%)	94 (29.3%)	67 (28.3%)	730 (26.6%)
Pornography makes me feel uncomfortable	573 (83.6%)	780 (89.4%)	500 (79.4%)	284 (88.5%)	217 (91.6%)	2,354 (85.8%)

Note: The percentages are of young people who agreed or strongly agreed with the statements about pornography.

40 Young men were more likely to find it hard to stop watching pornography than young women (OR 1.68, 95% CI 1.36–2.07) as were heterosexual young people compared to those identifying as LGBQ+ (OR 1.51, 95% CI 1.24–1.85).

41 The more frequently young people viewed pornography, the more likely they were to agree that pornography is hard to stop watching (OR 4.58, 95% CI 3.52–6.02).

9. EXPERIENCES OF INTIMATE PARTNER VIOLENCE AND UNWANTED SEX

Unwanted sexual experiences and intimate partner violence remain critical issues for young people. These experiences have lasting impacts on young people's emotional wellbeing and the formation of future relationships. In this chapter we report findings on young people's experience of violence. To protect young people's wellbeing, we did not ask in-depth questions about negative or traumatic experiences, and we assured young people that these questions were optional. Information about support services were made available alongside these questions.

INTIMATE PARTNER VIOLENCE

This section includes the 61% of young people (n = 2,596) who reported they had ever been in a sexual or romantic relationship that lasted for 3 or more months.

Among young people who had ever been in a relationship:

- 37% (n = 957; 23% overall) had ever felt frightened of a partner
- 31% (n = 793; 19% overall) had had experienced technology-facilitated harassment or tracking by a partner
- 44% (n = 1,120; 27% overall) had experienced verbal abuse such as being called names, insulted or shamed
- 18% (n = 459; 11% overall) had experienced physical violence such as being hit, pushed, or grabbed

As can be seen in Table 9.1, young women were more likely than young men to report that they had experienced: fear of a partner, technology-based harassment, or verbal abuse.[42]

Trans young people were also more likely than young men to report that they experienced fear of a partner.[43]

LGBQ+ young people were more likely than heterosexual young people to report that they had experienced fear of a partner or verbal abuse.[44]

42 Compared to young men, young women were more likely to report that they had experienced: being frightened of a partner (OR 2.05, 95% CI 1.68–2.51), technology-based harassment (OR 1.42, 95% CI 1.16–1.74) or verbal abuse (OR 1.47, 95% CI 1.22–1.77)

43 Trans young people were more likely to reporting having felt frightened of someone they were in a relationship with (OR 1.28, 95% CI 0.93–1.76).

44 LGBQ+ young people were more likely to have been frightened of a partner (OR 1.83, 95% CI 1.53–2.18) or to have experienced verbal abuse than heterosexual young people (OR 1.45, 95% CI 1.22–1.72).

Table 9.1. Young people's experiences with intimate partner violence, by gender (n = 2,566)

Types of intimate partner violence	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Verbal abuse	254 (36%)	757 (47%)	109 (48%)	**1,120 (44%)**
Frightened of partner	171 (24%)	678 (42%)	108 (48%)	**957 (37%)**
Technology-based harassment	177 (25%)	536 (33%)	80 (35%)	**793 (31%)**
Physical abuse	109 (15%)	316 (19%)	34 (15%)	**459 (18%)**

We measured whether young people had experienced sexual assault from a partner by asking: 'Has someone you were in a relationship with ever forced you to have sex or perform sexual acts by restraining you or through physical violence?' Two per cent (n = 62, 2.6%) said yes. Young women were more likely to have experienced sexual assault from a partner than young men.[45]

SSASH 8 is not a population-based sample and so we cannot assume these findings are representative of the Australian population of young people. However, these figures are similar to Australian population-based studies of young people. Findings from the Longitudinal Study of Australian Children (LSAC) showed that, in 2018, 29% of 18–19-year-olds had experienced at least one form of intimate partner violence in the 12 months prior to the survey: 25% had experienced emotional abuse, 12% had experienced physical violence and 8% had experienced sexual abuse (O'Donnell et al., 2023). The Australian Child Maltreatment Study found that, among participants aged 16–24 who had 'ever' been in a relationship: 44% had experienced psychological violence, 25% had experienced physical violence and 18% had experienced sexual violence (Mathews et al., 2025).

EXPERIENCES OF UNWANTED SEX

Young people were asked about their experiences of unwanted sex by asking: 'Have you ever experienced sex, including oral sex, when you did not want to (i.e. sex that you did not want or desire regardless of whether you agreed to it or not)?' This question was designed to include experiences where someone felt pressured or felt like saying no would have negative consequences, as well as experiences that were forced or coerced. When responding to questions about unwanted sexual experiences, young people were given full control over their level

45 Young women were more likely to have experienced sexual assault by a partner than young men (OR 4.82, 95% CI 2.16–13.2).

of participation to minimise distress. Young people were provided with options allowing them to skip individual questions or the entire section. This approach was taken to prioritise participant wellbeing and to recognise that these topics can be sensitive or emotionally challenging. Because of this, some missing data are expected.

One in five young people (n = 872, 21%) had experienced sex that they did not want. While 9.1% of young men (n = 125) reported these experiences, trans young people (28%, n = 80) and young women (27%, n = 667) were significantly more likely to report unwanted sexual experiences.[46]

To better understand the situations in which young people felt unable to say no to sex, we asked about the contexts in which their unwanted sexual experiences had occurred. Young people were asked whether they had ever had unwanted sex because of the following reasons:

- to avoid upsetting their partner (n = 554, 13%)
- to avoid hurting someone's feelings (n = 516, 12%)
- someone kept asking after being told no/felt hassled (n = 485, 12%)
- being too intoxicated to consent (n = 264, 6.4%)
- fear of rejection from their partner (n = 219, 5.3%)
- being physically forced 5.8% (n = 240)
- being threatened 2.4% (n = 98)

Young women were significantly more likely than young men to report unwanted sex due to physical force, persistent pressure, to avoid hurting a partner's feelings, due to fear of rejection, because they were too drunk or high to consent, and due to peer pressure from friends.[47]

Compared to young men, trans young people were also more likely to have experienced physical force or have unwanted sex due to persistent pressure, or to avoid hurting a partner's feelings.[48]

Table 9.2. The context in which unwanted sex occurred, by gender (n = 4,136)

Context	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
To avoid upsetting partner	68 (5%)	432 (17%)	54 (19%)	**554 (13%)**
To avoid hurting partner's feelings	64 (4.7%)	402 (16%)	50 (18%)	**516 (12%)**
Hassled	48 (3.5%)	393 (16%)	44 (15%)	**485 (12%)**
Intoxicated	27 (2%)	224 (9%)	13 (4.6%)	**264 (6.4%)**
Forced	22 (1.6%)	196 (7.9%)	22 (7.7%)	**240 (5.8%)**
To avoid rejection	25 (1.8%)	171 (6.9%)	23 (8.1%)	**219 (5.3%)**
Threatened	17 (1.3%)	70 (2.8%)	11 (3.9%)	**98 (2.4%)**
Peer pressure from friends	10 (0.7%)	81 (3.2%)	5 (1.8%)	**96 (2.3%)**
Promised something in return	19 (1.4%)	56 (2.2%)	13 (4.6%)	**88 (2.1%)**

46 Young women (OR 3.21, 95% CI 2.60–3.98) and trans young people (OR 2.74, 95% CI 1.93–3.87) were more likely to have reported unwanted sexual experiences than young men.

47 Young women were significantly more likely than young men to report unwanted sex due to: physical force (OR 4.61, 95% CI 2.99–7.48), persistent pressure (OR 4.39, 95% CI 3.25–6.06), avoiding hurting a partner's feelings (OR 3.28, 95% CI 2.50–4.37), fear of rejection (OR 3.27, 95% CI 2.18–5.14), being too drunk or high to consent (OR 4.02, 95% CI 2.72–6.17), having sex to keep the peace (OR 3.38, 95% CI 2.59–4.46), and peer-pressure from friends (OR 3.86, 95% CI 2.10–7.88).

48 Compared to young men, trans young people were more likely to report unwanted sex due to physical force (OR 3.93, 95% CI 2.08–7.45), persistent pressure (OR 3.67, 95% CI 2.33–5.79), avoiding hurting a partner's feelings (OR 2.80, 95% CI 1.83–4.28), and having sex to keep the peace (OR 2.87, 95% CI 1.90–4.34).

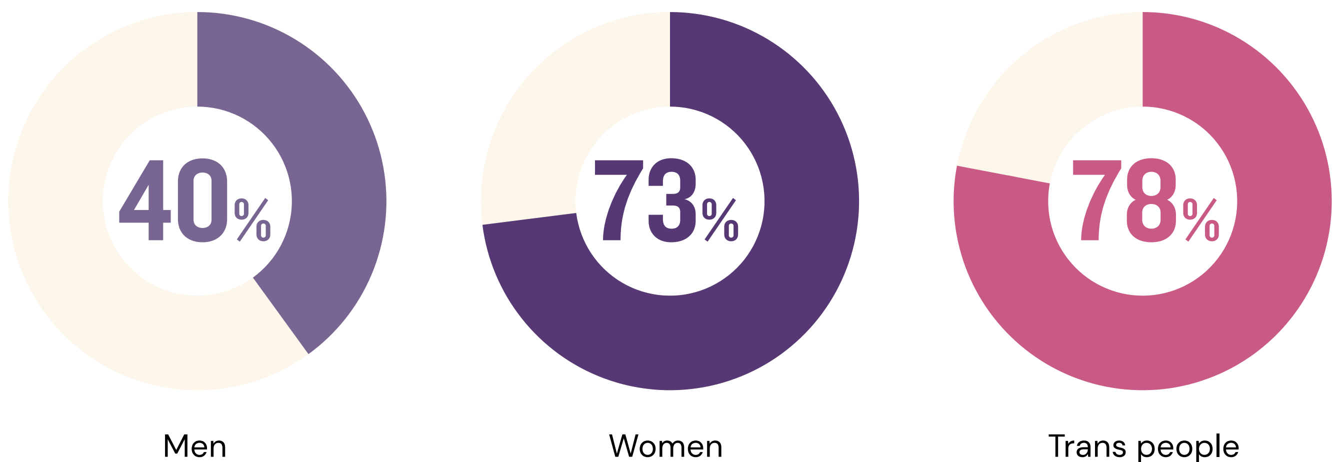
SEEKING HELP FOR UNWANTED SEXUAL EXPERIENCES

Young people who had experienced unwanted sex were asked if they had ever spoken to someone about their experience. By this stage in the survey, 540 had elected to skip the questions about unwanted sexual experiences and 12 skipped this question. Of the 315, who answered the question, 69% (n = 216) had talked to someone about their experiences, which is 25% of all young people who reported experiencing unwanted sex.

Talking to someone about unwanted sexual experiences was more common for young women and trans young people than young men, with 73% of women (n = 176) and 78% of trans young people (n = 21) reporting that they sought help compared to 40% of young men (n = 19; see Figure 9.1).

Written responses indicated that young people spoke to a variety of people about their experiences including friends, family, doctors, therapists, parents, partners, police and schools.

Figure 9.1. Young people who talked to someone about their unwanted sexual experience, by gender (n = 315)



"MOST YOUNG PEOPLE WERE CONFIDENT ABOUT SAYING 'NO' TO SEX, YET MANY WORRIED ABOUT MISREADING CUES."

CONFIDENCE TO SAY NO TO SEX

Most young people felt confident that they could say 'no' to sexual partners if they did not want to have sex (n = 3,043, 76%) and would let their partner know when they wanted to have sex (n = 1,363, 70%). Compared to young men, young women were less likely to feel confident that they could say 'no' to a sexual partner when they did not want to have sex. Young people became more confident saying 'no' to sexual partners as they got older and were more likely to feel confident letting their partner know when they wanted to have sex.[49]

Table 9.3 presents young people's agreement with these statements by gender.

49 Compared to young men, young women (OR 0.75, 95% CI 0.63–0.89) were less likely to feel confident that they could say 'no' to a sexual partner when they did not want to have sex. Young people became more confident saying 'no' to sexual partners as they got older (OR 1.17, 95% CI 1.11–1.24) and were more likely to let their partner know when they wanted to have sex (OR 1.19, 95% CI 1.08–1.30).

Table 9.3. Young people's beliefs about consent, by gender

Belief statements	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
I feel confident I could say no to sexual partners (n = 4,023)	1,034 (79%)	1,808 (74%)	201 (72%)	**3,043 (76%)**
I let my partner know when I want to have sex* (n = 1,961)	368 (69%)	897 (70%)	98 (70%)	**1,363 (70%)**
I worry that I might misread signals (n = 4,030)	622 (48%)	865 (35%)	157 (56%)	**1,644 (41%)**

Note: The percentages are of young people who agreed or strongly agreed with each statements.
* Only sexually active young people were shown these statements.

WORRIES ABOUT NON-VERBAL CUES

Open text responses in the SSASH 7 (Power et al., 2022) survey indicated that some young people worried that they would misread their partner's body language or non-verbal cues relating to sexual consent. To see if this was a broader experience, in SSASH 8, we directly asked young people if they worried about this. Less than half (n = 1,644, 41%) indicated they worried about misreading signals or cues and think that someone wants to have sex when they do not. Young men and trans young people were more likely to worry about misreading signals than young women.[50] LGBQ+ young people were more likely to worry about misreading signals than heterosexual young people.[51]

50 Young men (OR 1.82, 95% CI 1.58–2.10) and trans young people (OR 1.79, 95% CI 1.38–2.33) were more likely than young women to worry about misreading signals and think someone wants to have sex with them when they do not. LGBQ+ young people were more likely to worry about misreading signals than heterosexual young people (OR 1.53, 95% CI 1.33–1.76).

51 OR 1.53, 95% CI 1.33–1.76.

10. COMMUNICATION ABOUT SEX AND RELATIONSHIPS

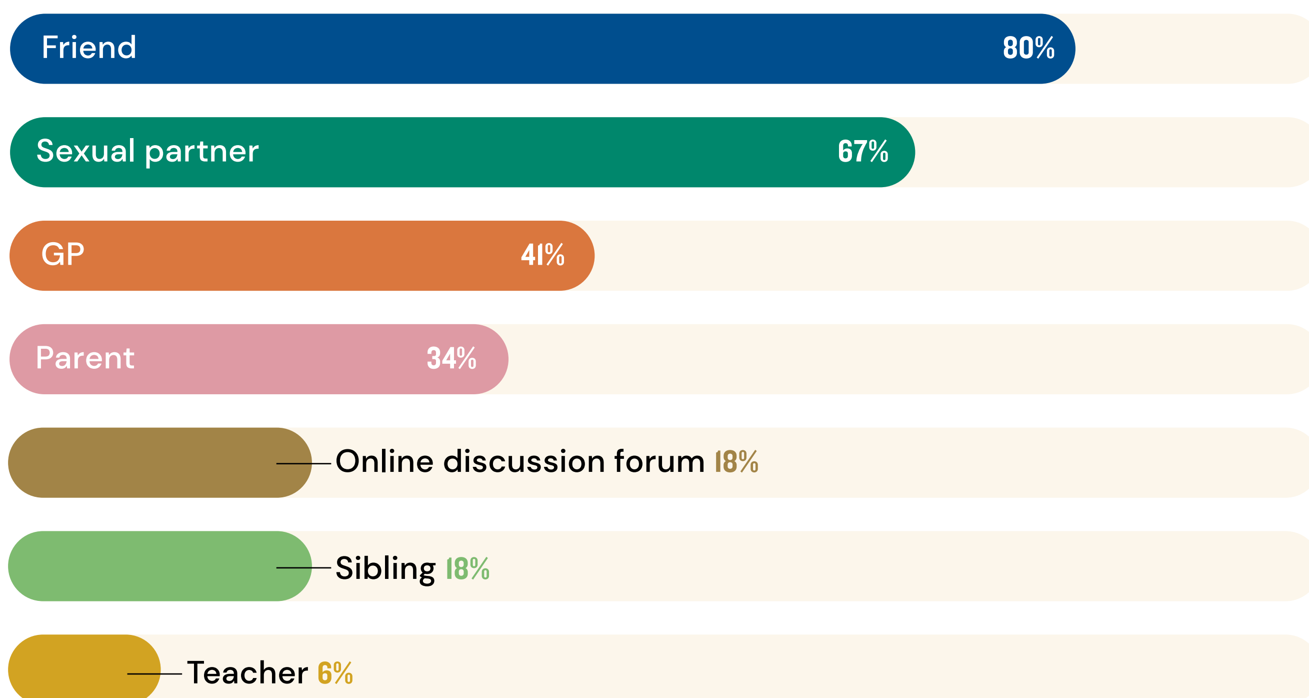
In this chapter we report findings from a series of questions we asked young people about their confidence, and willingness, to have conversations about sex and relationships with significant people in their lives, including their friends, parents and GPs. Opportunities to speak about sex and relationships, and seek help and advice when needed, are important for sexual health development and for young people to learn about themselves and make sense of their early sexual experiences. However, talking about sex can be uncomfortable and it sometimes discouraged, and many barriers prevent young people from having open conversations about sex and relationships with their parents or other significant adults (Power et al., 2025). Here we look more closely at the conversations young people have with adults about sex and relationships.

We also look at young people's communication with their sexual partners about safety and enjoyment. Even among sexual partners, talking about sex can be awkward or difficult. Here we report on whether young people feel confident speaking with their sexual partners about sex and the topics most commonly spoken about.

WHOM DO YOUNG PEOPLE SPEAK TO ABOUT SEX AND RELATIONSHIPS?

We asked young people, 'Who are the top three people you'd talk to about sex or relationships?' Friends (n = 3,385, 80%) were the most commonly cited person, followed by sexual partners (n = 2,806, 67%), GPs (n = 1,733, 41%) and parents (n = 1,419, 34%), see Figure 10.1.

Figure 10.1. Whom young people would like to talk to about sex and relationships (n = 4,205)



When asked whom young people had approached or initiated conversations with about sex and relationships, experiences varied between sexually active and non-sexually active participants (see Figure 10.2).

Sexually active young people were much more likely to talk to someone about sex and relationships than non–sexually active young people. Compared to men, women and trans young people were more likely to talk to someone about sex and relationships. LGBQ+ young people were more likely than heterosexual young people to talk to someone about sex and relationships. Young people were more likely to talk to someone as they got older.[52]

Most sexually active young people had initiated conversations about sex and relationships with their friends (n = 1,598, 76%) or a sexual partner (n = 1,465, 70%). Sexually active young people also commonly approached a parent (n = 660, 32%) or a GP or doctor (n = 512, 24%) to talk about sex and relationships. Only 6.2% of sexually active young people (n = 130) reported that they had never talked to anyone about sex and relationships.

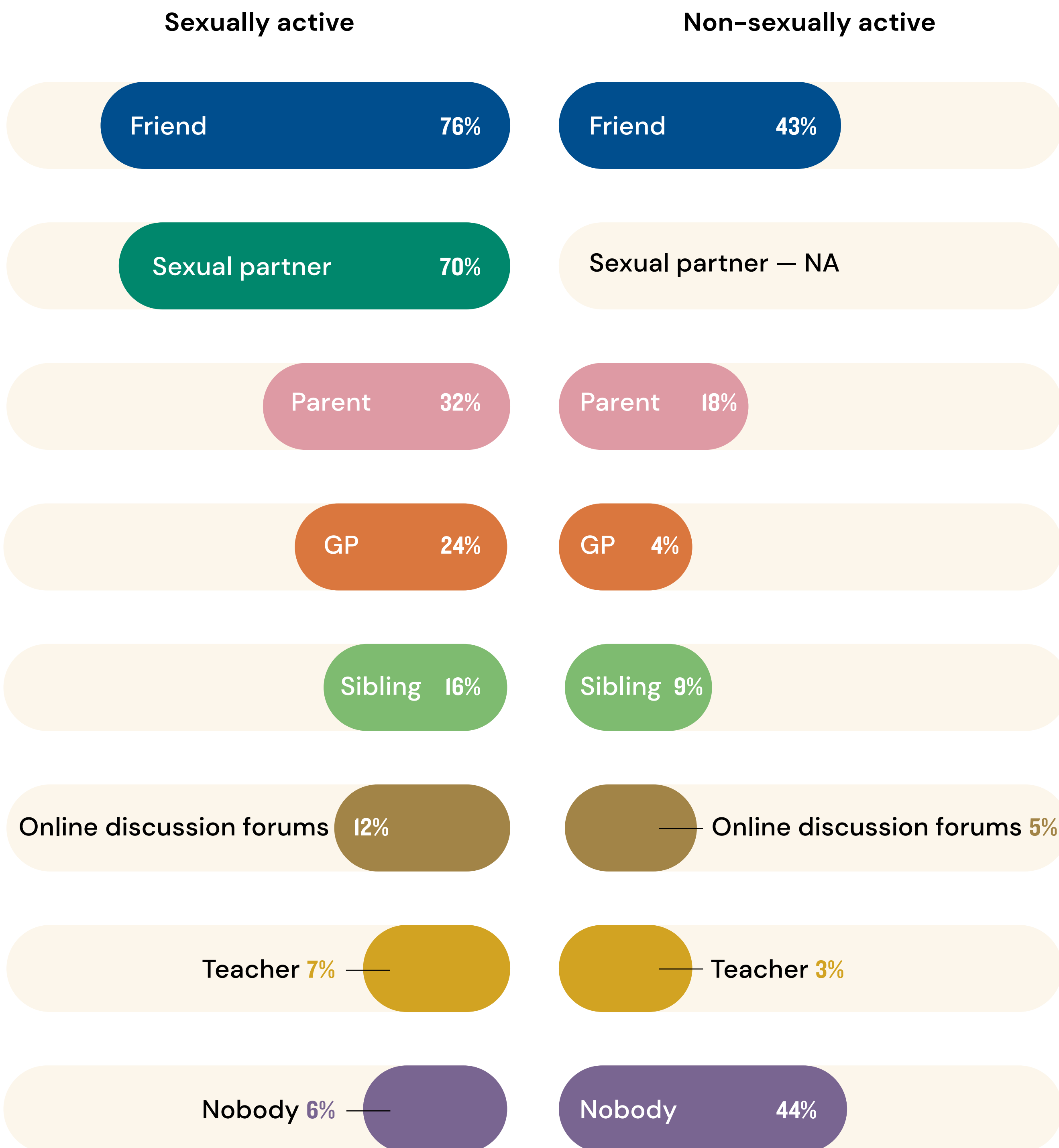
In comparison, many non–sexually active young people reported that they never initiated a

52 Sexually active young people were much more likely to talk to someone about sex and relationships than non–sexually active young people (OR 9.48, 95% CI 7.73–11.7). Compared to young men, young women (OR 1.85, 95% CI 1.56–2.20) and trans young people (OR 2.20, 95% CI 1.49–3.32) were more likely to talk to someone about sex and relationships. Compared to heterosexual young people, LGBQ+ young people were more likely to talk to someone about sex and relationships (OR 1.85, 95% CI 1.56–2.20). Young people were more likely to talk to someone as they got older (OR 1.21, 95% CI 1.14–1.28).

conversation about sex and relationships (n = 928, 44%). If they did initiate a conversation about sex and relationships, it was usually with friends (n = 914, 43%) and a small number (n = 382, 18%) had approached a parent.

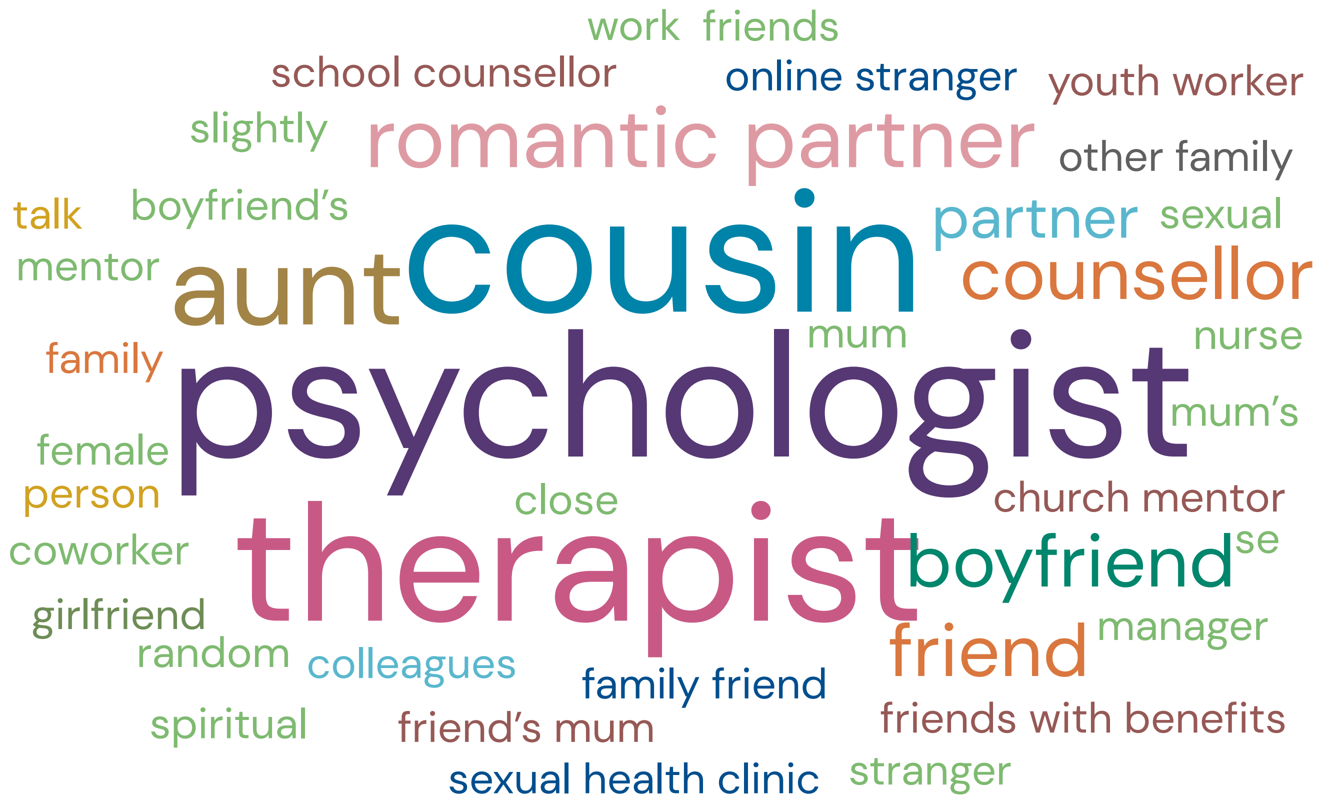
Discussing sex and relationships online in discussion forums was uncommon, both for sexually active young people (n = 243, 12%) and non–sexually active (n = 116, 5.5%) young people. Approaching school staff was also rare (sexually active: n = 144, 6.9%; non–sexually active: n = 64, 3%).

Figure 10.2. Whom sexually active and non–sexually active young people approach to talk about sex and relationships (n = 4,212)



We provided an open text box so young people could tell us if there were other people in their lives with whom they spoke to about sex and relationships. There were 84 young people who responded to this question. Answers included: other family members (e.g. aunt, cousin); professional sources such as psychologists, counsellors, therapists and youth workers; church or spiritual advisors; and strangers met online (see Figure 10.3).

Figure 10.3. Other people whom young people would talk to about sex and relationships (n = 84)

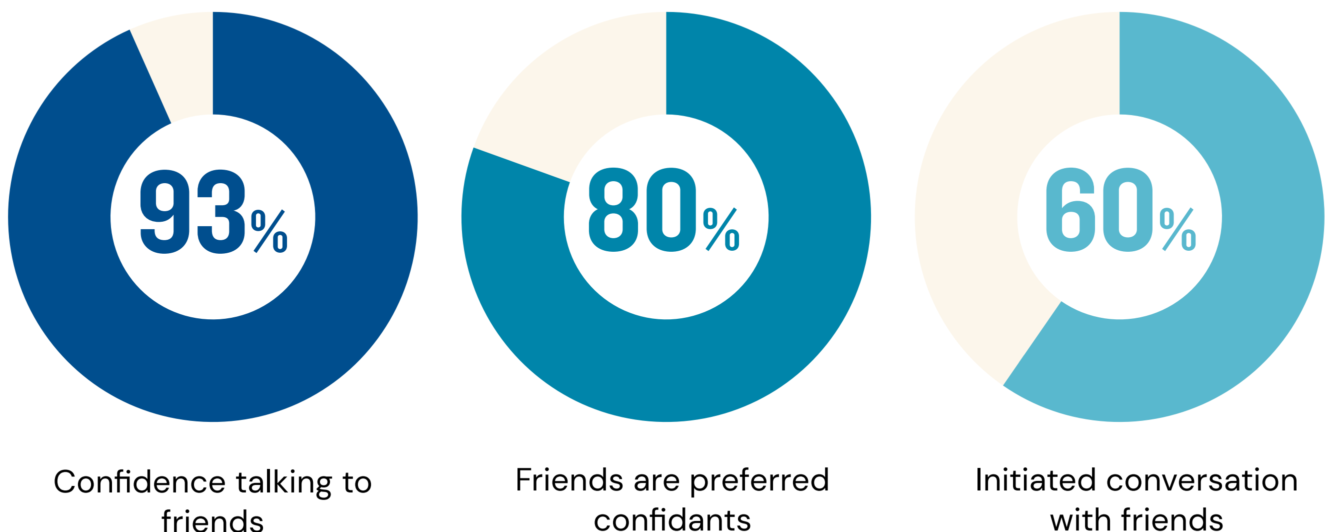


Note: This word cloud visualises the words mentioned most often in the open text responses, with larger words appearing more frequently in young people's responses.

TALKING ABOUT SEX AND RELATIONSHIPS WITH FRIENDS

Among potential sources of information and support, young people most often turned to their friends to discuss sex and relationships (see Figure 10.2). As shown in Figure 10.4, young people generally felt comfortable talking to their friends. Most young people in this survey had initiated conversations with their friends about sex and relationships (n = 2,512, 60%). Friends were also the top choice of someone to talk to about sex and relationships (n = 3,385, 80%). Confidence talking to friends about sex and relationships was high; 60% (n = 2,513) reported feeling 'very' confident talking to friends and 33% (n = 1,396) reported feeling somewhat confident.

Figure 10.4. Young people's engagement with friends about sex and relationships (n = 4,188)



Confidence talking to friends

Friends are preferred confidants

Initiated conversation with friends

Young men were significantly less likely than young women to feel 'very' confident talking to friends about sex and relationships, and were less likely to have initiated conversations about these issues. LGBQ+ young people were more likely than heterosexual young people to have initiated conversations with friends.[53]

TALKING TO PARENTS ABOUT SEX AND RELATIONSHIPS

Young people's reports of support from parents and confidence and communication about sex and relationships with parents are presented in Figure 10.5. Most young people (n = 3,470, 79%) felt that their parents were supportive in everyday life and 48% (n = 2,088) said they could discuss most things that were important to them with a parent, while 44% (n = 1,922) said that they could only discuss some things with a parent.

When it came to talking to parents about sex and relationships, 25% of young people (n = 1,042) reported they had initiated conversations with a parent about sex and relationships, and 34% (n = 1,419) indicated they would choose to speak to a parent about these issues.

Most young people (n = 2,807, 69%) reported that they were somewhat or very confident talking to a parent about sex and relationships. Young people were more likely to be confident talking to their mother about these issues than their father: 64% (n = 2,633) felt 'somewhat' or 'very' confident talking to mothers, while 36% (n = 1,433) felt 'somewhat' or 'very' confident speaking with fathers.

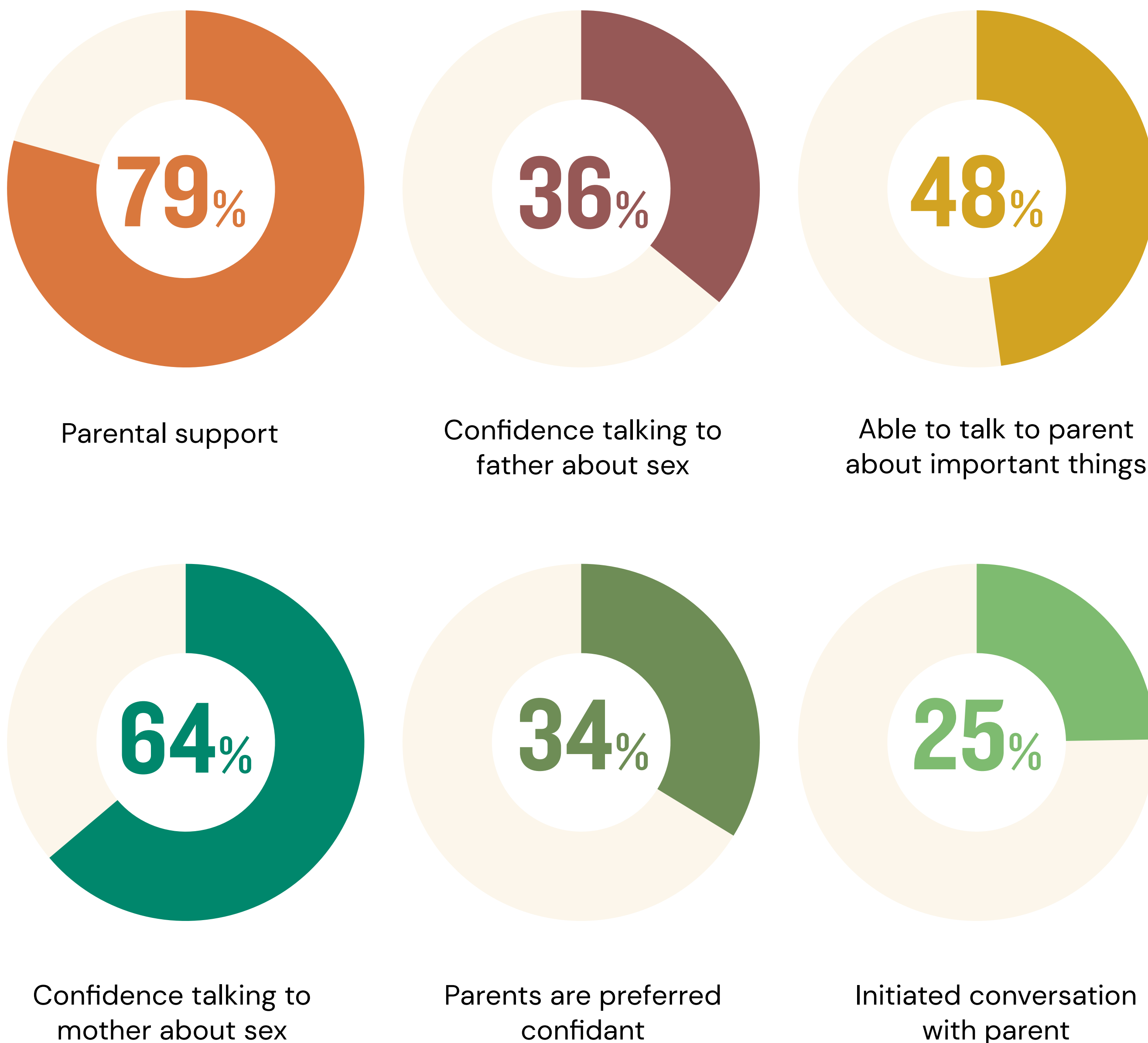
Young men were less confident talking about sex and relationships to both fathers and mothers and were also less likely than young women to have initiated conversations with parents (see Table 10.1).[54]

53 Compared to young women, young men were significantly less likely to feel 'very' confident talking to friends (OR 0.54, 95% CI 0.47–0.62) and less likely to have initiated conversations with friends (OR 0.48, 95% CI 0.41_0.55). Compared to heterosexual young people, LGBQ+ young people were more likely to have initiated conversations with friends (OR 1.76, 95% CI 1.51–2.04).

54 Compared to young women, young men were less confident talking about sex and relationships to both fathers (OR 0.62, 95% CI 0.54, 0.72) and mothers (OR 0.62, 95% CI 0.52, 0.74). Young men were also less likely than young women to have initiated conversations with parents (OR 0.66, 95% CI 0.56, 0.78).

Compared to heterosexual young people, LGBQ+ young people were less confident talking to mothers and less likely to choose their parents to speak to about sex and relationships.[55]

Figure 10.5. Parental support and communication about sex and relationships



55 Compared to heterosexual young people, LGBQ+ young people were less confident talking to mothers (OR 0.75, 95% CI 0.63–0.89) and less likely to choose their parents to speak to about sex and relationships (OR 0.69, 95% CI 0.60–0.80).

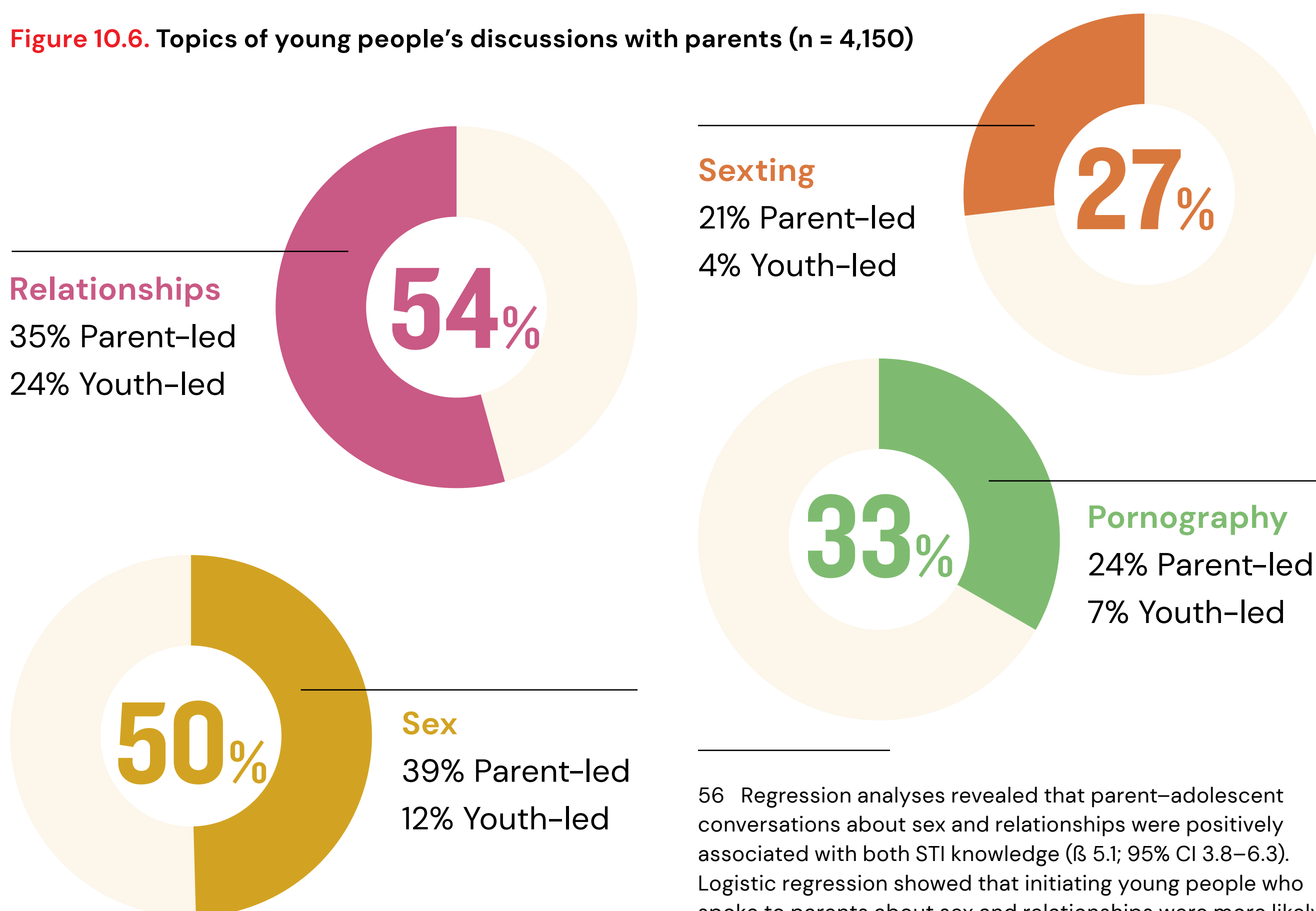
Table 10.1. Confidence in parents, by gender (n = 4,126)

Confidence in parent	Men n (%)	Women n (%)	Trans people n (%)	Overall n (%)
Father or male carer				
Not at all	612 (48%)	1,740 (71%)	202 (73%)	**2,554 (64%)**
Somewhat	486 (38%)	591 (24%)	66 (24%)	**1,143 (29%)**
Very	177 (14%)	105 (4.3%)	8 (2.9%)	**290 (7.3%)**
Mother or female carer				
Not at all	555 (42%)	817 (32%)	121 (42%)	**1,493 (36%)**
Somewhat	537 (41%)	1,124 (44%)	112 (39%)	**1,773 (43%)**
Very	217 (17%)	590 (23%)	53 (19%)	**860 (21%)**

We asked young people what topics they had spoken to their parents about. Responses included: relationships (n = 2,262, 54%), sex (n = 2,064, 50%), pornography (n = 1,383, 33%), and sexting (n = 1,119, 27%). These conversations were usually initiated by parents rather than by young people (see Figure 10.6).

Young people who spoke with their parents about sex and relationships reported a higher level of knowledge about STIs and were more likely to have initiated conversations about sex and relationships with a GP.[56]

Figure 10.6. Topics of young people's discussions with parents (n = 4,150)



56 Regression analyses revealed that parent–adolescent conversations about sex and relationships were positively associated with both STI knowledge (ß 5.1; 95% CI 3.8–6.3). Logistic regression showed that initiating young people who spoke to parents about sex and relationships were more likely, compared to those who did not, to have initiated a discussion with a GP (OR 2.33, 95% CI 1.84–2.98).

PARENT MESSAGES ABOUT SEX AND RELATIONSHIPS

We asked young people, using open text responses, to describe the main messages they had heard or learned from their parents about sex and relationships. A total of 751 young people responded, and their comments have been thematically grouped below. Parental messages varied widely and included themes of safety, values and advice.

'Stay safe'

The most frequently reported message young people received from their parents emphasised a harm-reduction approach (n = 208, 28%), relating to protecting themselves from potential risk and harm. Some of the statements were general in nature, such as 'be safe' or 'be careful', while other young people reported that their parents were specific about using condoms or contraception:

> *Mostly from my mum, she'd mainly just be checking that I was safe and that I knew what was/wasn't ok. She'd never really go into detail as I did not want her to. (18-year-old woman, bisexual)*

> *I have been taught many things, but it essentially boils down to 'as long as it's safe and consensual, it's fine'. (16-year-old non-binary person, queer).*

> *[My parents] know the teenage brain and have educated me on condoms and protection and have an accessible stash just in case. (15-year-old man, heterosexual)*

'Don't have sex'

Just under one in three young people (n = 208, 28%) described the main message they received from their parents as emphasising abstinence in some form, including waiting until they were older or waiting for marriage:

> *'Don't do it until marriage. Don't date until you've got a stable job. Make sure your partner is of the same religion and comes from good family or is at least of good nature. (16-year-old woman, heterosexual)*

> *Abstain from sex or any form of physical intimacy, whether it's kissing, holding hands or hugging. (18-year-old man, heterosexual)*

> *That sex is a wonderful gift from God that is best saved until marriage. Having sex outside of marriage damages relationships. (18-year-old man, heterosexual).*

Abstinence messaging was often coupled with a harm-reduction approach:

> *My mum believes that I should, not under any circumstances, be having sex. Yet she still believes if I am to have sex that I use condoms and stay on the pill. I haven't had a conversation about safe sex practices with her since I was 15. I am now 17. I am unsure if she now knows I am having sex with my current partner. I also think she believes that I do not need a 'refresher' on how to have safe sex. (17-year-old trans man, bisexual)*

'Be open and honest'

Close to one in five young people said that the main message they received from their parents related to having good communication (n = 124, 17%). These included messages relating to openness and honesty with partners as well as openness in communication about sex in general:

> *[My parents said] it is important to be open and honest with your partner. You should express how you feel, while also considering your partner's response and feelings. Consent and conversations are vital. (18-year-old woman, queer).*

> *It's never been a walled-off subject, just another element of life. Sex exists, and that was never hidden from me. I always got the message that anything that happened should be consensual and safe, and that I wouldn't be punished if something went wrong and I needed their help. We have had more discussions about romantic relationships and dating than about sex. (18-year-old man, asexual).*

We do not talk about sex

More than one in 10 young people (n = 111, 15%) said that their parents did not want to talk about sex and relationships, and that their parents avoided the topic or considered it inappropriate or shameful to discuss:

> *I haven't really learnt anything from them, I assume they assumed that the school would teach us everything. I have a boyfriend, but sexual conversations have never occurred with them [my parents]. (17-year-old woman, heterosexual)*

> *It's not something we talk about in my household. Where I live makes it difficult to date as a queer person, so for me the idea of a relationship is not a real thing. I think my*

parents have sort of internalised this and we don't talk about this stuff. (18-year-old man, queer)

Closely related, some young people (n = 41, 5.5%) wrote that sex was a shameful or taboo topic to discuss with their parents. As an example of this, one young person wrote:

> *'They make it sound very taboo to even discuss? And like a bad thing really … and heavily shame anyone who does it out of marriage. (17-year-old non-binary person, questioning).*

Love, trust and self-agency

Less common messages included emphasis on love and trust, self-agency and waiting until one feels ready to have sex. Some examples of this included:

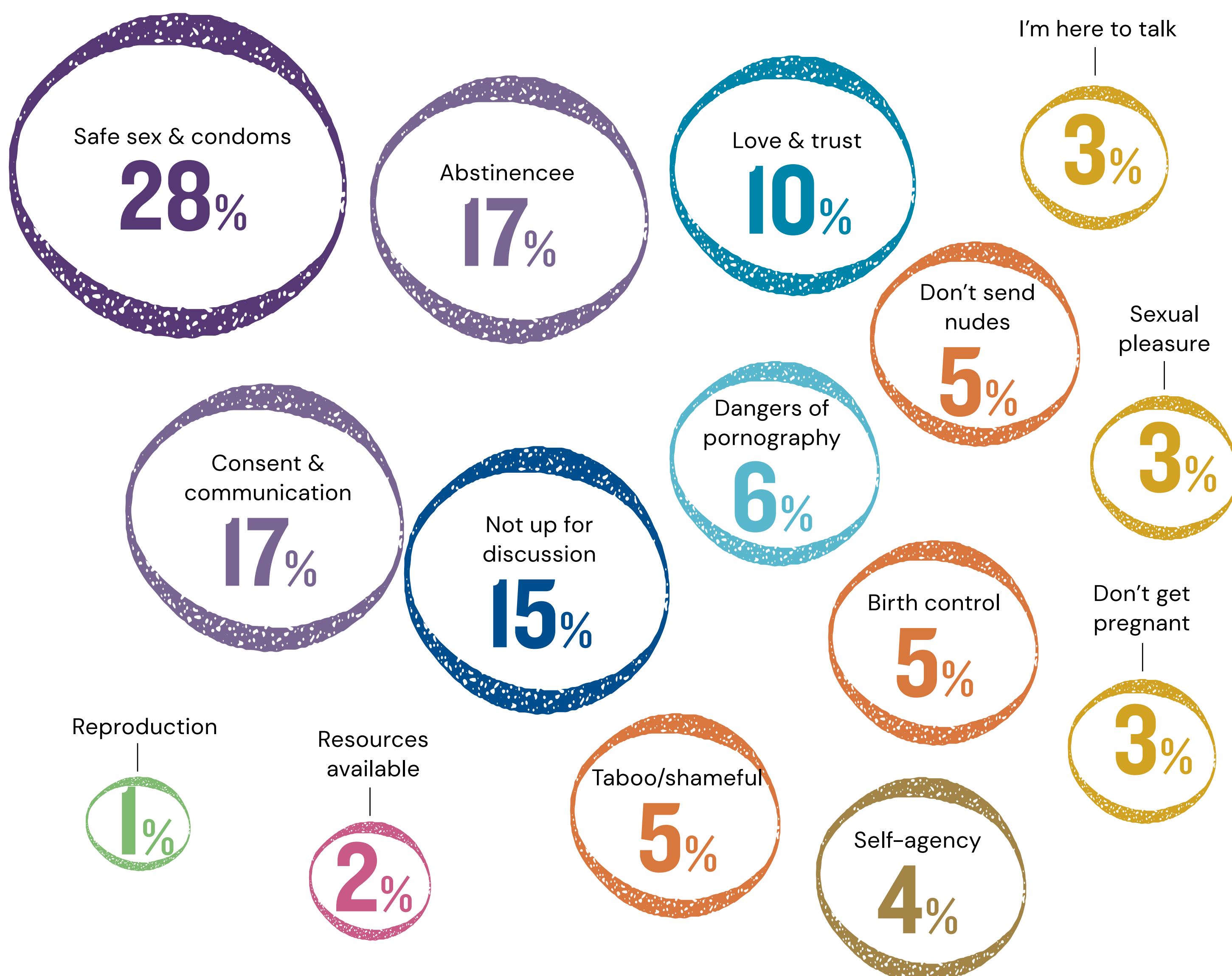
> *If you and your partner are in a healthy relationship, sex is just a nice way to solidify your trust and love for each other. It's not something that is necessarily required in order to have a healthy relationship. (18-year-old man, heterosexual).*

> *It's about a trustful, loving (depending on circumstance) and safe experience with someone. They [my parents] preach safe sex and sex positivity. (18-year-old woman, queer)*

> *Be caring and safe. It is completely normal to have sex at my age, but it is special and should be reserved for special people. (17-year-old woman, bisexual)*

Figure 10.7 shows the types of messages young people described.

Figure 10.7. Main messages learnt from parents about sex and relationships (n = 751)



COMMUNICATION WITH SEXUAL PARTNERS

Open communication with sexual partners is a key part of navigating safe and respectful relationships, consent and sexual wellbeing. This section focuses on sexually active young people and the discussions they have had with sexual partners.

Over 90% had spoken to a sexual partner about what they enjoy when it comes to sex (n = 1,630, 97%), how to avoid pregnancy (n = 1,348, 92%), boundaries and what they do not want to do (n = 1,542, 92%) and using condoms (n = 1,391, 92%); see Figure 10.8. Fewer had talked to their sexual partner about avoiding STIs (n = 817, 51%).

Figure 10.8. Topics sexually active young people spoke to their sexual partner about (n = 1,608)

Frequency

Not at all
A little
A lot

What you both enjoy
3%
21%
76%

Avoiding pregnancy
8%
29%
63%

Using condoms
8%
37%
56%

What you both don't want to do
8%
39%
53%

Avoiding HIV/STIs
49%
36%
15%

11. SCHOOL-BASED RELATIONSHIPS AND SEXUALITY EDUCATION

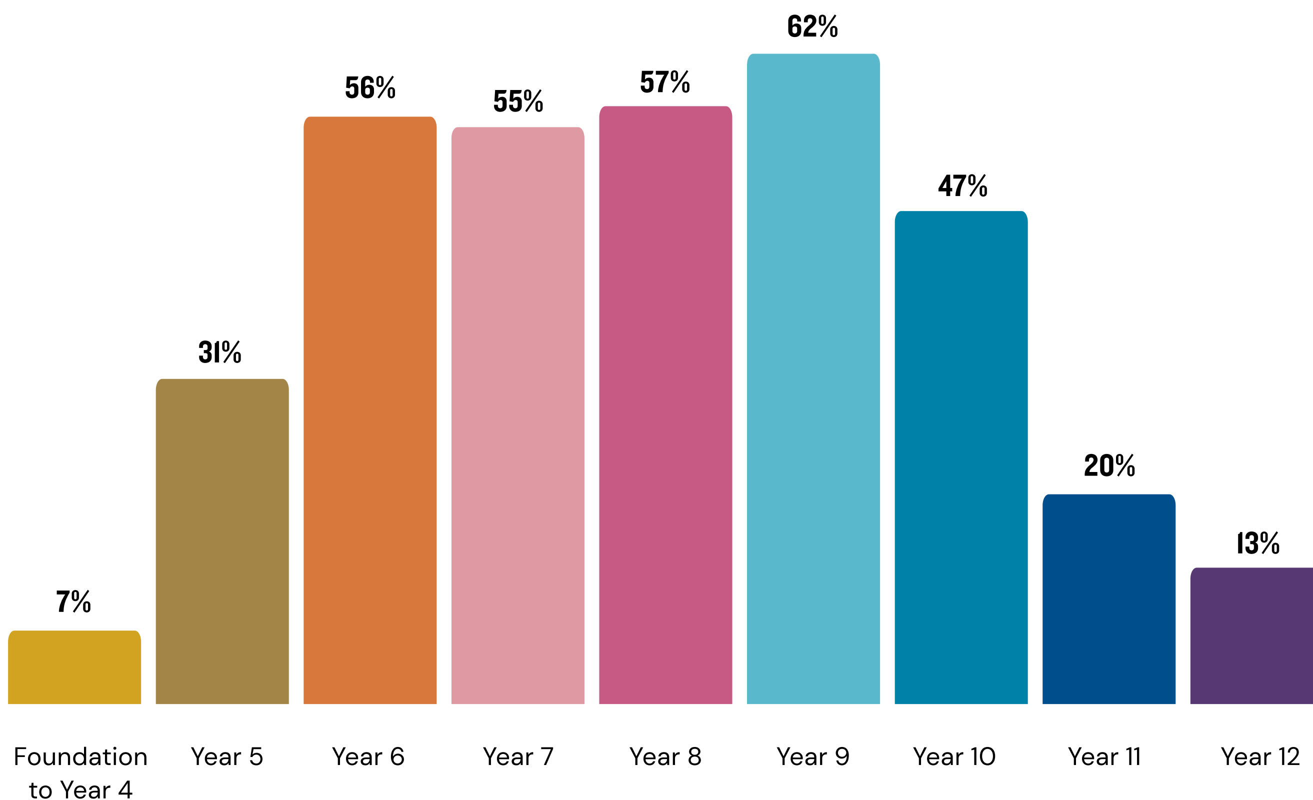
Relationships and sexuality education (RSE) is part of national curriculum guidelines (Australian Curriculum, Assessment and Reporting Authority, 2025) and consent education has been introduced for all Australian schools since 2023. However, the delivery of RSE and consent education is inconsistent across the country and across different schools with regards to the breadth of topics taught and time dedicated to these topics. In this chapter we look at young people's experiences with RSE and consent education.

PARTICIPATION IN RSE

Almost all young people who completed the survey had received RSE at least once in their school years (n = 3,728, 92%).

We asked young people in which school years they had received RSE (see Figure 11.1). Most commonly, young people received RSE between year 6 and year 10. Less than one in four had received any RSE in years 11 or 12.

Figure 11.1. Year levels in which RSE was received (n = 3,751)



Young people who attended government schools were more likely to have received RSE than those attending Catholic schools,[57] but there were no statistically significant differences in RSE attendance by gender, sexual orientation, age or rurality. Table 11.1 lists the rates of RSE attendance for school type and gendered schools.

Table 11.1. Percentage of young people who had received RSE, by school type and gendered schools (n = 3,399)

School characteristics	n (%)
School type	
Government	1,938 (94%)
Independent	608 (92%)
Catholic	514 (86%)
Other type of school (including home schooling)	72 (82%)
Gender composition of schools	
Mixed	2,525 (93%)
All-boys	127 (86%)
All-girls	356 (92%)

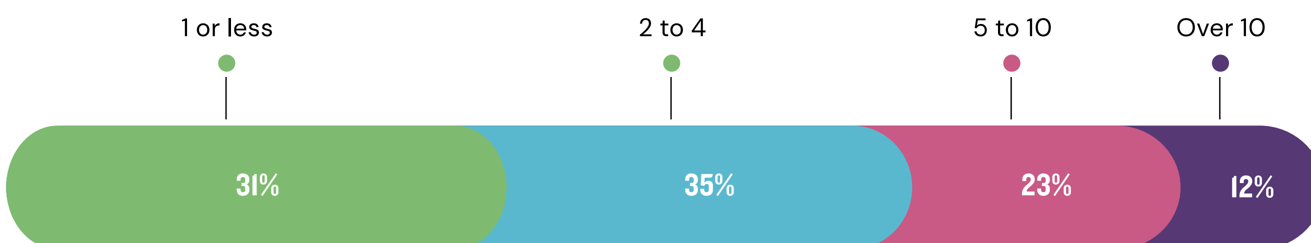
PERMISSION TO ATTEND RSE AND OPTING OUT

Most young people (n = 3,023, 76%) reported that, as far as they were aware, they had never missed an RSE class. A small proportion missed classes because they chose not to attend (n = 240, 6%) or RSE wasn't offered at their school (n = 189, 4.8%). Few reported that their parents did not want them to attend (n = 77, 1.9%) or that their teacher refused to teach them (n = 26, 0.7%). Some schools required young people to have parental permission to attend RSE (n = 1,289, 46%). There were no differences for parental permission across school types.

FORMAT OF RSE CLASSES

When asked about the last/most recent time they received RSE, nearly one in three (n = 1,035, 31%) said they had received only a single RSE lesson, while 35% (n = 1,181) reported receiving between two and four lessons (Figure 11.2). A smaller proportion (n = 769, 23%) reported five to 10 lessons, and just 12% (n = 406) had received more than 10.

Figure 11.2. Number of lessons taught at most recent RSE (n = 3,412)



57 Young people who attended government schools were more likely to have received RSE than those attending Catholic schools (OR 2.67, 95% CI 1.97–3.61) or other types of schools, which includes home schooling (OR 4.11, 95% CI 2.22–7.21).

Most commonly, young people were taught RSE in their health and physical education subject (n = 2,644, 71%) or across multiple different subjects (n = 1,834, 76%) rather than in a one-off specialist session (n = 582, 24%). A small number of students reported that RSE was taught within science (n = 497, 13%) or as a subject on its own (n = 440, 12%). Few reported that RSE was taught in religious education (n = 150, 4%).

One in three (n = 1,173, 31%) reported RSE was taught at an assembly, although this was mostly in addition to other RSE lessons. Only (n = 493, 13%) received RSE exclusively as an assembly (see Table 11.2).

Most young people who attended mixed gender schools had at least one RSE class that was split by gender (n = 2,476, 76%) with 17% (n = 551) reporting that this occurred every time they were taught RSE.

Table 11.2. Format of RSE classes by school type (n = 3,728)

RSE characteristics	Government n (%)	Independent n (%)	Catholic n (%)	Overall n (%)
Taught within health and physical education	1,453 (75%)	388 (64%)	334 (66%)	**2,175 (72%)**
Taught within science/biology	247 (13%)	93 (15%)	74 (15%)	**414 (14%)**
RSE as its own subject	231 (12%)	84 (14%)	43 (8.5%)	**358 (12%)**
Taught within religious instruction/ education	17 (0.9%)	40 (6.6%)	62 (12%)	**119 (3.9%)**
RSE taught exclusively at an assembly	195 (10%)	110 (18%)	84 (17%)	**389 (13%)**

RSE TEACHERS

Classroom teachers were the most common provider of RSE (n = 2,966, 80%), particularly if there were multiple classes of RSE (n = 2,065, 76%).

One in three participants (n = 1,075, 29%) reported they had received RSE from an external educator, which usually consisted of a single class (n = 447, 44%).

Less commonly, school nurses (n = 259, 7%), school counsellors (n = 120, 3.2%) or religious instructors (n = 84, 2.3%) taught RSE. Table 11.3 lists who taught RSE by school type.

Table 11.3. RSE teachers, by school type (n = 3,706)

Teacher	Government n (%)	Independent n (%)	Catholic n (%)	Total
Classroom teacher	1,601 (84%)	424 (70%)	396 (79%)	**2,421 (80%)**
Someone outside the school	441 (23%)	280 (46%)	160 (32%)	**881 (29%)**
School nurse	182 (9.5%)	14 (2.3%)	18 (3.6%)	**214 (7.1%)**
School counsellor	62 (3.2%)	26 (4.3%)	11 (2.2%)	**99 (3.3%)**

TOPICS TAUGHT IN RSE

Figure 11.3 lists the topics young people remember being taught in RSE.

Puberty and reproduction were the most commonly covered topics (n = 3,356, 92%). Most young people had also received education about sexual consent (n = 2,991, 82%) and respectful relationships (n = 2,661, 73%). Other topics commonly covered were: condom use (n = 2,780, 76%), contraception (n = 2,467, 67%), and STIs or HIV (n = 2,365, 65%).

Coverage of practical information about sex was mixed, with 44% (n = 1,603) reporting they had learned where to get help or support for sexual

“RSE FOCUSED HEAVILY ON BIOLOGICAL AND SAFETY-BASED CONTENT, FAR FEWER RECEIVED EDUCATION ON PRACTICAL ASPECTS OF SEX, DIVERSITY OR DISABILITY.”

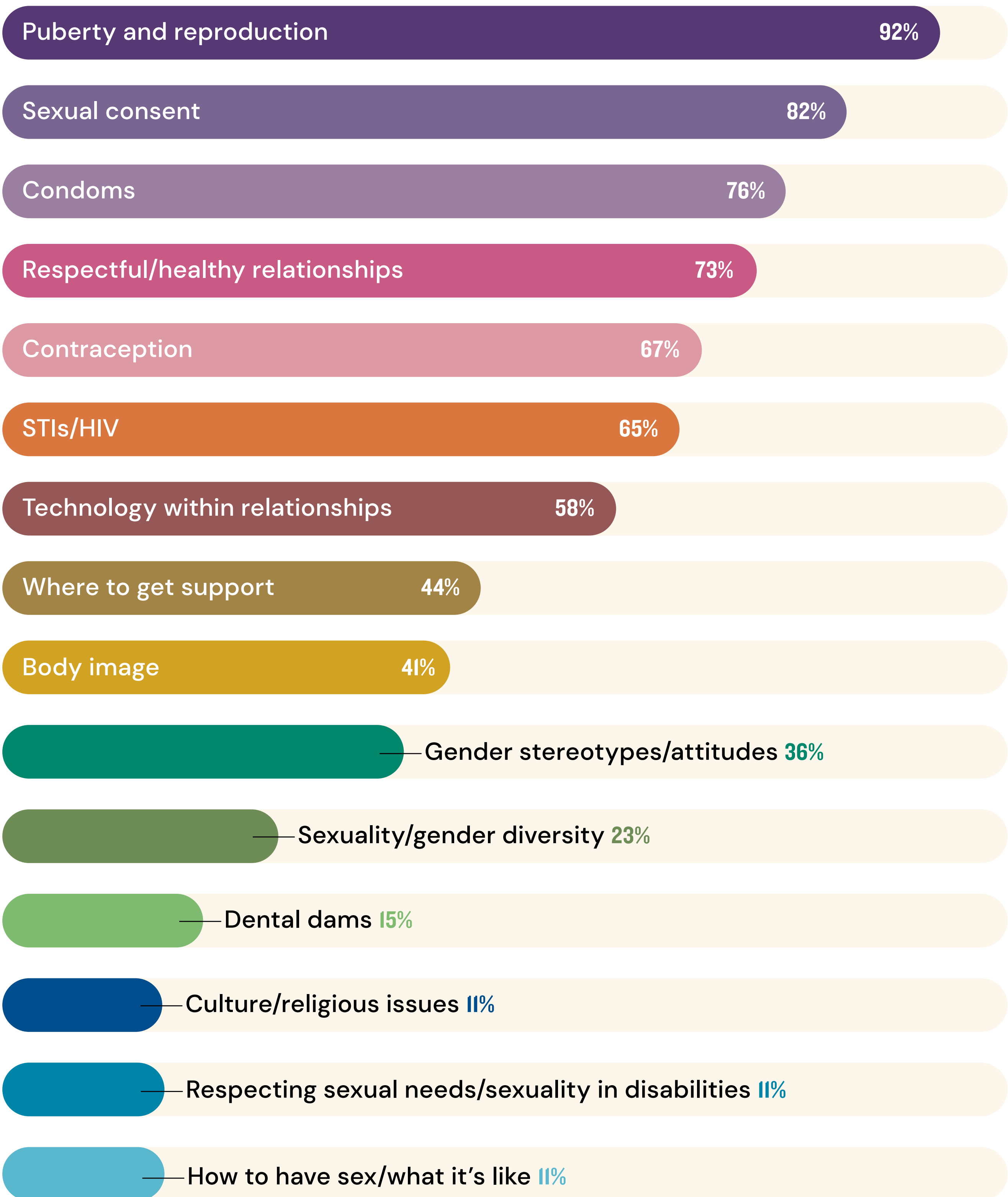
issues, while 11% (n = 402) had received lessons on what sex is like or what sex involves (how to have sex).

Education that focused on equity and diversity was similarly mixed. More than one in three (n = 1,309, 36%) had received education about gender stereotypes and attitudes. Close to one in four (n = 843, 23%) had received education about sexual and gender diversity, although only around one in 10 (n = 393, 11%) had received education about sex in relation to disabilities. One in 10 (n = 405, 11%) reported they had received RSE that included cultural or religious perspectives.

There was some variation in the topics students learnt about according to the type of school they attended.[58] Compared to young people who attended government schools, those who attended independent or Catholic schools were less likely to have learned about condom use. Young people attending Catholic schools were also less likely to have learned about sexual and gender diversity, but more likely to have learned about cultural and religious issues and body image.

58 Compared to young people who attended government schools, those who attended independent schools (OR 0.59, 95% CI 0.45–0.79) or Catholic schools (OR 0.27, 95% CI 0.20–0.36) were less likely to have learned about condom use. Compared to young people who attended government schools, young people attending Catholic schools were more likely to have learned about cultural and religious issues (OR 2.40, 95% CI 1.69–3.41) and body image (OR 1.67, 95% CI 1.32–2.12) but less likely to have learned about sexual and gender diversity (OR 0.49, 95% CI 0.35–0.67).

Figure 11.3. Topics young people learned about in RSE (n = 3,679)



WHAT YOUNG PEOPLE WANT TO LEARN ABOUT IN RSE

Some of the topics regularly taught in schools were what young people wanted to learn, including STIs or HIV, respectful relationships, contraception, sexual consent, and puberty and reproduction. However, young people reported that they wanted RSE to include more education on the practical aspects of sex and what sex is like. Table 11.4 presents a side-by-side comparison of the topics young people reported being taught in RSE and the areas they would like to learn more about.

Table 11.4. Comparison of topics taught in RSE and topics young people want to learn

Topics	Want to learn (n = 4,074) n (%)	Received education on this (n = 3,679) n (%)
Practical aspects of having sex/what it's like	1,558 (38%)	404 (11%)
STIs/HIV	1,153 (28%)	2,375 (65%)
Respectful/healthy relationships	879 (22%)	2,675 (73%)
Contraception	827 (20%)	2,479 (67%)
Sexual consent	798 (20%)	3,010 (82%)
Puberty and reproduction	797 (20%)	3,376 (92%)
Respecting sexual needs/sexuality in disabilities	669 (16%)	397 (11%)
Body image	630 (15%)	1,513 (41%)
Where to get support	629 (15%)	1,609 (44%)
Sexuality/gender diversity	531 (13%)	848 (23%)
Culture/religious issues	468 (11%)	406 (11%)
Technology within relationships (e.g. 'sexting', online pornography)	413 (10%)	2,132 (58%)
Gender stereotypes/attitudes	363 (8.9%)	1,319 (36%)
Condoms	334 (8.2%)	2,795 (76%)
Dental dams	268 (6.6%)	557 (15%)

PERCEIVED RELEVANCE OF RSE

Although 92% of young people (n = 3,753) had received RSE at school, when asked if they found it relevant, only 45% (n = 1,683) rated it as relevant or very relevant to their lives (see Figure 11.4). Table 11.5 lists the demographic and school characteristics of young people who perceived RSE relevant or very relevant.

Compared to heterosexual young people, LGBQ+ young people were less likely to find RSE relevant. There were no statistically significant differences by gender. Young people who were sexually active were more likely to find RSE relevant (than non–sexually active young people.[59] Young people who

59 Compared to heterosexual young people, LGBQ+ young people were less likely to find RSE relevant (OR 0.70, 95% CI 0.60–0.83). There were no differences by gender. Young people who were sexually active were more likely to find RSE relevant (OR 1.39, 95% CI 1.18–1.63) than non–sexually active young people.

had received more RSE, both in terms of years and number of classes, were more likely to see it as relevant.[60]

Table 11.5. Demographic and school characteristics of young people who perceived RSE as relevant or very relevant (n = 1,683)

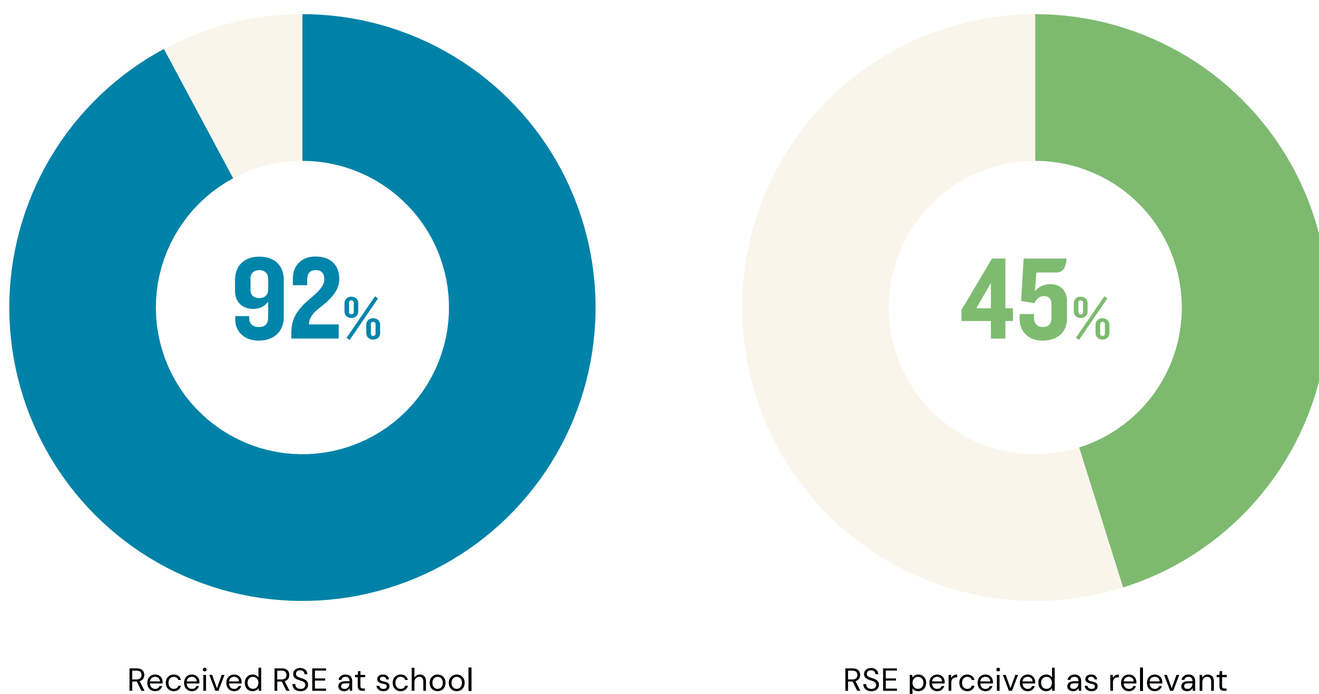
Frequency	Perceived RSE as relevant/very relevant n (%)
Gender	
Men	523 (43%)
Women	1,058 (47%)
Trans people	102 (40%)
Sexual orientation	
Heterosexual	965 (48%)
Gay/lesbian	74 (30%)
Bisexual	397 (45%)
Queer/questioning/ace	188 (40%)
Rurality	
Major city	1,101 (45%)
Regional/remote	456 (45%)
Sexual activity	
Not sexually active	787 (42%)
Sexually active	896 (49%)
School type	
Government	917 (48%)
Independent	276 (46%)
Catholic	217 (43%)
Other type of school (including homeschooling)	29 (40%)
Not in school	233 (39%)

60 A logistic regression analysis adjusted for gender, sexual orientation, sexual activity and school type revealed that young people were more likely to rate RSE as relevant or very relevant with increased exposure to RSE classes both in terms of number of years received (OR 1.21, 95% CI 1.16–1.25) and with high number of classes at most recent RSE (OR 1.58, 95% CI 1.34–1.85).

Table 11.5. **Demographic and school characteristics of young people who perceived RSE as relevant or very relevant (n = 1,683)**

Frequency	Perceived RSE as relevant/very relevant n (%)
Attributes of RSE	
Number of years RSE was received	
1–3 years	760 (38%)
4–6 years	707 (52%)
7–9 years	192 (62%)
Number of lessons at most recent RSE	
Less than five lessons	907 (41%)
Five or more lessons	629 (55%)

Figure 11.4. **Percentage of young people who received RSE at school and perceived RSE as relevant/very relevant to their lives (n = 4,072)**



REASONS YOUNG PEOPLE SAW RSE AS NOT RELEVANT

Young people who perceived RSE as 'not at all' or 'not very relevant' were asked for more information about why RSE was not relevant to them. There were 1,128 young people who responded to this question. Figure 11.5 shows the 50 most frequent words that young people used to describe why RSE was not relevant to them.

Figure 11.5. Most frequent words used to describe why RSE was not relevant to young people (n = 1,128)

Note: This word cloud visualises the words mentioned most often in the open text responses, with larger words appearing more frequently in young people's responses.

There were a range of reasons why young people did not find RSE relevant to them. Below we provide a snapshot of these responses grouped by themes.

RSE does not provide guidance on sexual relationships

Many young people felt that the RSE they had received was not comprehensive or practical enough to be useful to them. While most young people had received consent education, young people said that it lacked detail on how they could apply this knowledge in a sexual relationship. Young people also felt that RSE lacked detail on the mechanics of sex and rarely emphasised the pleasurable aspects of sex, instead focusing on biology or risks. Others also wanted more information on where they could find information or support if needed. One young person captured this in their comment:

> *I just don't think it was comprehensive enough and what was discussed felt like a cop out in all manners of topics, like, it's all well and good to be, like, 'don't abuse people'. But practically what do you do if you find yourself in a position where you need to seek help from being abused? And sex ed is just not comprehensive, like sure 'this goes there' or whatever, but what about same-sex relationships and what happens before that? This lack of information leads to people seeking more comprehensive explanations from places that really aren't reliable nor appropriate or even sometimes safe, like porn or randoms on the internet. It's not good enough that this is happening. I think educational videos are important as well so teachers aren't left to impart their bias too (+ it's just awkward) also consent is so important too, even for things like kissing and hugs. (18-year-old woman, government school)*

Many young people wanted more in-depth, practical education about what healthy sexual relationships should be like and what they need to be attuned to in order to understand and foster these relationships.

> *They never covered things like consent, boundaries, STI conversations and how to be in a sexual relationship in a healthy way. Only ever covered scientific things about getting pregnant, condoms, contraception and how the body works. But never did we cover anything we could use realistically, like how to tell when you're in a toxic sexual relationship, or how to know when you're actually ready to be sexually involved with someone. (18-year-old woman, government school)*

> *It wasn't really about sex, only about how pregnancy works. I was never taught or knew that one could have sex for pleasure. (18-year-old man, independent school)*

Gaps in information about where to seek help or support were also emphasised. Young people recalled being taught about the risks of STIs or pregnancy, but not how to access testing, sexual health services or anonymous support if needed. Even lessons on biology and anatomy lacked breadth and relevance for many young people.

> *I feel that it wasn't very comprehensive. It was very heteronormative and did not do anything to address or acknowledge same-sex relationships. It also did not do much to teach us about STIs and STI prevention. Our 'safe sex' conversations were limited primarily to contraception and preventing pregnancy. We weren't informed of any means of accessing STI tests or sexual health services. The content was also dominated by male biology; we learnt little in comparison about periods and female anatomy. For example, there was no mention of the fact that vaginas or vulvas can look different, and of the few images that we were shown, all depicted 'innies' (small, closed outer lips, like those often shown in pornography). At no point was there any mention of conditions such as PCOS, endometriosis, PMDD, or other medical issues which may impact women in regards to their reproductive or sexual health. (18-year-old woman, not at school)*

RSE is not inclusive of sexuality and gender diversity

Many young people described feeling unrepresented in the RSE they had received, noting that the content did not reflect a diversity of bodies, genders or sexual identities.

> *I'm sure it was [relevant] to other people, so in that respect it was fine. But they touched very little on queer sex, and most of the discourse was on heterosexual sex. So as a bisexual guy, it felt kinda weird being told about how guys don't treat women right in sexual relationships. Very important info that is necessary to know, but simply not applicable to me. They go off the assumption that every guy there is straight. (18-year-old man, government school)*

Sex ed never touched on relationships between two women. As a lesbian, learning about preventing accidental pregnancy wasn't applicable to me. The only part that was remotely relevant was about STI safety, and that only covered condoms. I only learnt about dental dams and safe ways to share toys and personal post-sexual hygiene through the internet. (18-year-old woman, not at school)

Some young people said that RSE focused on reproduction and biology but lacked information that would be relevant to their body, relationships or sexual experiences:

It kind of just focused on the biological and reproductive purposes, there was nothing about queer sex, consent, pleasure. We learned a lot about the anatomy of the penis but not of the female reproductive organs. (17-year-old non-binary person, government school)

Many young people told us that the RSE they received gave limited attention to typical female anatomy and puberty, or women's experiences of sex, leaving some feeling that the curriculum focused predominantly on cisgender men.

Did not talk a lot about the female reproductive systems, very heteronormative. Did not discuss gay or lesbian or queer issues. No discussion around pleasure. Bad explanations of things e.g. the 'tea' video (don't give anyone tea if they don't want it). General awkwardness from teachers and educators. No discussions around porn and unrealistic standards shown in porn. Overall, very poor and only really catered towards straight, cisgender men and heterosexual sex. (18-year-old woman, government school)

Classroom dynamics

The way RSE was delivered shaped young people's perceptions of its relevance, with some pointing to awkward classroom dynamics or teachers who seemed uncomfortable or underprepared. Some wrote that the teaching and teaching style were not appropriate for RSE or that their teachers were moralistic or judgemental.

> *Coming from a Catholic school, we are constantly reminded during the lesson that we should not have sex until marriage and that it is only being taught because of the curriculum. This makes it difficult to engage and feel comfortable in the lesson. I don't know how to describe the education we receive other than not good enough. We are shown ridiculous videos of analogies about sex, such as a cup of tea consent video, that further reinforce to us that sex is uncomfortable to speak about. (17-year-old woman, Catholic school)*

A number of young people also reported that they found RSE lessons hard to engage with as their classmates were awkward, rude or disruptive.

> *It wasn't really about actual sex ed. Only learning of the genitals, what sex is, protection, and STIs. The rest of 'sex ed'/health' was about drugs, alcohol, parties, etc. It did not go into detail and it was hard to learn anything because people were immature and kept interrupting and being stupid. (16-year-old woman, government school)*

Received better information elsewhere

Some felt RSE was of little relevance to them because they had already learnt the information they needed or would prefer to learn about the topics elsewhere. Young people wrote about learning more from parents, peers, personal experience or online sources than RSE.

> *I learnt most of my sexual education online in my own time because I was in alternative schooling and was not in health classes, meaning that mainstream kids were getting sex ed and I would not be. Thankfully my teacher realised we weren't getting sex ed and held some sexual health classes before the end of year 10. Although by then it did not cover anything I hadn't already answered, but I'm sure it helped others. Year 7 sex ed was just puberty stuff, by the way, I don't know if that counts. (18-year-old man, independent school)*

> *It came from a Christian based perspective, yes they did tell me actions of sex and what an STI is but the overarching idea of the assemblies were to tell us to abstain because if not we would go to hell and it's unchristian like. I understand these are the views of the school but I never felt like I learnt anything about what can happen to me, what an STI actually does or anything like that. My sixth grade sex ed teacher who was meant to be teaching us about our own bodies told our small group of girls that when putting in a tampon we will hit our cervix because it is only the length of the tampon and the tip of our finger. I was lucky I had parents I could go home to and ask if that was true, most of the girls and guys of my grade do not have that luxury. (17-year-old woman, independent school)*

Not relevant to age and stage

Many young people felt that RSE did not align with their developmental stage. For example, many young people reported that they were not interested in sex or not currently sexually active when they received RSE and so the information did not stay with them. Many acknowledged that the information was probably useful to other students and might help them in the future, but they felt it would have been more helpful when they were older. Conversely, some young people felt that RSE was delivered when they were too old, and that they should have learnt about these topics when they were younger.

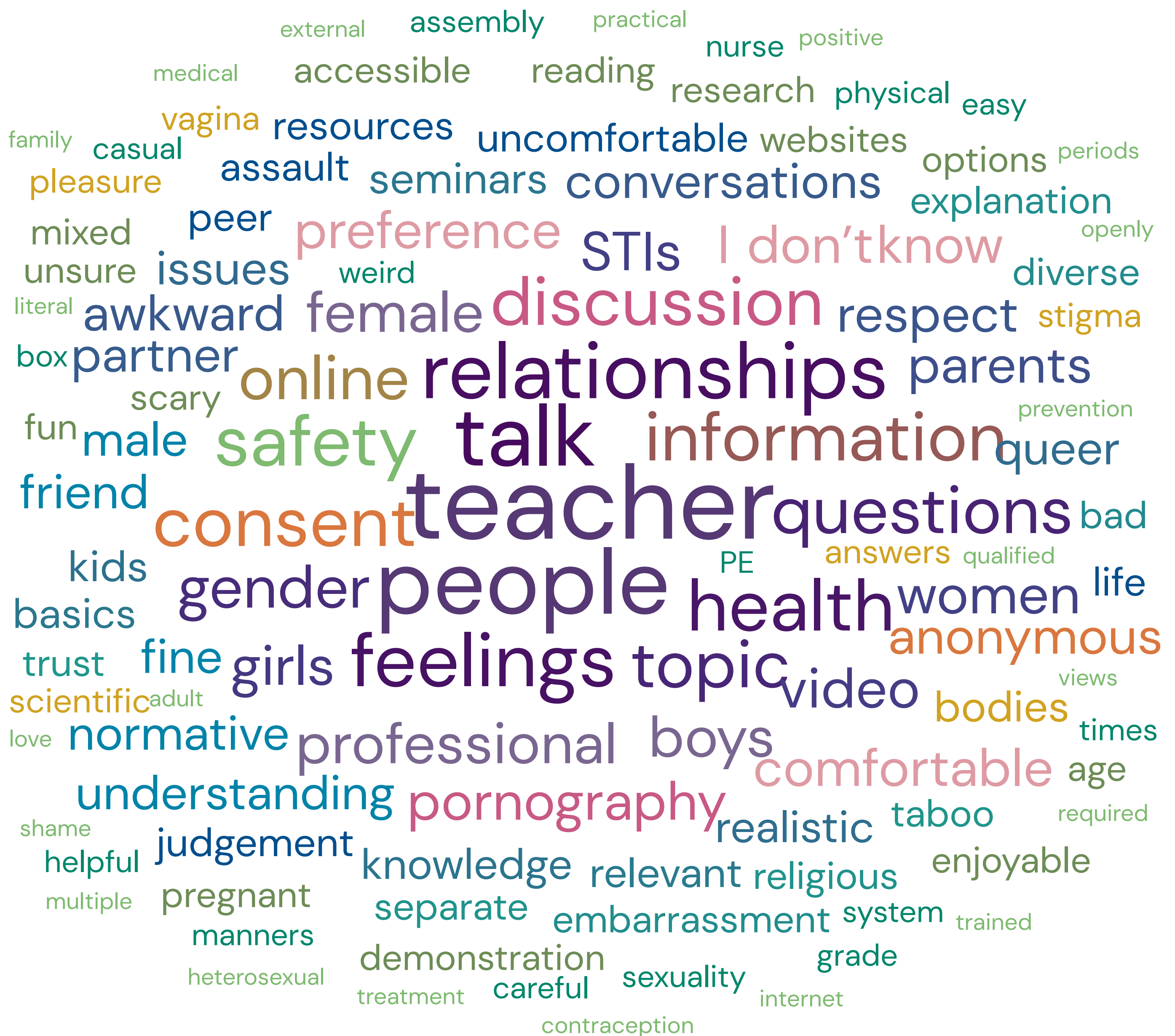
> *Never been in a relationship or had an encounter of sexual or romantic nature. The extent of the information's relevance is for future reference, for general knowledge, to provide others with potential advice, and for the unavoidable aspects of sexual health (e.g. periods). (18-year-old woman, government school)*

> *The education we received was good and I'm sure it was relevant to many students, but not as much for myself since I'm not in any relationships and don't have a sexual desire. But it still could be relevant since if I ever change my mind, what we learnt should come in handy. (16-year-old woman, government school)*

HOW YOUNG PEOPLE WANT TO LEARN RSE

Young people were asked how they would like to learn about sex and relationships. There were 702 young people who responded to this question. Figure 11.6 shows the most common words that young people used to describe how they would like to learn about RSE.

Figure 11.6. Most frequent words used to describe how young people would like to learn about sex and relationships (n = 702)



Note: This word cloud visualises the words mentioned most often in the open text responses, with larger words appearing more frequently in young people's responses.

Those who responded to this question showed a strong desire for learning environments that felt safe, honest and respectful, with teaching that is relevant to their lives and delivered by people they trust. While many preferred school-based learning, others emphasised the importance of learning from trusted adults, peers or online resources in their own time. Young people also highlighted the need for more comprehensive, inclusive and engaging content that reflects the diversity of their experiences. Below we provide an overview of these responses organised by themes.

Schools should provide consistent, reliable RSE

Many young people said they wanted RSE to be taught in schools, describing school as the most reliable and consistent place to learn. This preference often reflected a broader frustration that RSE is inconsistently delivered or missing altogether, with some young people indicating that they had received very little RSE, while others said they had never been taught anything meaningful at all. The following quotes describe this sense of wanting RSE to be delivered in schools, not just because it is convenient, but because it is a setting where young people have access to information delivered in a way that feels safe, respectful and taken seriously.

> *Probably [the best way to receive RSE is] through a teacher. It means that everyone is taught the same, whereas parents/carers can give a wide array of advice. A classroom also means less people making it less awkward rather than a whole school assembly. Something my school did which could be implemented more is everyone writing a question on a piece of paper and the teacher picking them out of a hat so it's anonymous and answering the question in front of everyone. (18-year-old man, no longer at school)*

> *I would prefer if sex education was more widespread throughout the school curriculum, as I did not find it beneficial to only have it taught once throughout high school. (18-year-old man, government school)*

> *I would have loved to learn [RSE] from my school, my cohort were not gonna be silly about it, we were wondering when we were gonna have [RSE]. (18-year-old woman, no longer at school)*

RSE is best when the classroom culture is informal and respectful

The importance of classroom culture in the delivery of quality RSE was noted by many young people. For many, the quality of the learning environment mattered just as much as the content itself. A common theme was the desire for spaces where peers are not allowed to make fun of the content or each other, and where teachers set clear expectations for respectful behaviour.

Many young people said they wanted RSE to be taught in small groups. As described by participants below, smaller groups were seen as less intimidating and easier to participate in than large class groups or assemblies, with fewer distractions and more space for honest discussion.

> *Instead of 150 of us in a seminar, opt in sessions in smaller groups about specific subjects in a conversational manner instead of a lecture. (17-year-old woman, independent school)*

> *[I'd like to learn from] a serious respected and known teacher, with a class that is usually together, both genders, people having the opportunity to ask private questions without having to say it out loud, no judgment, with realistic scenarios and life experiences, and not when I'm 13; when I'm 15–16, when it's actually relevant. In a class in year 9 & 10 with a serious teacher. (17-year-old woman, government school)*

> *[Learning] from both teachers and professionals in health or sexual health. In an environment that's not near other classes or has distractions. Also any rude or inappropriate comments made by people to be removed and have a talking to. (18-year-old woman, government school)*

RSE should include the opportunity to ask anonymous questions

Many said they felt uncomfortable asking questions in front of peers, especially when the classroom atmosphere was immature or disruptive. Anonymous question boxes or other ways to ask questions privately were seen as especially helpful. These tools allowed young people to raise sensitive topics without fear of embarrassment, teasing or stigma.

> *[I'd like to learn] in a safe environment at school, where everyone's opinions and experiences are respected. (17-year-old woman, Catholic school)*

I think it'd be a good idea to have like an online anonymous poll that students could ask questions or let teachers know what they like to learn about. I do think it should be mandatory in schools though. (18-year-old woman, no longer at school)

RSE teachers should be open and trusted

Young people consistently described wanting RSE teachers who are confident, well trained and able to facilitate open conversations without judgement. Younger teachers or external professionals were mentioned by several young people, who felt they might be more relatable, better trained or more comfortable discussing sensitive topics. Others valued being taught by teachers they already knew and trusted, emphasising that comfort and rapport can make difficult conversations easier.

[Learning] from a younger person, from an outsourced specialist who can answer questions with real life experience, and still an understanding that it may be funny now but they're passionate in teaching kids how to be safe later on. (18-year-old woman, government school)

Again, it's a really awkward topic and everyone is cringing. Why don't schools deploy a young person to make it more relatable, feel like a conversation, no teachers in the room. (14-year-old man, government school)

[I'd like to learn] in a respectful and realistic way, I would prefer someone who is qualified but younger and able to connect with a young audience. Students would really benefit from a discussion, rather than being spoken at. (18-year-old woman, independent school)

Some young people valued peer discussions or peer-led learning, saying that peers can feel more relatable and easier to talk to. For some, learning from friends helped them feel less alone or confused about their experiences, and they appreciated it when peer-education was part of RSE.

I'm involved in a peer-designed and peer-led respectful relationships workshop that I deliver to young people. I think much more sex and relationship education should be delivered in a similar way that is considerate of all experiences, with an emphasis on positive experiences in order to help young people understand what is good, not just what is bad. (17-year-old woman, Catholic school)

"[I'D LIKE TO LEARN] IN A RESPECTFUL AND REALISTIC WAY, I WOULD PREFER SOMEONE WHO IS QUALIFIED BUT YOUNGER AND ABLE TO CONNECT WITH A YOUNG AUDIENCE. STUDENTS WOULD REALLY BENEFIT FROM A DISCUSSION, RATHER THAN BEING SPOKEN AT."

(18-YEAR-OLD WOMAN, INDEPENDENT SCHOOL)

Classrooms are not the only place for RSE

While many young people preferred school-based RSE delivery, a significant number of young people said they wanted to learn about sex and relationships from trusted adults outside school. This included parents, carers or other trusted adults, as well as GPs or health professionals, who were seen as knowledgeable and reliable sources of information.

It should be the parent's job … it's part of being a parent. I feel that sexual education being taught in school is taking away that parental responsibility. (18-year-old woman, government school)

A substantial group of young people indicated they preferred to learn in their own time, using online resources or other self-directed sources. These young people valued privacy, autonomy, and the ability to seek information when it felt relevant to them. They described online resources as accessible, up-to-date and often more inclusive than what they received at school.

In general, I would prefer to learn through self-teaching with provided resources that I can read through in my own time and when I feel comfortable to do so. Otherwise, classroom settings have been pretty good in terms of sex ed for the topics that we have covered and I have never had any issues with it. (16-year-old man, government school)

Consent education needs to be better

Many young people wanted more comprehensive content, saying that current RSE often felt too limited, too biological or too focused on risk. They wanted RSE that reflects the full spectrum of relationships and sexual experiences, including emotional, social and interpersonal aspects. A strong theme was the need for consent education, especially for boys and from an early age. Young people felt that consent should be taught clearly, consistently, and in ways that reflect real-life situations. They also wanted RSE to include pleasure and the positive aspects of sex, saying that learning only about risks and dangers left them unprepared for healthy, consensual and enjoyable relationships.

There needs to be a higher focus on consent because the boys in my peer group do not seem to understand. Making a class watch the 'tea video' once doesn't count as teaching consent. The girls also need more education in that they don't have to agree to anything even if they're dating the guy. I'd like my school to have made any effort beyond showing a diagram of a vagina in year 7. (18-year-old woman, Catholic school)

We never spoke about consent or pleasure or anything that was too, awkward for the teachers. I would've preferred it spanned across more years too because everyone gets introduced to sex at different times. The curriculum is severely lacking. There is a whole term and an assessment task put towards drug use and alcohol but only a week of a term put towards sex and relationships. (18-year-old woman, government school)

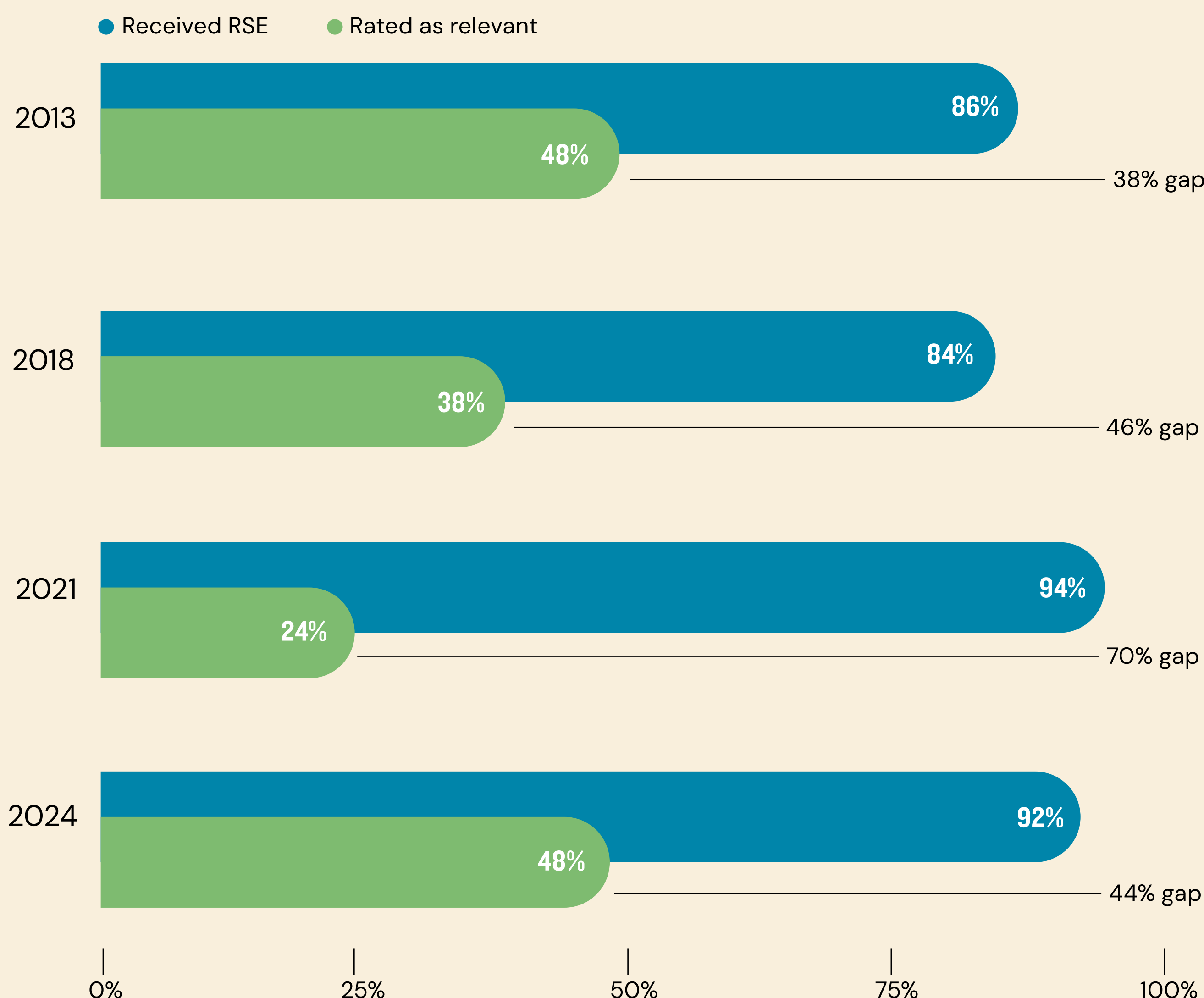
CHANGES OVER TIME FOR RELATIONSHIPS AND SEXUALITY EDUCATION

Figure 11.7 shows the proportion of year 10 to 12 students who reported receiving RSE since 2013, and their ratings of its relevance. Across the four survey waves, most year 10 to 12 students reported receiving RSE, with consistently high coverage across the years. Receipt of RSE remained stable between 2013 and 2018 (86% and 84%), increased in 2021 (94%), and remained high in 2024/25 (92%).

Students' ratings of RSE relevance showed more variation across the years. In 2013, 48% rated their RSE as relevant or very relevant, followed by a decline in 2018 (38%). Ratings reached their lowest level in 2021 (24%) before increasing again in 2024/25 (48%).

In 2021, there was a 70% gap between receipt of RSE and perceived relevance, almost twice that of previous years. As this occurred in the 2021 survey, it is possible that the COVID-19 social lockdowns had an impact, with online learning undermining the quality of RSE.

Figure 11.7. **Percentage of year 10 to 12 students who received RSE and rated it relevant or very relevant**



Note: Sample sizes by survey year: 2013 (n = 2,079); 2018 (n = 5,728); 2021 (n = 3,856); 2024 (n = 2,741)

12. CULTURALLY AND LINGUISTICALLY DIVERSE YOUNG PEOPLE

Culturally and linguistically diverse (CaLD) young people are recognised as a priority population within the National STI Strategy (Australian Centre for Disease Control, 2025). Young people identified as CaLD in this report are those who were born in a non-English speaking country and/or who speak a language other than English at home. While this definition and terminology is imperfect, we have used the term in line with the National STI Strategy as a practical way to identify young people who may face language or cultural barriers to accessing sexual health care and/or who may experience racism and marginalisation in ways that affect sexual relationships and wellbeing.

The aim of this chapter is to provide a broad overview of how CaLD young people engage with sexual health education and services.

PARTICIPANT CHARACTERISTICS

Almost one-quarter of the sample met the CaLD criteria (24%, n = 1,037).

On average, CaLD young people were 16.6 years of age (SD = 1.37).

The majority of CaLD young people identified as women (n = 578, 56%), with 39% (n = 401) identifying as men and 5.6% (n = 58) identifying as trans people.

Most CaLD young people identified as heterosexual (n = 658, 67%), with a further 18% (n = 172) identifying as bisexual, 9.5% (n = 93) as queer or questioning their sexuality, and 5.9% (n = 58) as gay or lesbian.

Most CaLD young people lived in major cities (n = 837, 87%) and attended government schools (n = 616, 60%). A further 15% (n = 155) attended independent schools and 13% (n = 130) attended Catholic schools. There were 10% (n = 106) who were not currently attending high school and 2% (n = 21) who were homeschooled or attended an alternative school.

RELATIONSHIPS AND SEXUAL EXPERIENCES

Of all young people from CaLD background, half (n = 485, 49%) had ever been in a romantic relationship and 33% (n = 346) were sexually active (defined as having experienced oral sex, penile–vaginal sex or penile–anal sex). This was lower than the overall sample, where 61% had been in a relationship and 50% had ever had sex.

The most common reasons for not having sex were not having a partner (n = 380, 56%), not being ready (n = 283, 41%), not having the opportunity to have sex (n = 272, 40%), and wanting to be in love before having sex (n = 270, 40%). In addition, 24% (n = 163) cited religious beliefs, 23% (n = 156) feared parental disapproval, and 23% (n = 160) were waiting until marriage. Of the 61 young people who typed in another answer, most (n = 21) reported that they were too young to have sex, six talked about insecurities with their body, and four talked about concerns about pregnancy.

CONDOM USE AND ACCESS

Of the 346 sexually active CaLD young people, 60% (n = 136) reported always or often using condoms, 78% (n = 144) reported that a condom was available the last time they had sex, and (n = 106, 56%) reported they had used a condom. This was comparable with condom use for the overall sample.

SAFETY IN SEXUAL RELATIONSHIPS

Most CaLD young people felt safe at their last sexual experience (n = 180, 77%), although this was lower than the whole sample (86%).

There were 32% of CaLD young people (n = 155) who reported the experience of feeling frightened of a sexual partner, compared to 37% of the overall sample.

ACCESS TO SEXUAL HEALTH CARE

CaLD young people had a mean score of 52% on the health care access knowledge scale; slightly lower than overall (59%).

Most CaLD young people reported never having an unmet need for sexual health care (66%, n = 614). Fewer than 10% reported not getting the help they needed for contraception (9.7%, n = 90) or for STI prevention or treatment (4.9%, n = 45).

The most common barriers to accessing care were concerns that parents would find out (52%, n = 70), fear of judgement (48%, n = 65), and cost (45%, n = 61), which followed similar patterns to the overall sample.

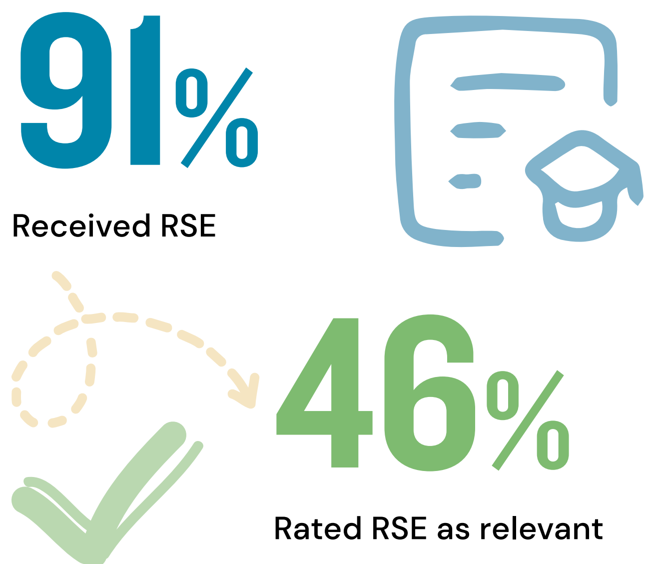
COMMUNICATING ABOUT SEX AND RELATIONSHIPS

Just over half (n = 505, 54%) of young people from CaLD backgrounds indicated they were confident talking to their mothers about sex and relationships, and 78% (n = 737) were confident talking to their GP. This was less than the overall sample, where 64% felt confident talking to mothers and 84% felt confident talking to GPs about sex and relationships.

Compared to the whole sample, CaLD young people were more likely to have never spoken to anyone about sex and relationships. There were 38% of CaLD young people (n = 376) who reported not talking to anyone about sex (compared to 25% overall). Similarly, most CaLD young people reported that they had never spoken to their parents about sex (n = 676, 68%) or relationships (n = 584, 59%).

RELATIONSHIPS AND SEXUALITY EDUCATION

Figure 12.1. Experiences with relationships and sexuality education among CaLD young people



Most young people from CaLD backgrounds indicated they had received RSE at school (n = 872, 91%) with around half receiving RSE over 3 or more years (n = 523, 53%). Few CaLD young people (n = 55, 5.8%) chose not to attend RSE. See Figure 12.1.

13. FIRST NATIONS YOUNG PEOPLE

This chapter provides a snapshot of the experiences of the 153 First Nations young people who participated in the study.

Ongoing experiences of racism, the intergenerational impacts of colonisation and structural inequality, and limitations in culturally safe sexual health information may undermine First Nations young people's access to sexual health care, quality services and education. At the same time, First Nations community-based learning and knowledge systems, along with community-controlled health services and organisations, can provide strong and culturally grounded sexual health education and support.

The SSASH study was not designed to comprehensively capture the sexual health experiences or needs of First Nations young people, and it is not a study led by First Nations communities or researchers. However, we felt it was important to present this brief overview of responses provided by First Nations young people, given that the National STI Strategy recognises First Nations communities as a priority population. On request, we will make these data available to First Nations researchers who are in a position to conduct further analysis and lead the reporting. For detailed, culturally informed findings, the community-led GOANNA Study (Poche Centre for Indigenous Health, 2026) is an important source of information about First Nations peoples.

PARTICIPANT CHARACTERISTICS

We heard from 153 First Nations young people.

On average, First Nations young people were aged 16.8 years (SD = 1.41).

Most identified as women (n = 106, 69%), while 23% (n = 35) identified as men and 7.8% (n = 12) identified as trans people. Almost half identified as heterosexual (n = 71, 47%), a further 32% as bisexual (n = 48), 14% (n = 21) as queer or questioning their sexuality, and 6.7% (n = 10) as gay or lesbian.

In terms of location, 46% of First Nations young people (n = 64) lived in major cities, 36% (n = 50) in inner regional areas, and 17% (n = 24) in outer regional, remote or very remote Australia.

Just over half attended government schools (n = 82, 54%), while 13% (n = 19) attended Catholic schools and 6.6% (n = 10) attended independent schools. A further 18% (n = 28) were not currently attending high school, and 8.6% (n = 13) were homeschooled or attending an alternative school.

RELATIONSHIPS AND SEXUAL EXPERIENCES

Most First Nations young people had experience with romantic relationships (n = 110, 74%), and many were sexually active (n = 107, 70%).

Among those who were sexually active, condom use was mixed. Some reported that they 'always' used a condom (n = 35, 43%). However, the most recent time they had sex, 76% (n = 53) reported that they had a condom available, but just 36% (n = 25) used a condom.

Most First Nations young people described their most recent sexual experience as enjoyable (n = 60, 80%) and safe (n = 60, 80%).

Most young people reported that their most recent sexual experience was with a steady partner (n = 55, 73%). Most young people said they had spoken with their most recent sexual partner about sexual boundaries/ what they did not want to do (n = 66, 92%), and condom use (n = 61, 88%).

For the 30% (n = 46) who had never had sex/were not sexually active, the most common reasons cited were not having a partner (n = 26, 57%), having no opportunity to have sex (n = 22, 48%), wanting to be in love (n = 18, 39%), and not being ready to have sex (n = 16, 35%).

COMMUNICATION ABOUT SEXUAL HEALTH

First Nations young people in the study showed strong foundations for sexual health and decision-making. Most reported that they felt confident talking to trusted people about sex and relationships including their friends (n = 134, 95%), GPs (n = 126, 91%) and mothers (n = 93, 69%). In terms of conversations about sex and relationships, the majority (n = 120, 85%) said that they had spoken to another person about sex and relationships, although 34% (n = 46) had never spoken to a parent about this.

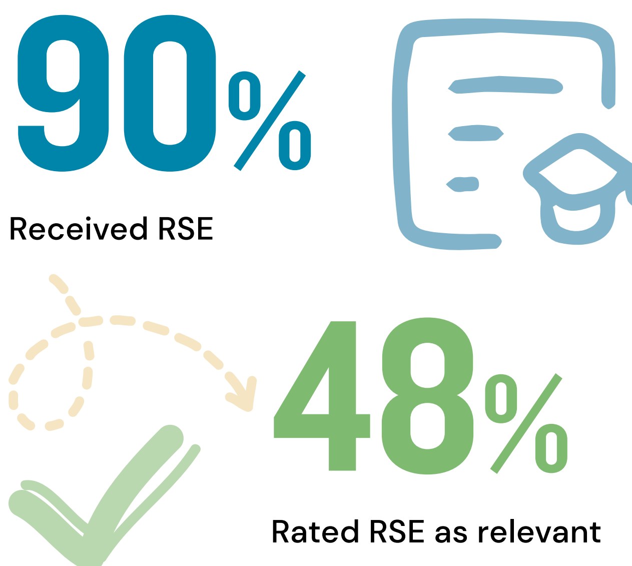
ACCESS TO SEXUAL HEALTH CARE

Most First Nations young people recognised that STIs could seriously affect their health (n = 142, 93%) and knew how to find a doctor to test for STIs (n = 99, 65%). At the same time, some faced barriers to accessing help for contraception (n = 29, 22%) or STI prevention or treatment (n = 15, 11%), although 42% (n = 56) had never felt like they needed to access health care for sexual reasons and 30% (n = 40) felt that they received the care they needed.

There were 38% (n = 38) who said that they had been for an STI checkup and 22% (n = 31) had spoken to a GP about sex and relationships. The main barriers First Nations young people faced were being worried about judgement (n = 22, 59%), cost (n = 15, 41%) and not knowing how to make an appointment (n = 12, 32%).

RELATIONSHIPS AND SEXUALITY EDUCATION

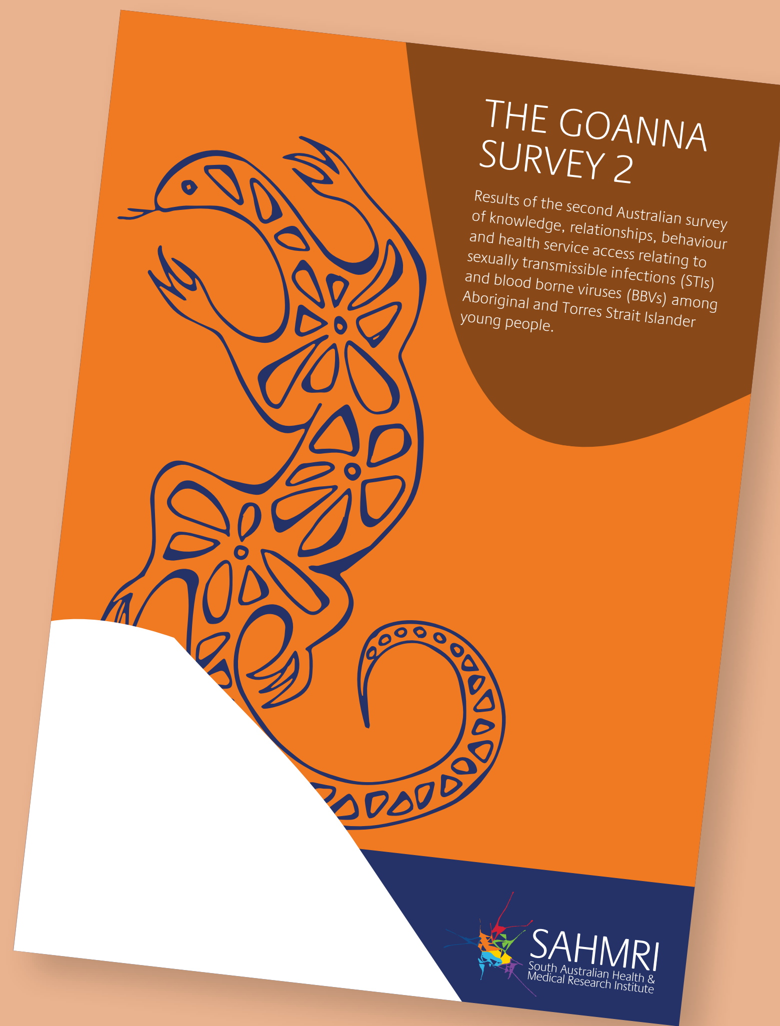
Figure 13.1. Experiences with relationships and sexuality education among First Nations young people



Most First Nations young people had received RSE at school (n = 120, 90%) and around half had received RSE for 3 or more years (n = 72, 53%). However, less than half found it meaningful, with 48% (n = 57) saying it was relevant to their lives. See Figure 13.1.

THE GOANNA STUDY (WARD ET AL., 2020)

The GOANNA study is designed specifically for and with Aboriginal and Torres Strait Islander communities. Rather than relying on online surveys or clinic-based samples, GOANNA surveys are conducted face-to-face at community events, festivals, sports carnivals and gatherings across the country. This approach ensures young people participate in a setting that feels familiar, culturally safe and community led, and it allows Aboriginal and Torres Strait Islander researchers and health workers to guide the process, answer questions and build trust. New findings from the GOANNA survey 3, run by Poche Centre for Indigenous Health at the University of Queensland (2026), are expected to be released in June 2026, offering updated insights into the sexual health knowledge, behaviours and priorities of First Nations young people.



A brief overview of the GOANNA 2

The GOANNA Survey 2 (Ward et al., 2020) was conducted between 2017 and 2020. A total of 1,343 Aboriginal and Torres Strait Islander young people between 16 and 29 years of age completed the survey, with 40% of the sample (n = 488) aged between 16 and 19 years. Below are some of the findings related to 16- to 19-year-olds.

STI knowledge

- The median knowledge score out of 10 for 16- to 19-year-olds was 6 (IQR = 4 to 8).
- 75% (n = 357) knew that the birth control pill does not protect a woman from HIV
- 71% (n = 338) knew that condoms help to protect people from getting HIV
- 66% (n = 312) knew that people who injected drugs are at risk for hepatitis C
- 62% (n = 301) knew that if a woman with HIV is pregnant, her baby could become infected with HIV
- 60% (n = 287) knew that someone who looks healthy could pass on the HIV infection

Sexual practices

- 66% (n = 313) had ever had oral, penile–vaginal or penile–anal sex
  - o 52% (n = 247) had ever had oral sex
  - o 60% (n = 280) had ever had penile–vaginal sex
  - o 12% (n = 56) had ever had penile–anal sex
- 43% (n = 129) last had sex with a current partner
- 49% (n = 122) last partner was Aboriginal or Torres Strait Islander
- 29% (n = 132) used an app to find a partner in the past year
- 78% (n = 213) always or often used condoms
- 9% (n = 28) had not wanted to have sex at their last sexual experience

STI testing and diagnosis

- 37% (n = 173) had ever had an STI test
- 15% (n = 26) of those tested were diagnosed with an STI
- 20% (n = 91) were tested for HIV

14. NATIONAL STI STRATEGY INDICATORS

Australia's (draft) Fifth National Sexually Transmissible Infections Strategy 2024–2030 (Australian Centre for Disease Control, 2025) identifies young people (aged 15-24) as a priority population for action on STI prevention. Young people are significantly impacted by STI, with higher rates of common STIs (e.g. chlamydia) than other age groups. Despite this, STIs are underdiagnosed in this age group, as young people often face significant structural and cultural barriers to sexual health care, including limited capacity to access or pay for health services independently of their parents, social judgements about young people's sexuality, and high levels of stigma relating to sexual health care. These barriers may disproportionately affect young people from marginalised backgrounds or with marginalised identities.

Several targets within the Fifth National STI Strategy have specific relevance to young people, including:

- 'Increase in the number of people, including priority populations, tested for STI via no cost and lower cost GP appointments and in accordance with guidelines.'
- 'Increase the number of primary, secondary and tertiary level schools delivering sexual health education with high quality and comprehensive STI content.'
- 'Increase STI knowledge, awareness and attitudes, among general and priority populations.'
- 'Increase in the proportion of priority and general populations using any STI prevention strategy (e.g. condoms, doxy PEP), within the past 12 months.'
- 'Increase coverage of HPV vaccination to 90% by the age of 15.'
- 'Decrease notification rates and morbidity of all other nationally notifiable STI [besides syphilis] such as chlamydia and gonorrhoea.'

Below we report findings from this survey that provide data to inform these targets for school-aged young people (see Table 14.1). School-age young people (aged 14 to 18 years) have distinct sexual health needs compared to older adolescents and young adults. At this age, particularly among those aged 14 to 16, most young people are sexually inexperienced and may be unfamiliar with navigating safe sexual practices, relationships and consent.

Many are living with parents or caregivers who may control their access to information, education, or sexual health services, and young people may be unaware of how to independently access health care or may be concerned about confidentiality when doing so. This age group is also at an early stage of forming attitudes, expectations and skills related to relationships, gender, and sexuality, meaning that experiences and information received during this period can have lasting effects on sexual health and wellbeing.

At the same time, most school-age young people are engaged in formal education and are likely to receive RSE at school. This presents a unique opportunity to provide accurate information, build skills for safe and respectful relationships, and support young people before patterns of behaviour are established. However, to be effective, these efforts must be informed by robust knowledge of the experiences, needs and concerns of school-aged young people.

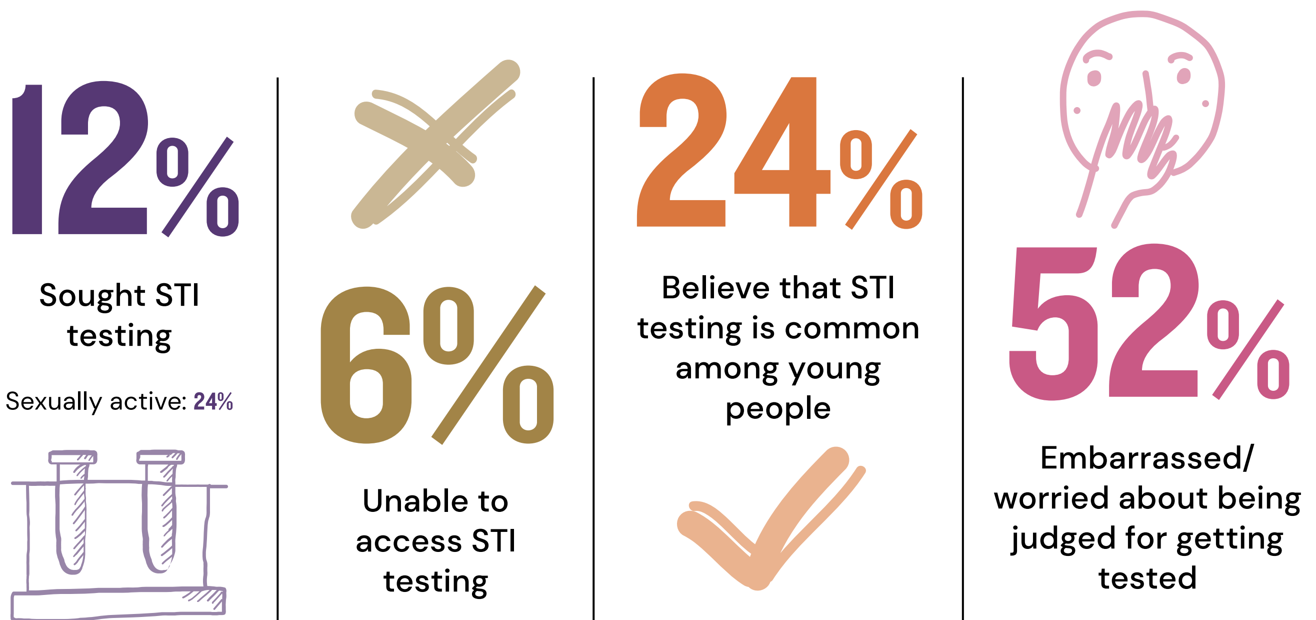
Many of the findings shown in this chapter have been presented earlier in this report. The purpose of this chapter is to collate findings of direct relevance to the National STI Strategy. Where data are available, we report on changes since the 2018 iteration of the SSASH study.

Table 14.1. Alignment between relevant Fifth National STI Strategy 2024 to 2030 targets and SSASH 8 data

Key Indicator	Relevant 2030 targets (National STI Strategy)	Data within SSASH 8
Integrated Primary Care	Increase in the number of people, including priority populations, tested for STI via no cost and lower cost GP appointments and in accordance with guidelines.	• Proportion of young people seeking STI testing • Perceived barriers to STI testing/sexual health care • Awareness of sexual health care options
Education and Awareness	Increase STI knowledge, awareness and attitudes among general and priority populations. Increase the number of primary, secondary, and tertiary level schools delivering sexual health education with high quality and comprehensive STI content.	• Beliefs about STIs • Knowledge and awareness of STIs • Proportion of young people receiving RSE • Proportion of young people who perceive RSE to be relevant • Topics covered in RSE • School years in which young people receive RSE
Prevention, Testing and Treatment	Increase in the proportion of priority and general populations using any STI prevention strategies (e.g. condoms, doxy PEP), within the past 12 months.	• Proportion of young people reporting consistent condom use • Young people's attitudes toward condom use
Equity and Access	Reduce experiences of stigma for priority populations accessing health services, including reducing stigmatising attitudes among health care workers. Reduce differences in STI rates between geographic locations and between priority populations and all Australians.	• Access to health care services among regional/remote, LGBQ+ and trans young people.

INTEGRATED PRIMARY CARE

Figure 14.1. SSASH indicators of integrated primary care



STI TESTING

Of the total sample, 12% (n = 512) had 'ever' been screened for STIs. Young women were more likely to have accessed STI screening than young men. Young people living in regional or remote areas were more likely to have accessed screening than young people in major cities.[61]

Barriers to STI testing and sexual health care

There were mixed responses regarding young people's confidence in being able to access STI screening if they needed it. Just 5.8% (n = 225) felt unable to access STI screening or testing services if they needed them. However, only half (53%, n = 2,313) indicated they knew where to find a doctor for STI testing.

Young people were asked if they had ever needed help for sexual issues but could not get it: 19% of young people (n = 748) indicated this was the case. The issues young people indicated they were unable to get help with were:

- contraception (n = 486, 13%)
- STI prevention or treatment (n = 225, 5.8%)
- other sexual health issue (n = 190, 4.9%)

Of the 748 young people who indicated they had an unmet sexual health need, the most commonly cited barriers to accessing sexual health care or STI screening services were:

- being worried or embarrassed about judgement (n = 385, 52%)
- being afraid that parents would find out (n = 337, 46%)
- being unable to afford the costs of screening services (n = 314, 43%)

Awareness of sexual health care options

Most young people knew that they could ask a doctor for an STI test even without symptoms (n = 3,913, 89%), and two-thirds (n = 2,899, 66%) were aware that common STIs like gonorrhoea, chlamydia and syphilis can be treated with medicine.

Just over half the young people in this survey (n = 2,573, 59%) understood that they could access free sexual health services (see Table 14.2). A similar number (n = 2,451, 56%) were aware that they could get their own Medicare card before 18, although fewer (n = 1,412, 32%) were aware that their parents could not access their Medicare records after age 14. While many parents will facilitate access to

61 A multivariable logistic regression model examined how demographic characteristics were associated with STI screening practices. Young women had significantly higher odds of having been screened compared with young men (OR 2.03, 95% CI 1.58–2.63). Young people living in regional or remote areas also had higher odds of screening compared with those in major cities (OR 1.43, 95% CI 1.16–1.76). Older age was associated with increased likelihood of screening (OR 1.64, 95% CI 1.48–1.84).

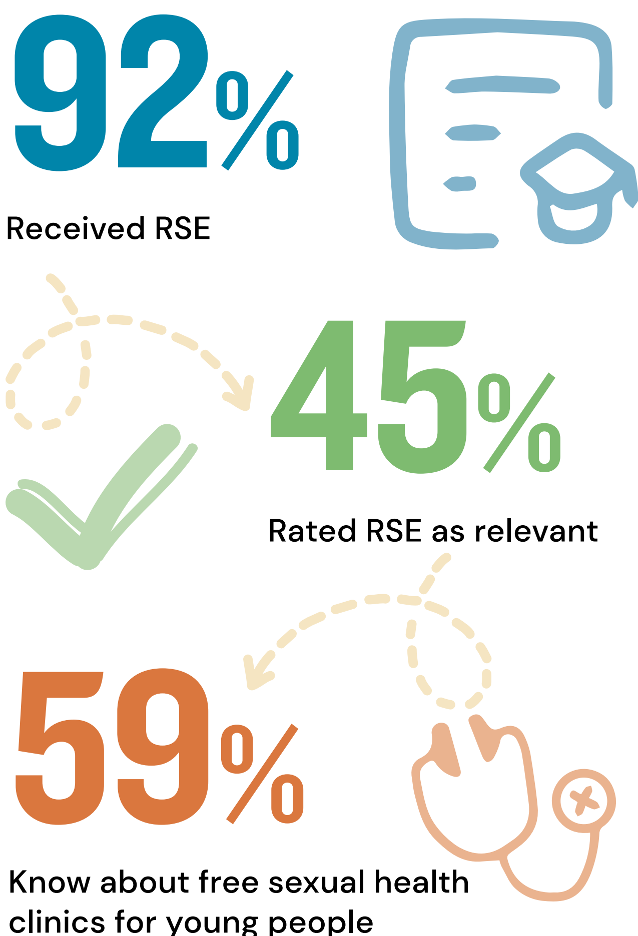
sexual health care access for their children, this is not always the case, and it is notable that fear of parents finding out was cited as a barrier to accessing STI screening among young people who had an unmet sexual health care needs.

Table 14.2. **Frequency of correct responses to questions about access to care (n = 4,369)**

Items	Men	Women	Trans people	Overall
There are free sexual health clinics that young people can access without a Medicare card (true)	856 (60%)	1,550 (58%)	167 (54%)	**2,573 (59%)**
You can ask a doctor for an STI test even if you don't have symptoms (true)	1,250 (88%)	2,386 (89%)	277 (90%)	**3,913 (89%)**
You need to be 18 to get your own Medicare card (false)	742 (52%)	1,518 (57%)	191 (62%)	**2,451 (56%)**
Until you turn 18, your parents can access your Medicare records (false)	334 (23%)	951 (36%)	127 (41%)	**1,412 (32%)**

EDUCATION AND AWARENESS

Figure 14.2. **SSASH indicators for education and awareness**



Beliefs about STIs

Young people were asked a series of attitudinal questions about STIs; these questions sought to identify barriers to, and motivators for, testing as well as understanding of STIs. Findings suggest that most young people understand the potential health consequences of STIs, but they still perceive a high level of stigma, which may impede testing or other help-seeking. Most young people also felt that STI testing was not common among their peers. Overall:

- 87% (n = 3,803) believed STIs could seriously affect their health
- 78% (n = 3,409) believed that having an STI would be embarrassing or shameful
- 76% (n = 3,299) believed that STI testing was uncommon among young people
- 63% (n = 2,736) believed that young people do not think about STIs

Knowledge and awareness of STIs

Young people were presented with a series of knowledge-based questions to assess their awareness and understanding of STIs. Young people demonstrated moderate overall sexual health knowledge, answering an average of 68% of questions correctly.

Knowledge was strongest in the areas of prevention and protection (80%), and symptoms and transmission (75%); while understanding of STI treatment and management (51%) was comparatively lower. Specifically:

- 66% (n = 2,899) were aware that gonorrhoea, chlamydia and syphilis can all be treated with medicine
- 57% (n = 2,516) were aware that antiviral treatment can prevent sexual transmission of HIV
- 56% (n = 2,477) were aware that untreated chlamydia can cause infertility
- 44% (n = 1,930) were aware that the virus that causes genital herpes is not treatable
- 30% (n = 1,313) were aware that human papillomavirus (HPV) can lead to cancer

STI knowledge questions have been consistently asked in SSASH surveys since 1997. Some key findings over time are:

- There has been consistently strong awareness among young people that STIs can be transmitted by someone who appears healthy (81% to 91%) and that condoms are effective in preventing HIV (84% to 95%).
- Knowledge about chlamydia has improved over time, including recognition that it affects people of all genders (11% to 80%) and that untreated infection can lead to infertility (29% to 56%). However, it is notable that close to half did not realise chlamydia can lead to infertility.
- Misconceptions that HIV can be transmitted through coughing have increased over time. This potentially reflects a decreased emphasis on 'myth-busting' in HIV education, rather than being an indicator that young people believe this is how HIV is transmitted (i.e. it is possible that asking this question led young people to question their knowledge).
- Understanding of the lifelong nature of genital herpes remains relatively low (33% to 49%).

Future iterations of the SSASH survey should be revised to include a more specific focus on young people's awareness of syphilis symptoms, prevention, testing and treatment.

Access to school-based RSE

Most young people (n = 3,753, 92%) reported receiving RSE at school. However, less than half (n = 1,683, 45%) felt that this education was relevant or very relevant to their lives.

STI education within RSE

Just over two in three young people reported they had learned about STIs in their RSE classes. The most common topics young people reported they had been taught in RSE were:

- puberty and reproduction (n = 3,356, 92%)
- sexual consent (n = 2,991, 82%)
- condom use (n = 2,780, 76%)
- respectful relationships (n = 2,66, 73%)
- contraception (n = 2,467, 67%)
- STIs or HIV (n = 2,365, 65%)
- where to get help or support for sexual issues 44% (n = 1,603)

Changes over time in receipt of RSE

Since 2013, the SSASH survey has asked young people about their receipt of, and experiences with, RSE. Receipt of RSE has consistently been above 80% across all four survey waves, with over 90% of participants reporting receiving RSE in 2021 and 2024. However, there is a persistent gap between widespread delivery and young people's perceptions of its relevance. Across all four survey waves, fewer than 50% of young people rated RSE as relevant or very relevant. Perceived relevance declined in 2021, possibly reflecting the negative impact of online learning during COVID-19 lockdowns.

Young people were also asked to report the school years in which they received RSE. In each survey wave, participants most frequently reported receiving RSE in years 9 to 10 (76% to 80%) and years 7 to 8 (68% to 76%), with fewer than one in four reporting receipt of RSE in years 11 or 12. The drop-off in years 11 and 12 likely reflects the fact that RSE is commonly delivered within the health and physical education curriculum, which is compulsory only until year 10. Schools also tend to prioritise academic outcomes for senior students within an already crowded curriculum. Nevertheless, limited RSE provision in years 11 and 12 represents an important gap. At these year levels (approximately ages 16 to 18), many young people become sexually active and may be navigating sexual or romantic relationships for the first time. Therefore, these years are likely to be when RSE has the greatest relevance to young people's lives.

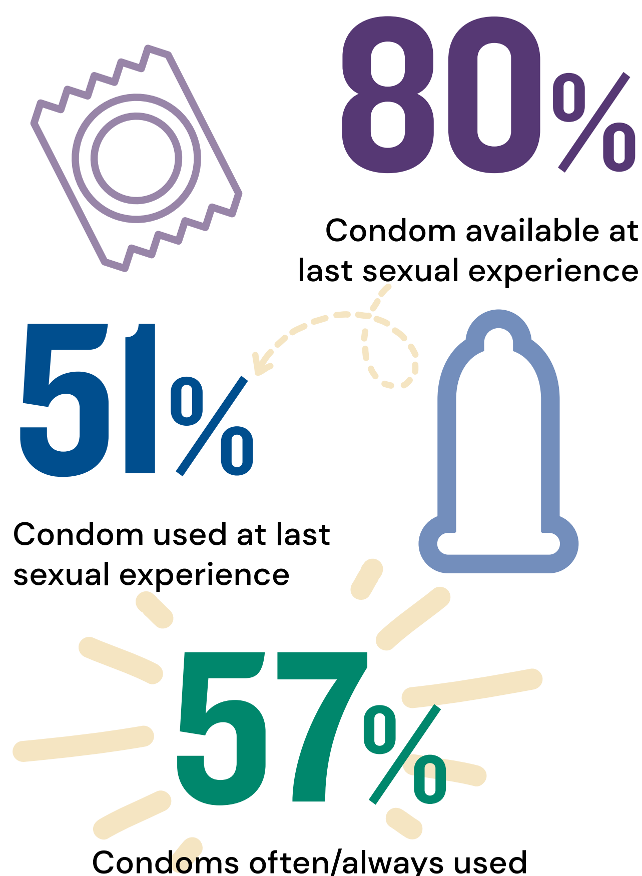
Coverage of RSE in primary school (foundation to year 6) increased substantially over time, from 43% in 2013 to 64% in 2024; while provision in secondary school remained relatively consistent. This increase likely reflects the impact of several initiatives implemented in Australia during this period related to the primary prevention of sexual violence and child sexual abuse. For example, state and territory governments have worked to embed respectful relationships education within primary school curricula. Provision of developmentally appropriate RSE in primary school also aligns with the global recommendations (United Nations Educational, Scientific and Cultural Organization, 2018).

Table 14.3. Participants' reported experience of RSE by survey year (years 10 and 12)

	2013 n = 2,032 n (%)	2018 n = 5,344 n (%)	2021 n = 3,797 n (%)	2024 n = 2,660 n (%)
Ever received RSE	1,749 (86%)	4,482 (84%)	3,569 (94%)	2,465 (93%)
RSE received in primary school	786 (39%)	2,443 (55%)	2,173 (57%)	1,587 (64%)
RSE received in secondary school	1,770 (87%)	4,270 (96%)	3,394 (89%)	2,118 (86%)
Year levels in which RSE was taught				
Between foundation and year 4	80 (4.6%)	278 (6.2%)	252 (7.1%)	170 (6.9%)
Years 5 and 6	738 (42%)	2,403 (54%)	2,114 (59%)	1,562 (63%)
Years 7 and 8	1,267 (72%)	3,381 (76%)	2,590 (73%)	1,685 (68%)
Years 9 and 10	1,351 (77%)	3,586 (80%)	2,783 (78%)	1,874 (76%)
Years 11 and 12	392 (22%)	1,081 (24%)	741 (21%)	620 (25%)
RSE relevant/very relevant	846 (50%)	1,678 (38%)	864 (25%)	1,182 (48%)

PREVENTION, TESTING AND TREATMENT

Figure 14.3. SSASH indicators for prevention, testing and treatment 14



Condom use: Attitudes and frequency

Young people were asked to rate how much they agreed with five statements about condom use (using a 5-point Likert scale from strongly disagree to strongly agree).

Responses, on the whole, showed that young people have a positive attitude toward condoms. Many young people agreed that using condoms:

- shows care for a partner (n = 3,513, 80%)
- can make sex less stressful (n = 3,452, 79%)
- made sex less enjoyable (n = 1,224, 28%)

Despite generally positive attitudes toward condoms, only half (n = 2,283, 52%) believed that use of condoms with new partners was common among people their age.

Accordingly, around half of young people reported frequent use of condoms:

- 57% (n = 939) always or often used condoms
- 11% (n = 176) never used condoms

At their most recent sexual experience:

- 80% (n = 1,127) reported that a condom was available
- 51% (n = 732) used one

Availability or use of condoms at most recent sexual experience did not differ according to gender, sexual

orientation, or between young people living in major cities and regional/remote areas.

Among young people who did not use a condom the most recent time they had sex, the most common reasons given were about feeling protected by using another form of contraception (n = 409, 57%), knowing their partner's sexual history (n = 327, 46%), trusting their partner (n = 292, 41%), or having low concern about STIs (n = 191, 27%).

Young people who consistently ('always') used a condom were more likely than those who did not consistently use a condom to agree that 'using condoms shows you care about your partner' (95% compared to 73%) and 'using condoms would be less stressful' (93% compared to 71%). In contrast, those who agreed that 'using condoms is less enjoyable' were less likely to always use a condom (18% compared to 54% who did not always use a condom).[62]

Changes over time in condom use

Young people's access to condoms at their last sexual experience has increased steadily over time, rising from 68% in 1992 to 82% in 2024.

In contrast, actual condom use at last sexual experience has followed a different trajectory: it improved through the 1990s, remained relatively stable in the 2000s at around 65%, and then declined notably in recent years, reaching 49% in 2021 before a slight increase to 52% in 2024.

There is a need for further research to better understand this widening gap between availability and use of condoms. It is possible that the shifting focus in HIV prevention from condom use to biomedical prevention has changed young people's perceptions of the need for condom use. In addition, increasing availability of LARC may also have had an effect on the choices young people make about condoms.

EQUITY AND ACCESS

Regional and remote young people

Young people living in regional (inner or outer regional) and remote areas were also more likely than those living in major cities to have had an STI check-up, to have spoken to a GP about sex, relationships or sexual health, and to have a GP initiate the discussion about sexual health matters.[63]

As these findings are contrary to typical concerns about reduced sexual health access in regional and remote areas, we undertook further analysis of the data. We found that there was a large cluster of young people (n = 100) from a single inner regional postcode in Western Australia, which likely reflects strong local support for the study and proactive RSE which may have meant these young people were more likely to have accessed sexual health services. To account for this, we reanalysed the data adjusting for state/territory, then by excluding this postcode, and then by excluding all young people in WA. The pattern of the findings remained the same across all these analyses.

We then used a different comparison by grouping young people living in major cities and innerregional areas together and comparing them with those living in outer regional and remote areas. In this comparison, we found that young people in outer regional/remote areas were more likely to have spoken to a GP about sexual health matters, but there were no differences in STI screening. Analyses were adjusted by age, gender and sexual orientation.[64] Table 14.4 shows the STI access responses from young people by the ARIA+ remoteness category they lived in.

"DESPITE BROADLY POSITIVE ATTITUDES, ONLY HALF OF YOUNG PEOPLE REPORTED USING A CONDOM AT THEIR MOST RECENT SEXUAL EXPERIENCE."

62 Young people who agreed that 'using condoms shows you care about your partner' (OR 1.13, 95% CI 1.07–1.19) and that 'using condoms would be less stressful' (OR 1.12, 95% CI 1.06–1.18) were more likely to 'always' use a condom, rather than not consistently use a condom (either using a condom 'often', 'occasionally' or 'never'). Young people who agreed that 'using condoms is less enjoyable' were less likely to consistently use a condom (OR 0.78, 95% CI 0.74–0.81).

63 Young people living in regional (inner or outer) and remote areas were also more likely than those living in major cities to have had an STI checkup (OR 1.55, 95% CI 1.33–1.82) and to have seen a GP for sexual health matters (OR 1.43, 95% CI 1.16–1.76) and to have GPs initiate these discussions (OR 1.46, 95% CI 1.21–1.76).

64 Young people in outer regional/remote areas were more likely to have spoken to a GP about sexual health matters (OR 1.49, 95% CI 1.15–1.94, p = .002) than young people living in major cities or inner regional areas, but there were no differences in STI screening. Analyses were adjusted by age, gender and sexual orientation.

It is possible that young people living in regional and remote areas are more likely to receive care within an integrated model. This is a model that has been adopted by many Aboriginal Community Controlled Health Organisations (ACCHOs) as part of efforts to adopt STI screening (or offering screening) into routine health consultations. A 2023 study of integrated models within ACCHOs (McCormack et al., 2023) showed that 24% of health assessments for 16- to 29-year-old Aboriginal or Torres Strait Islander people integrated a test for STIs. This figure was higher in remote areas, at 38%. It is also possible that young people have benefited from specific outreach programs to promote STI testing or initiatives such as point of care testing for STIs. Further research is needed to confirm this and better understand access to STI testing and sexual health care for young people in regional and remote areas (Kularadhan et al., 2022).

Table 14.4. **STI testing and sexual health care and STI diagnoses, by areas of living**

	Major cities n = 2,842 n (%)	**Inner regional n = 877 n (%)**	**Outer regional n = 197 n (%)**	**Remote/very remote n = 118 n (%)**
Ever seen a GP for sexual reasons	817 (30%)	339 (40%)	82 (44%)	48 (45%)
STI check-up (all %)/(sexually active %)*	293 (10%)/(23%)	128 (15%)/(27%)	30 (15%)/(23%)	19 (16%)/(24%)
STI symptoms (all %)/(sexually active %)*	280 (10%)/(23%)	99 (12%)/(22%)	24 (13%)/(20%)	9 (8%)/(12%)
STI diagnosis (all %)/(sexually active %)*	22 (0.8%)/(1.7%)	14 (1.6%)/(3%)	4 (2%)/(3.1%)	4 (3.4%)/(5.1%)
Unable to access STI prevention or treatment	137 (5.4%)	46 (5.9%)	13 (7.4%)	7 (7.4%)
Embarrassed or worried about judgement when seeking care	240 (54%)	76 (49%)	26 (54%)	11 (61%)
Beliefs†				
Testing for STIs is common for people my age	671 (24%)	217 (25%)	50 (26%)	40 (34%)
I know how to find a doctor to test for STIs	1,464 (52%)	495 (57%)	121 (62%)	64 (54%)
I'd feel embarrassed/ashamed if I had an STI	2,207 (78%)	689 (79%)	151 (77%)	85 (72%)
Belief that STIs seriously affect health	2,464 (87%)	776 (90%)	169 (87%)	103 (88%)

* Values show the percentage of all young people followed by the percentage among sexually active young people; the same n applies to both.
† Agree/strongly agree with this statement

LGBQ+ and trans young people

LGBQ+ and trans young people were more aware of STIs and more likely to attend sexual health screening than their heterosexual and cisgender peers. Specifically:

- LGBQ+ young people reported higher levels of sexual health knowledge than heterosexual young people.[65]
- Bisexual young people were more likely than heterosexual young people to have talked to a GP about sex and relationships, and to have initiated the discussion with their GP.
- Trans young people as well as young women were more likely than young men to talk to GPs about sex and relationships.
- Trans young people as well as young women were more likely than men to report that GPs initiated conversations about sex and relationships with them.[66]

Despite these strengths, LGBQ+ and trans young people reported greater barriers to sexual health care, education and support than heterosexual young people, including:

- Pansexual and bisexual young people were more likely to report unmet sexual health needs than heterosexual young people.
- Embarrassment or fear of judgement was a more commonly cited barrier to sexual health care for LGBQ+ young people compared to heterosexual young people.
- LGBQ+ young people were less confident than heterosexual young people talking to mothers and less likely to want to speak to their parents about sex and relationships. [67]
- Compared to heterosexual young people, LGBQ+ young people were less likely to find RSE relevant.[68]

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65 LGBQ+ young people were more likely to have better sexual health knowledge than heterosexual young people (ß 5.3, 95% CI 3.9–6.6).

66 Bisexual young people were more likely than heterosexual young people to have talked to a GP about sex and relationships (OR 1.61, 95% CI 1.36–1.90) and to have initiated the discussion with GPs (OR 1.44, 95% CI 1.16–1.79). Young women (OR 3.29, 95% CI 2.77–3.92) and trans young people (OR 3.15, 95% CI 2.33–4.27) were more likely than young men to have talked to GPs about sex and relationships. Young women (OR 2.20, 95% CI 1.77–2.75) and trans young people (OR 2.06, 95% CI 1.42–2.97) were more likely than men to report that GPs initiated conversations about sex and relationships with them.

67 Compared to heterosexual young people, LGBQ+ young people were less confident talking to mothers (OR 0.75, 95% CI 0.63–0.89) and less likely to choose to speak to their parents about sex and relationships (OR 0.69, 95% CI 0.60–0.80).

68 Compared to heterosexual young people, LGBQ+ young people were less likely to find RSE relevant (OR 0.70, 95% CI 0.60–0.83).

SUMMARY OF KEY FINDINGS

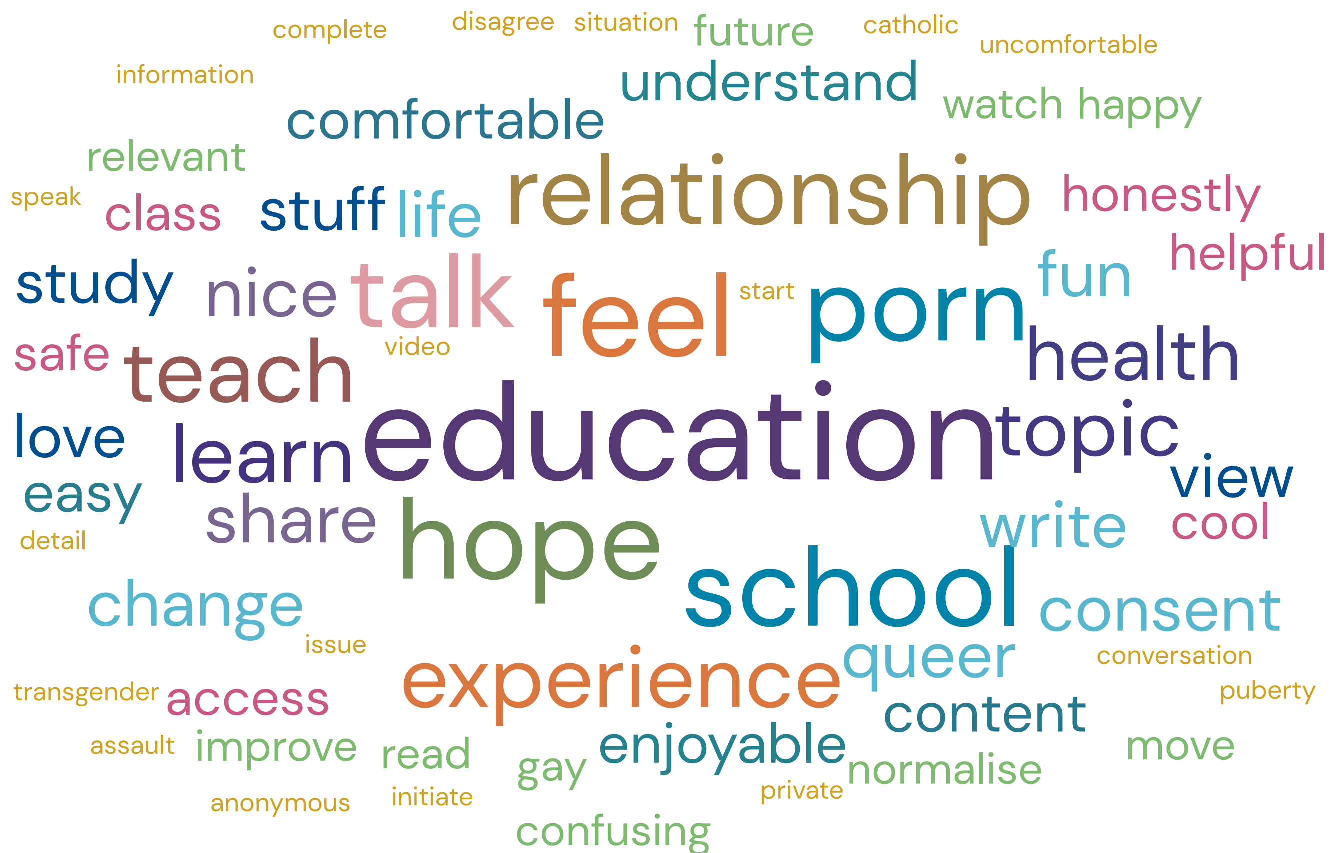
Table 14.5. Key findings from SSASH 8 in relation to the Fifth National STI Strategy 2024 to 2030 targets

Indicator	Relevant 2030 targets (National STI Strategy)	Key findings from SSASH 8
Integrated Primary Care	Increase in the number of people, including priority populations, tested for STI via no cost or lower cost GP appointments and in accordance with guidelines. Increase number of sexual health services providing care under expanded scope of practice arrangements by 2030.	• 12% had ever screened for STIs • 19% indicated having unmet sexual health needs (accessing contraception, STI testing or other issues) • 33% had spoken to a doctor about sex or relationships • 89% knew they could ask a doctor for an STI test even without symptoms • 34% were not aware that many common STIs are treatable • 41% were not aware that they could access free sexual health clinics • 44% were not aware that they could get their own Medicare card
Education and Awareness	Increase STI knowledge, awareness, and attitudes among general and priority populations. Increase the number of primary, secondary and tertiary level schools delivering sexual health education with high quality and comprehensive STI content.	• 87% believed that an STI could seriously affect their health • 78% believed having an STI would be shameful or embarrassing • 76% believed STI testing was not common for their peer group • 92% had received RSE in school • 45% perceived RSE to be relevant to their lives • 76% learnt about condom use in RSE • 65% learnt about STIs or HIV in RSE
Prevention, Testing and Treatment	Increase in the proportion of priority and general populations using any STI prevention strategies (e.g. condoms, doxy PEP) within the past 12 months.	• 57% used a condom often or always during sex • 80% had a condom available the last time they had sex, while 51% used a condom • 80% agreed that using a condom shows care for their partner and makes sex less stressful • Common reasons for not using a condom included use of other contraception, knowing a partner's sexual history and not being concerned about STIs
Equity and Access	Reduce experiences of stigma for priority populations accessing health services, including reducing stigmatising attitudes among health care workers. Reduce differences in STI rates between geographic locations and between priority populations and all Australians.	• LGBQ+ young people were less likely to find RSE relevant to their needs • Bisexual young people were more likely than heterosexual people to have unmet sexual health needs, although bisexual people were more likely to speak to a GP about sex or relationships • LGBQ+ young people had higher levels of sexual health knowledge than heterosexual young people

15. YOUNG PEOPLE'S EXPERIENCES OF COMPLETING THE SSASH SURVEY

This chapter summarises young people's reflections on completing the SSASH survey. There were 309 young people who provided feedback via an open text box at the end of the survey. This feedback provides valuable insight into how the young people felt about the survey, what worked well and where improvements could be made. Figure 15.1 shows the most frequent words young people used to describe their experiences participating in the SSASH 8 survey. The themes below summarise the most common types of feedback shared by participants.

Figure 15.1. Most frequent words young people used to share their thoughts about completing the SSASH survey (n = 309)



Note: This word cloud visualises the words mentioned most often in the open text responses, with larger words appearing more frequently in young people's responses.

POSITIVE FEEDBACK

Over a third of young people who provided feedback about the survey (119 out of the 309 who provided feedback) described the survey as clear, well written and inclusive. They appreciated that it was easy and 'fairly quick' to complete. Several participants did not offer any specific reasons for their positive feedback, only describing it as 'fun', 'cool', 'interesting' or 'enjoyable!' Others commented that they felt comfortable completing the survey and 'it was good talking about this stuff'.

> *It was lowkey fun, the most I've ever enjoyed. It helped me understand a bit more about myself and how I feel about certain things in terms of sexual health and relationships and got me thinking. Thank you! (16-year-old woman, bisexual)*

> *I found that in its detail it is very well managed (I speak as a person who has experienced sexual assault) sometimes being asked upfront about it can be daunting and the way things were worded in this survey is very reassuring and calming. (18-year-old man, queer)*

> *It was very well written and thorough. It was also very inclusive and included options about gender identity and disability/ neurodivergence which I was very excited and happy to see. (18-year-old woman, bisexual)*

THOUGHT-PROVOKING AND EDUCATIONAL

Many young people described the survey as engaging and meaningful. One participant said:

> *It asks about pretty much everything. OMG I HOPE MY ANSWERS GET PRINTED SOMEWHERE. (14-year-old man, undisclosed sexual orientation)*

Others appreciated that the survey was comprehensive without feeling overwhelming, noting that it was 'not over complicated'. A recurring theme was that the survey prompted self-reflection and learning. Young people described it as 'educational' and 'very useful', with one participant saying:

> *Most questions asked were good, [they] really made me wonder how much I have really been taught on sex ed and made me want to educate myself even more. I'd like to add how I think it is very important to teach about porn and sending nudes online. I never had talks like these in sex ed classes and honestly think this would be super important to learn about, as many young kids make these mistakes and learn from these websites, not understanding that it is scripted and highly unrealistic. Just wanted to elaborate on how important I think this part of sex ed is but the rest [of the survey] was good. Thank you 😊 (17-year-old woman, heterosexual)*

Another commented:

> *Honestly speaking, I thought it was just a mere answer and move on survey but I can tell that my understanding about sex education is enhanced and I really appreciate that. (17-year-old woman, heterosexual)*

Some participants reflected on their own experiences and gaps in their sexual health education. One young person wrote:

> *[It] made me realise how much I don't know. Thanks [redacted school name] 😘! I learnt nothing past what a period is and body parts. (18-year-old trans person, gay/lesbian)*

Participants also valued feeling heard, with one writing:

> *It's nice to know someone cares about my opinion and what I as a teenager do and don't know, rather than just assuming. (14-year-old woman, heterosexual)*

Some comments were deeply personal or reflective, including reflections on past relationships, school experiences, or identity. One young person shared that:

> *It's embarrassing sharing this information and it shouldn't be. There's still so much stigma around sex even though we're trying to progress. Also, it would be great if this had options for students in TAFE or university or people graduated or dropped out. Also, I think there should be more education around attachment in relationships once you've had sex, as I see friends struggling with it. (18-year-old woman, heterosexual)*

NEGATIVE FEEDBACK

Although only a small number of participants reported negative aspects of the survey (19 out of the 309 providing feedback), these comments are particularly important because they reflect where young people may have felt unclear about the questions, uncomfortable or had difficulty completing the survey. It is important to note that

this was the final question in the survey, meaning only participants who completed the entire survey had the opportunity to provide this feedback. As a result, it is likely that additional negative comments were not captured from young people who dropped out earlier. Understanding these experiences helps ensure the survey is respectful, accessible, and supportive for all young people. The main concerns raised about the survey related to its length, the repetitiveness of some questions, and feeling uncomfortable with certain items as demonstrated by the quotes below:

It was very long and some questions repeated and I did feel uncomfortable at times about the questions and I was unsure about some but at the end of the day I am glad I did this because research for this will go a long way. (18-year-old woman, bisexual)

It made me very uncomfortable and I don't know why. I don't believe it should, as it is a natural thing. But I don't like the thought in general so it may just be me. (18-year-old woman, bisexual)

SUGGESTIONS FOR IMPROVEMENT

Participants offered a range of constructive suggestions, including requests for clearer wording, more inclusive response options, or additional topics they felt should be covered. These suggestions reflect young people's engagement with the survey and their interest in helping shape a tool that better reflects their needs and experiences. Mainly young people wrote about wanting more questions to reflect their experiences, particularly more questions where they could type in an answer, as described below:

> *I somewhat wish that there was an additional comments section on each page to explain some answers as I feel there was not enough context for some of mine and it may skew the data. (15-year-old woman, queer)*

Some participants mentioned that the questions were difficult to answer because they did not have experience with the topic. In addition, young people wanted more response options, particularly neutral choices and 'not applicable' options for questions that did not fit their experiences, such as items about condom use or sexual activity:

> *It was pretty good but there should be more options to, like, be more neutral; like sometimes in the last section I would get a question where I did not really agree or disagree but there was no option for that. (16-year-old man, heterosexual)*

> *… it needs to ask questions that are on a deeper level [to] actually get the person taking the survey engaged, and actually [it would help] the person be able to talk about this as most might find it uncomfortable to talk about this to people in person (15-yeal-old man, heterosexual)*

Young people also would have liked more questions about diverse gender identities and different sexual experiences including masturbation. While the survey included three items designed to explore young people's perceptions of gender norms, some young people felt that these questions were too heteronormative and not fully reflective of the range of gender identities represented among participants.

SUPPORT FOR SSASH

A number of young people ended their feedback with messages of encouragement, wishing the research team 'good luck', expressing hope that their responses would be useful, or wanting to know when the results would be released. These comments, while brief, reflect a sense of goodwill and willingness to contribute to research that aims to improve sexual health education and support for young people. Examples below:

> *I respect and encourage what you are doing, this is a very important issue. (18-year-old woman, sexuality undecided)*

> *Thank you for actually doing research into youth sexual health. It is very much lacking!!! Especially for LGBTQ youth!!! (18-year-old woman, bisexual)*

CONCLUSION

Taken together, young people's reflections show that the SSASH survey was largely experienced as clear, inclusive, and meaningful, while also highlighting specific areas where improvements could strengthen its relevance and accessibility. Young people's suggestions were varied and offer practical guidance for refining future iterations. Importantly, many participants described the survey as thought-provoking and educational, and they expressed genuine appreciation for being asked about topics that matter to them. Their feedback not only validates the value of the survey but also demonstrates the importance of continuing to involve young people directly in shaping sexual health research and education as suggested by one young person:

> *We should have more of these surveys to include the youth in sexual conversations. This survey helped me feel more confident talking and thinking about sexual topics. Sex should be more normalised and destigmatised by our communities, because keeping us in the dark only makes things amplified and confusing. (14-year-old woman, lesbian)*

16. DISCUSSION

The findings from SSASH 8 provide a comprehensive and nuanced picture of young people's sexual health, relationships and help-seeking in contemporary Australia. Consistent with previous iterations of the survey, the findings highlight both strengths and areas of concern.

Many young people who participated in this study report positive, safe and enjoyable relationship experiences, and demonstrate a willingness to seek information and support from peers, partners and professionals. This is an important finding, as these are precisely the kinds of experiences and capabilities we aim to better understand and foster.

At the same time, survey findings show that persistent challenges remain. There were unacceptable levels of unwanted sex, coercion and intimate partner violence; safe sex practices, including effective contraception and condom use, were not consistently followed; and many young people perceive RSE to be inadequate their needs.

These strengths and challenges sit within the broader social and cultural contexts shaping young people's lives, including digital sexual cultures, evolving gender norms, and structural barriers to care.

NAVIGATING COMPLEXITY

SSASH 8 findings speak to the complexity of sexual experiences for young people. Even consensual sex may involve uncertainty or ambivalence, often shaped by social or sexual stigma, concerns about body image or struggles to assert needs or wants within a relationship. Decisions about contraception or condom use can be similarly complex, often shaped by relationship context, beliefs about trust and desirability, and experiences of pleasure and desire. It is this complexity that we seek to emphasise here. Young people's sexual health and wellbeing is not straightforward. Recognising complexity and contradiction is essential for identifying where support, reflection and skill building are most needed, particularly in relation to sexual consent. Supporting young people in this context involves equipping them with the skills to navigate ambiguity, negotiate changing desires, and reflect on the social context, their own boundaries, and their developing awareness and experience of sexual relationships.

IMPROVING RESPONSES TO SEXUAL AND INTIMATE PARTNER VIOLENCE

Young people in this study reported high levels of sexual and intimate partner violence including fear of a partner (23%), technology-facilitated harassment by a partner (19%), physical violence by a partner (11%) and forced sex by a partner (1.5%).

SSASH 8 is not a representative study, and these figures should therefore be interpreted with caution. However, as mentioned previously, the sample does mirror findings from population based studies that have looked at young people's experience of violence.

The Australian Child Maltreatment Study, a nationally representative survey of child abuse and neglect in Australia, found that among participants aged 16–24 who had 'ever' been in a relationship:

- 44% had experienced psychological violence from a partner
- 25% had experienced physical violence from a partner
- 18% had experienced sexual violence from a partner (Mathews et al., 2025)

Similarly, the Longitudinal Study of Australian Children (LSAC), a nationally representative study that has followed approximately 10,000 children and their families since 2004, reported that, in 2018, 29% of 18–19-year-olds had experienced at least one form of intimate partner violence in the 12 months prior to the survey. Specifically:

- 25% had experienced emotional abuse
- 12% had experienced physical violence
- 8% had experienced sexual abuse (O'Donnell et al., 2023)

There is a need for further research, prevention and education initiatives, and improved support for young people experiencing intimate partner violence. While Australia has strengthened primary prevention efforts in relation to family, domestic and

sexual violence in recent years, these initiatives do not always adequately reach younger adolescents (Hobbs, 2022).

Findings from the LSAC (O'Donnell et al., 2023) point to potential protective factors: high levels of trust and open communication with parents, and supportive friendships, is associated with a reduced likelihood of experiencing intimate partner violence. However, there remains a need for further research to better understand how young people navigate safety, respect and communication within relationships and the impact of contemporary gendered-cultures and attitudes to relationships. We also need research to better identify effective strategies for prevention.

PERSISTENT GAPS IN STI PREVENTION, CONTRACEPTION AND HEALTH CARE ACCESS

Despite widespread awareness of condoms and contraception among young people in this study, the relatively high reliance on 'withdrawal' for contraception (a method known to be ineffective), alongside inconsistent condom use, indicates a gap between knowledge and practice. These gaps are likely shaped not only by individual decision-making, but by relational and cultural dynamics. In this study, young people's attitudes toward condom use and STI testing appear to be influenced by perceptions that condom use is uncommon among peers, as well as ongoing stigma associated with STIs. There is a need for new, contemporary research on young people's sexual cultures that examines attitudes toward STIs, contraception and condom use in the current context.

Access to sexual health care remains a significant area of concern. While many young people had spoken to a GP about sexual health, nearly one in five reported being unable to access care when needed. Barriers such as cost, concerns about confidentiality, and fear of judgement remain highly salient. Misunderstandings about Medicare access and visibility of Medicare records to parents further compound these challenges.

These findings suggest that improving sexual health outcomes requires not only education, but also structural changes to ensure that services are accessible, affordable, confidential and youth friendly.

THE CENTRAL ROLE, AND LIMITATIONS, OF RSE

While RSE is almost universally provided in Australian schools, young people's experiences of it are uneven, inconsistent, and often misaligned with their developmental needs. Nearly all participants had received RSE at least once, yet only 45% found it relevant or very relevant, and many felt it did not prepare them for the realities of sex and relationships.

Young people were most likely to receive RSE between years 6 and 10, with years 8 and 9 being the years young people were most likely to receive RSE. Yet less than one in four received any RSE in years 11 or 12, precisely the period when many are beginning to form intimate relationships, explore sexuality and become sexually active. This gap leaves young people without structured opportunities to revisit earlier content with greater maturity, or to learn the more nuanced relational, emotional and ethical skills that become increasingly relevant as they grow older. The absence of RSE in senior secondary school also helps explain why many participants described the content as poorly timed, either arriving, as one participant said, 'when I was 13... not when it's actually relevant' or long before they were ready to make sense of it.

Across all year levels, young people emphasised that RSE is too often biological, risk-focused and disconnected from real relationships. They wanted practical guidance on consent in context, including understanding of how to navigate and enact boundaries in relationships, recognising unhealthy dynamics, and understanding their own emotions. These were areas they felt were missing or superficial.

Young people also highlighted significant gaps in inclusivity. Many felt unrepresented by RSE content that centred on heterosexual, cisgender experiences and gave limited attention to diverse bodies, identities and relationships. Others noted that even basic anatomy and puberty education was uneven, with female and gender diverse experiences often overlooked.

The learning environment itself played a major role in shaping young people's perceptions of relevance. Awkward classroom dynamics, moralistic messaging, and teachers who seemed uncomfortable or underprepared undermined engagement. In contrast, young people valued RSE that was respectful, conversational and facilitated by confident, relatable educators. They consistently asked for smaller groups, opportunities to ask anonymous questions, and teachers or external specialists who could speak openly and without judgement.

Finally, young people were clear about what they want: consistent, comprehensive, practical and inclusive RSE, delivered across more years of schooling (including the senior secondary years) and taught by people they trust. They want education that reflects the diversity of their experiences and identities, and that prepares them not only for the

biological aspects of sex, but also for the relational, emotional and ethical dimensions that shape healthy, respectful and fulfilling relationships.

Strengthening RSE in Australia will require moving beyond narrow, one-off lessons toward a developmental, whole-school approach. Such an approach recognises sexuality as a lifelong aspect of wellbeing and equips young people with the skills they need as they grow, change, and navigate increasingly complex relationships.

DIGITAL SEXUAL CULTURES AS A KEY LEARNING ENVIRONMENT

These findings confirm that, far from being peripheral, the digital environment is integral to the sexual and relationship practices of most young people. For many young people, digital sexual engagement begins early, including accessing pornography from around age 13.

Again, complexity is central to the story here. Young people described pornography as informative and enjoyable, but also uncomfortable, underscoring its role as a site of sexual learning while also showing that young people need education and critical literacy skills to engage with pornography safely and confidently. Similarly, sexting is often experienced as a form of intimacy within trusted relationships, yet also involves risks such as coercion, receiving unwanted content, and non-consensual sharing. Dating apps can provide opportunities to meet partners, while also introducing new forms of vulnerability, negotiation and safety considerations. These contradictions reflect a broader reality: online sexual practices do not fit neatly into categories of 'good', 'bad', 'healthy' or 'harmful'. This complex and nuanced understanding of digital sexual practices needs to be reflected in research, education and policy.

Supporting digital sexual literacy requires prioritising education that builds the skills young people need to navigate the digital landscape, including critical thinking, communication, consent, boundary setting and emotional reflection. Young people need opportunities to develop skills to navigate ambiguity, and often this will involve recognising when something (e.g. sharing images) feels uncomfortable or pressured, interpreting cues in online interactions, making decisions about what aligns with their values and emotional responses, and identifying when something feels unsafe or crosses their boundaries. These competencies must be fostered in ways that acknowledge diversity across gender, sexuality and cultural contexts.

Efforts to reduce harm cannot, of course, rely solely on young people's choices, but must also include holding digital platforms accountable for

environments that enable image-based abuse, unwanted contact, or exposure to harmful content. Digital sexual literacy education must include critical insight into the limitations of the regulatory environment regarding online safety.

Overall, digital technologies do not simply introduce new risks, but also create new opportunities for intimacy, exploration, and learning, while amplifying existing inequalities and introducing new pressures. A holistic, youth-centred approach to digital sexual literacy and safety should recognise this complexity. By listening to young people's perspectives and acknowledging the full range of their experiences, we can better support young people to navigate digital sexual cultures with confidence, autonomy, and care.

COMMUNICATION, STIGMA, AND SUPPORT NETWORKS

Communication is central to navigating safe, respectful and enjoyable sexual relationships. This may mean having conversations about sex and relationships with educators or people who can offer advice and support, or it may mean communicating sexual needs, wants and boundaries with a sexual partner. In both cases, talking openly about sex can be hard, for adults as well as young people, and many people find it embarrassing or shameful to talk about their bodies or emotions and desires related to sexuality. It is a topic that is often avoided unless there are specific problems or issues to be addressed. We were keen to focus on communication in this study, to explore whether young people felt able to initiate conversations, and seek help and support for their sex lives and relationships.

Across the findings, it is clear that while many young people have someone in their lives with whom they can discuss sex and relationships, their opportunities and comfort in doing so vary widely depending on context, identity and experience.

Friends were the primary and most trusted source of conversation for most young people. Young people, particularly young women and LGBQ+ young people, reported high confidence talking with friends, underscoring the importance of peer relationships in navigating early sexual experiences.

While less frequently approached by young people, parents also played an important role for many young people in talking about sex and relationships. Young people who communicated with parents about these issues reported greater STI knowledge and stronger engagement with health care professionals, suggesting that parent–child communication continues to have protective and educational benefits even when conversations are infrequent or uncomfortable. Yet, parental messages themselves varied from harm reduction and support, to abstinence-based or moral messaging, to silence or shame. This variation reflects diverse family cultures, values and levels of comfort. There is an ongoing need for interventions to support parents to initiate and sustain conversations with their children about sex and relationships.

Communication within sexual relationships also appears to be a strength among many sexually active young people in this study. Most reported discussing pleasure, boundaries, contraception and condom use with partners, demonstrating that young people are actively negotiating many aspects of respectful and safe sexual engagement. However, fewer discussed STI prevention, highlighting an important gap in how sexual safety is understood and prioritised.

These findings show that while many young people have strong foundations for open communication, access to supportive conversations remains uneven. Young men, in particular, report lower confidence talking to friends and parents, suggesting gendered constraints around vulnerability and sexual communication. LGBQ+ young people, meanwhile, were more likely to talk to peers but less likely to rely on parents, reflecting both the importance of queer peer networks and the challenges some face in heteronormative or unsupportive home environments.

Ultimately, young people benefit most when they have multiple pathways for talking about sex and relationships through peers, partners, parents and trusted adults such as GPs or counsellors. Strengthening these communication ecosystems means creating environments where sexuality is discussed openly and without shame, where adults are equipped to provide accurate and affirming guidance, and where young people feel empowered to ask questions, seek help and articulate their needs. Supporting communication is therefore not simply about encouraging young people to 'talk more', but also about fostering environments— at home, in health care, in education and in peer groups— that normalise and value conversations about sex and relationships and grounds them in respect, safety and inclusivity.

CONCLUDING NOTE

Overall, SSASH 8 highlights that young people are navigating their sexual and relational lives with care, curiosity and a strong desire for accurate information and supportive environments. The challenge for policy, education, families and health systems is not only to reduce harm, but also to actively enable young people's capacity to experience safe, respectful and positive relationships.

RECOMME

RECOMMENDATIONS FOR POLICY

Strengthen national and state/territory investment in comprehensive RSE, respectful relationships and consent education

- Support sustained, developmentally appropriate RSE across all year levels, including years 11 and 12
- Ensure respectful relationships and consent education curriculums meaningfully address sexual consent, sexual ethics, and gender-based intimate partner violence
- Resource pre-service and in-service teacher training in RSE to support enhanced confidence to deliver RSE at all year levels
- Resource the development of accessible resources and lesson plans to support teachers and other educators to deliver inclusive, non-judgemental and engaging RSE and consent education, and to address sensitive topics, including pornography

Improve access to youth-friendly sexual health care

- Expand bulk-billed and low-cost sexual health services for young people
- Improve public awareness of young people's right to access Medicare independently from age 14

Fund targeted, community-led approaches

- Support culturally safe and inclusive programs for priority populations
- Invest in co-designed interventions with young people, including peer-led initiatives

RECOMMENDATIONS FOR SCHOOLS AND OTHER EDUCATORS

Deliver relevant and engaging RSE

- Focus on practical relationship skills (communication, consent negotiation, help-seeking)
- Use real-life scenarios that reflect young people's experiences and open up conversations about sexual experiences, emotions and the complexities of relationships
- Integrate digital sexual literacy education that aims to support young people to safely learn about sex and relationships using online content and platforms
- Create space for open, non-judgemental conversations about pornography and sexual ethics

Extend RSE into senior secondary years

- Provide age-appropriate RSE in years 11 and 12 to ensure young people receive relevant education in the years they are more mature and more likely to be sexually active

Create safe and inclusive learning environments

- Ensure RSE and consent education reflects diverse genders, sexualities and cultural backgrounds
- Ensure the curriculum addresses harmful gender norms and peer cultures that normalise disrespect, harassment and violence

NDATIONS

RECOMMENDATIONS FOR PARENTS

Encourage open, ongoing communication with children and young people

- Create opportunities for regular, judgement-free conversations about relationships, sex and pornography
- Demonstrate curiosity and focus on listening and supporting rather than providing instructions or setting rules

Build knowledge and confidence to initiate and sustain conversations

- Access resources to support discussions about consent, relationships, sexual ethics and sexual health
- Practice talking openly about sex, relationships, consent, pornography or other issues with a friend or partner in order to build confidence to talk to young people

Support young people's autonomy and privacy

- Understand young people's rights to confidential health care
- Balance guidance with respect for independence

RECOMMENDATIONS FOR GPS AND OTHER HEALTH PROFESSIONALS

Provide proactive sexual health care for young people

- Routinely initiate conversations with young people about sexual health and relationships in all consultations
- Where possible, regularly offer STI testing for young people in consultations

Address confidentiality clearly

- Explain privacy rights and Medicare access to young people in consultations
- Reassure patients about confidentiality to reduce fear of parental disclosure
- Ensure that young people are given an opportunity to speak with clinicians privately

Reduce stigma in clinical interactions

- Use non-judgemental, inclusive language
- Recognise the diversity of young people's experiences and identities
- Normalise STI testing and diagnoses

Strengthen referral pathways

- Connect young people to specialised sexual health, counselling and support services when needed

RECOMME

RECOMMENDATIONS FOR FUTURE RESEARCH

Develop and validate comprehensive, strengths-based outcome measures for young people's sexual health and wellbeing

- There are currently few quantitative measures that capture positive sexual health and wellbeing outcomes for young people, or that take a comprehensive view of sexual and relationship wellbeing. Developing these tools would support strengths-based approaches to policy and education, and help build an evidence base on the factors that support and protect sexual health and wellbeing.

Strengthen longitudinal and developmental research

- Longitudinal studies that follow young people across adolescence and into early adulthood would provide valuable insight into sexual cultures and the processes that support the development of safe, respectful and enjoyable relationships, including the impact of RSE, respectful relationships and consent education.

Focus on younger adolescents (ages 12 to 14)

- There is a need for age-appropriate research with younger adolescents to better understand how norms around gender, relationships, consent and digital practices are formed, and how early intervention can be most effective.

Deepen understanding of sexual and intimate partner violence, and protective factors

- Further research is needed to examine the contexts, dynamics and trajectories of violence in young people's relationships, including technology-facilitated abuse, as well as the role of protective factors such as peer support, family communication and school environments.

Examine the gap between knowledge and practice in STI prevention and contraception

- New research is needed to explore how relational, cultural and emotional factors shape young people's decisions about condom use, STI testing and contraception in real-life contexts. This is particularly important given that shifts in HIV prevention toward biomedical approaches have reduced investment in condom promotion, and alongside this, there have been recent increases in STIs, including syphilis.

Investigate access to and navigation of sexual health care

- Further research should explore how young people understand and navigate sexual health care systems, including barriers related to cost, confidentiality, stigma and Medicare, and identify models of care that are genuinely youth-friendly and accessible.

Evaluate and reimagine RSE delivery models

- There is a need for rigorous evaluation of different approaches to RSE, respectful relationships and consent education. This should include:
  - examining the effectiveness of whole-school approaches delivered across multiple year levels
  - developing a set of well-defined indicators, based on a clear theory of change, that articulate what effective RSE, respectful relationships and consent education aims to achieve to guide implementation and monitoring

NDATIONS

Advance research on digital sexual cultures as learning environments

- While there is strong evidence of the risks associated with online sexual engagement, further research is needed to understand how young people engage with pornography, sexting and dating apps as sites of learning, including how they interpret, critique and integrate these experiences into their sexual development.

Develop and evaluate digital sexual literacy interventions

- There is a need to design and test interventions that build critical thinking, communication, consent, and boundary-setting skills in online contexts, with attention to how young people navigate ambiguity, pressure and risk.

Strengthen research on communication ecosystems

- Further research is needed on how communication about sex and relationships operates across peers, partners, parents and professionals, including how to support more inclusive and effective conversations. This includes developing strategies to support parents to communicate with young people about sex, gender, sexual relationships and digital sexual engagement (including pornography).

Prioritise diversity and intersectionality

- All future studies should be designed to capture variation across gender, sexuality, culture and socio-economic context, recognising that risks, resources and experiences are unevenly distributed.

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