

Young people and sexual health in rural and regional Victoria

A discussion paper by the Youth Affairs
Council of Victoria and the Victorian Rural
Youth Services initiative

June 2013

The Youth Affairs Council of Victoria

The Youth Affairs Council of Victoria (YACVic) is a vibrant, member based organisation that represents and advocates for young people and the organisations that work with them. YACVic has worked for and with young Victorians and the services that support them for over 50 years.

Our vision is for a Victorian community in which all young people are valued as active participants, have their rights recognised and are treated fairly and with respect.

The Victorian Rural Youth Services

The Victorian Rural Youth Services (VRYS) initiative sets out to advance research, training and policy development to support the rural youth sector. It aims to promote the strengths of young people in rural communities, and address the disadvantages these young people can face. The initiative is supported by the VRYS network, a network of services concerned with young people's wellbeing in rural Victoria, and it operates through the Youth Affairs Council of Victoria.

The Youth Affairs Council of Victoria Inc
Level 2, 180 Flinders St, Melbourne VIC 3000
Ph: (03) 9267 3799 Fax: (03) 9639 1622

www.yacvic.org.au

Joanna Hatcher, Rural Youth Services Support and Advocacy Officer
rural@yacvic.org.au

June 2013

Contents

Introduction.....	4
Policy background.....	5
Health inequalities: rural young people.....	7
Young people and sexual health.....	7
Rural / metropolitan disparities.....	8
Family planning and safer sex.....	11
Access to condoms	11
Consistency and effectiveness.....	12
Relationships and attitudes.....	13
Gender norms and behaviours.....	14
Emergency contraception and family planning.....	15
Violence against women.....	17
Alcohol and 'boredom'.....	19
Education.....	20
Health promotion and prevention.....	21
Recommendations	25
Examples.....	30
Smart and Deadly – Albury Wodonga.....	30
Sexual Assault Prevention – Geelong.....	32
Safer Sex in the Sticks – Swan Hill and Robinvale.....	34
TESTme – Chlamydia screening for young people.....	37

Introduction

This paper addresses the inequalities of sexual and reproductive health experienced by young people living in rural and regional Victoria, and puts forward approaches to addressing these. Improved standards of sexual and reproductive health would result in lower tertiary health care costs and stronger social, economic and personal outcomes in rural and regional communities.

The World Health Organisation defines sexual health as follows:

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.¹

Health inequalities, as defined by VicHealth, are differences in health status, such as rates of illness and death or self-rated health, that result from social, economic and geographic influences that are avoidable, unfair and unnecessary. Health inequalities are affected by access to services which support health and wellbeing, and access to opportunities necessary to maintain good health, such as education, employment, and adequate housing.²

A study conducted through the Australian National University in 2005 used data modelling to estimate that if all Australians had the same health status as the most affluent 20% of the population, then health care costs would be around \$3 billion lower each year.³

Sexual and reproductive health are significant elements of this picture. Here, young people in rural communities are vulnerable to a range of inequalities.

Policy background

Engage, Involve, Create

Key aims of the Victorian Youth Statement (2012), *Engage, Involve, Create*, include:

- To increase opportunities for young people to get involved in activities which support their physical health and emotional wellbeing; and
- To address challenges experienced by rural young people in accessing support services.⁴

These objectives seem relevant to the sexual and reproductive health of young Victorians in rural and regional communities.

The Public Health and Wellbeing Plan, and Health Priorities Framework

In 2011, the Victorian Government Department of Health (DOH) released the *Victorian Public Health and Wellbeing Plan 2011-15*. DOH stated:

*Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment, on populations rather than individuals, and on the factors and behaviour that cause illness and injury.*⁵

This document stresses that preventative health is ‘everybody’s business’ and should encompass engagement with, and partnerships between, the business, community and volunteer sectors, as well as individuals and families. Priority settings for action are local communities, health services, early childhood and education settings, and workplaces.⁶

The plan notes the strong relationship between poor socio-economic status and poor health, the large health gap between the most advantaged and most disadvantaged members of the community, and rising rates of certain infections and illnesses, including sexually transmitted infections (STIs). As many chronic conditions and risky behaviours begin in adolescence, it is important to focus on young people.⁷ The plan aims to:

- Reduce the transmission of STIs and their personal and social impacts
- Support communities to take part in prevention, promotion and education activities
- Improve young people's sexual health literacy through school based education
- Collaborate with relevant agencies to reduce the number of unplanned pregnancies
- Increase access to health services across Victoria, particularly for at-risk populations
- Increase sexual health screening and use of treatment services by rural Victorians.⁸

The *Victorian Health Priorities Framework (2011-22)* outlines the Victorian government's initiatives to boost the rural health workforce and clinical services. The framework identifies children and young people as needing particular attention, and notes that young people are contracting STIs at a higher than average rate. Strategies to improve Victorians' health should extend beyond the health sector to engage the education, employment, human services, local government and business sectors.⁹

Sexuality Education in Victorian Schools

It is compulsory for government schools in Victoria to provide sexuality education, within the Health and Physical Education domain. The Department of Education and Early Childhood Development (DEECD) urges a whole-of-school approach, from P-

12, covering issues including family, reproduction, puberty, safer sex, abstinence, contraception, gender, relationships, sexual diversity, decision-making, safety and values. DEECD suggests these topics can be addressed across a number of settings, including science and English, and highlights the importance of evaluation, partnerships with parents and community, and a school ethos which seeks student input, ensures a safe environment, and promotes positive staff role-modelling. Schools are provided with the *Catching On* resource, to help develop and maintain sexuality education programs.

Victoria's Action Plan to Address Violence Against Women and Children

Victoria's Action Plan to Address Violence Against Women and Children (2012-15) recognises the health, personal, social and economic costs of violence towards women and children. Prevention approaches include educating to change behaviours and attitudes and promote respectful, non-violent relationships, and engaging organisations and communities to promote gender equity and stop violence. Initiatives supported by the Victorian Government include White Ribbon activities, Indigenous Family Violence and Sexual Assault Awareness campaigns, the Preventing Violence Against Women in our Community pilot projects, and the Reducing Violence Against Women and Their Children grants.¹⁰

Health inequalities: rural young people

Young people and sexual health

Young Australians are engaging in sexual activity at significant and growing rates. When the 4th National Survey of Australian Secondary Students (La Trobe University, 2008) surveyed 3000 Year 10 and 12 students from over 100 secondary schools, they found that 78% reported having experienced some form of sexual activity.¹¹

Unfortunately, young Australians are also disproportionately vulnerable to poor sexual health outcomes, incurring costs to individuals, communities and the economy. There has been a rapid rise in STI notifications in recent years, mostly amongst young people. In 2008, over three-quarters of Australia's STI notifications were amongst people aged 15-29, and between 2009-12 there was a 20% increase in the rate of STIs detected in this age group.¹²

The most commonly reported STI in Australia is chlamydia trachomatis, an infection which, if untreated, can lead to pelvic pain, ectopic pregnancy and infertility. There was a six-fold increase in chlamydia notifications in Victoria between 1995-2005; rates are still rising, and DOH estimates that around 75% of notifications are from individuals aged under 30. In 2012, Victoria saw 9923 new chlamydia infections recorded amongst people aged under 25, most of them young women.¹³

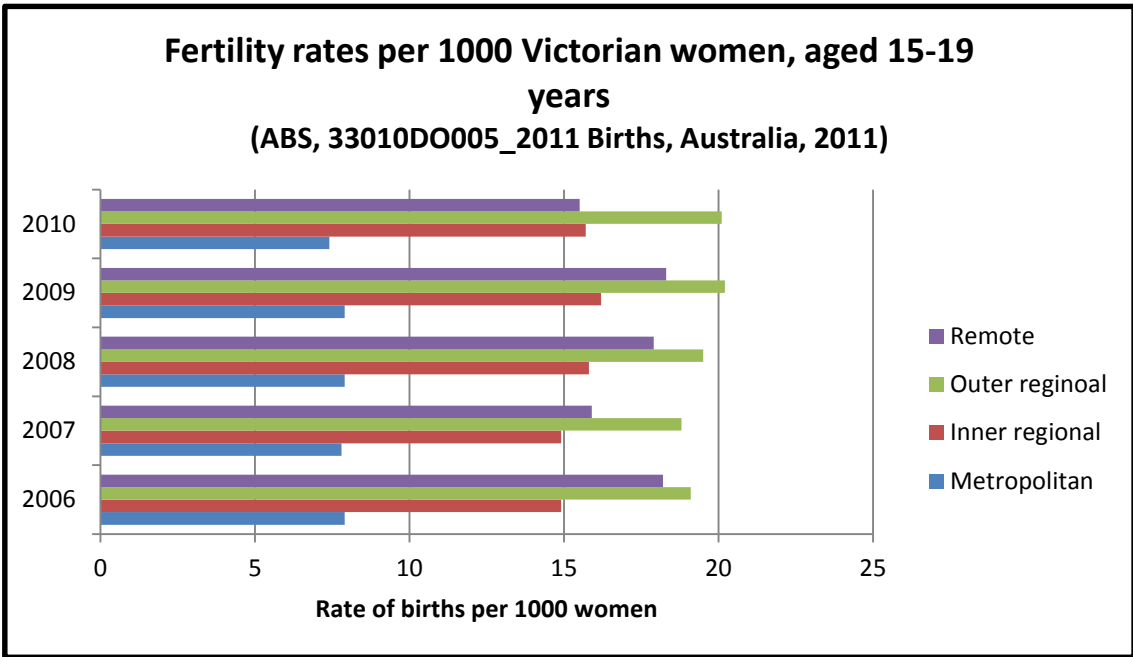
Meanwhile, new diagnoses of HIV have been rising steadily since 1999, mostly amongst young men. Between 2007-11, there were 20 new HIV diagnoses in the 13-19 year old age group in Victoria, and 340 in the 20-29 age group. Rates of syphilis also increased slightly, with 49 new infections reported in 2012 for people aged under 25, most of them young men.¹⁴

The Victorian Government Burden of Disease data (2005) listed unsafe sex as a risk factor responsible for 0.4% of the total disease burden in Victoria.¹⁵

Rural / metropolitan disparities

According to DEECD's *State of Victoria's Children report* (2013) and *Adolescent Community Profiles* series (2010), there are significant disparities in sexual health outcomes between rural and metropolitan Victoria.

In 2009, the percentage of young people aged 12-14 who had had sexual intercourse was higher in rural Victoria (6.2%) than in metropolitan Victoria (5.6%). The rate for 15-17 year olds was also higher in rural areas (30.5%) than in metropolitan ones (24.3%).¹⁶



Overall, the fertility rate of young Victorian women decreased between 2001-11. However, significant disparities exist between rural and metropolitan areas. According to the Australian Bureau of Statistics (ABS), between 2006-10 the fertility rate amongst 15-19 year olds was roughly twice as high in rural, regional and remote areas as it was in metropolitan Victoria. Outer regional Victoria showed the highest

rate of births to teenage women. Meanwhile, amongst 20-24 year olds, the fertility rate was two to three times higher in rural and regional areas than in Melbourne, and followed a clear pattern whereby fertility increased with increasing remoteness. Inner and outer regional Victoria showed a small rise in fertility rates between 2006-2010 for the 15-19 year old age group, and a clear rise in fertility amongst the 20-24 year olds.¹⁷

Young motherhood is not necessarily a negative or unwanted experience. However, the age at which women become mothers is likely to affect the types of support they need, and has implications for the levels of income and education they will be able to attain. Teenage motherhood, in particular, is often (although not always) associated with higher than average rates of poverty, poor housing, early school-leaving, and depression.¹⁸ Babies born to teenage mothers are also at higher than average risk of poor health outcomes such as low birth rate, pre-term births, poor emotional, cognitive and behavioural development, and fetal or perinatal deaths.¹⁹

Meanwhile, the rate of STIs among adolescents has been consistently higher in rural Victoria than the state average since at least 2004, when the Victorian Child and Adolescent Monitoring System (VCAMS) figures were first gathered. In 2010, the rate of infections per 1000 adolescents was 4.2 in regional Victoria, compared to 2.3 in Melbourne. Rates appear to be highest in inner regional Victoria.²⁰ Chlamydia infections increased in all rural regions and rural divisions of general practice, and almost all rural LGAs, between 2009-2011.²¹

However, perplexingly, the rates of STIs and births do not seem to relate in any immediate, obvious way to the reported rates of condom usage and contraception. According to the *State of Victoria's Children report* and the VCAMS profiles, rural young people are more likely than metropolitan young people to report that they have used condoms or contraception. (The measure of condom usage was calculated as a percentage of the students who said they had had sexual intercourse. The contraception measure was calculated as a percentage of the female students who said they had had sexual intercourse.)²²

In this briefing, we will suggest some reasons for this reported disparity, outline the causes behind sexual health inequalities, and suggest some approaches the Office for Youth could take to support healthier and more equitable outcomes.

Family planning and safe sex – access, consistency and attitudes

The relationship between young people's use of contraception and condoms, and rates of STI transmission, pregnancy and parenthood, is not a simple one. Many forms of protection can fail or be used incorrectly. A 2006 study of 2,003 Australian women by Marie Stopes International found that 60% of women who had experienced an unplanned pregnancy reported that they were using at least one form of contraception at the time.²³ Furthermore, condoms and other forms of contraception are not always used consistently or correctly.

Access to condoms

Buying condoms can be embarrassing for young people. One recent study from the Netherlands found that embarrassment was affected by the product's placement within the shop, with counter placement seen as the most awkward.²⁴ However, for young people in rural communities, it may be an uncomfortable experience regardless. In a survey of Victorian rural health providers conducted in 2012, respondents were asked how living in a rural area impacted on access to condoms. The most common concerns highlighted were privacy / confidentiality (30.6%), cost (21.2%) and availability / access (15.5%).²⁵ Comments included:

- *'In some towns they [condoms] are only available at local shops. I had a young person tell me that the shop keeper refused to serve them and threatened to tell their mum (who was a friend).'*
- *'Privacy. Buying condoms in a small town generally means purchasing them from someone you know which can be embarrassing. Access: supermarket and pharmacy closed after 8pm.'*²⁶

Similar concerns were raised in interviews conducted with health and community service providers in the Hume region in 2011. They also pointed to problems such as supermarkets not stocking condoms or keeping them under the counter, very limited availability of free condoms, and a reluctance to install or maintain condom vending machines due to vandalism in the past.²⁷

Consistency and effectiveness

Many young people use condoms and / or contraception inconsistently. The 4th National Survey of Australian Secondary Students (2008) found that only about half the students who were sexually active reported using a condom every time they had sex. 43% said they used condoms some of the time, while 7% reported never using them.²⁸ Studies from the United States point to similar trends. A US survey of 75,397 patients at an STI clinic found that 54% of them reported condom use in the previous four months, most of which was inconsistent.²⁹ This study concluded that the most striking differences in health outcomes were not between people who used condoms and people who did not, but between those who used them consistently and those who did not.

Closer to home, an in-depth qualitative study of young mothers from Seymour and Benalla (2007) found that many of these young rural women had used condoms and contraception before becoming pregnant. However, their usage was irregular and their knowledge was poor. Their comments included:

- *'a lot of girls forget to take the pill ... most of my friends have not used protection at least once'*
- *'We weren't told that condoms can have holes in them'*
- *'We used [a condom] when we had it and when we didn't have it I suppose we, you know, we'd withdraw'*
- *'My older sister was on the pill ... and I used to pinch her pill ... One day [I'd] miss it, and then the next [I'd] take two or three'.³⁰*

Additionally, a person's risk of contracting an STI is not related to their personal behaviour alone. It is also affected by the broader rates of infection in their sexual networks. Given rural young people's comparatively limited access to health services, and given that a relatively high proportion of them are sexually active at a young age, it is possible that their risk of (re)infection is higher than average.

Relationships and attitudes

While a lot of sexual health information treats young people as autonomous individuals making personal choices, it is important to recognise that these choices are made in the context of relationships. A longitudinal study of teenage young people in the US found that, of those who had been in two or more sexual relationships, over half reported that their use of contraception varied across these relationships.³¹ There is some evidence from Australian and American studies that young people in their teens are more likely to use condoms or contraception consistently if they have been in only one relationship, and less likely if they have had a high number of sexual partners.³²

Also important is the nature of these relationships. American studies suggest that young people are more likely to use contraception if they have engaged in a lot of 'dating' activities with their partners before having sex, if they know their partners well, if they have had prior conversations about contraception, and / or if they are with a partner of a similar age to themselves.³³ It also seems that young people are more likely to talk to their sexual partners about contraception and STIs if they have a history of communicating well with their parents about life matters in general.³⁴

Conversely, some young people have trouble applying knowledge about safer sex practices to real life situations. The 4th National Survey of Australian Secondary Students found that the most common reasons students gave for not using a condom during their last sexual encounter were 'it just happened' (39%), trusting their partner (31%) and knowing their partner's sexual history (27%). 22% of the young women reported 'my partner doesn't like them'.³⁵ Similarly, a 2009 study of Aboriginal and Torres Strait Islander young people in Townsville found that the most

common reasons for not using contraception were ‘I don’t think about it’, ‘I don’t think she / I will get pregnant’, and ‘having sex was unexpected.’³⁶

One respondent to the 2012 survey of rural Victorian health providers commented ‘Sometimes my experience with young people can be though they have the knowledge and access, they still do not make the right choice as they are experiencing non-respectful relationships and have poor self-esteem or self-respect. They may have poor role models and high risk taking behaviour through childhood trauma.’³⁷

The situation is complicated by attitudes towards the use of condoms, which many young people seem to associate with casual partners.³⁸ A 2012 study of young Australian men found that for some, switching from condoms to the contraceptive pill was associated with intimacy and trust. Some young couples prepared for this with STI checks, but many simply said that they trusted their partners. Fear of contracting an STI was associated with casual encounters; in relationships, pregnancy was the greater fear, and here the contraceptive pill was preferred. The authors linked this to young men’s lack of competence in condom use, but also to a culture that places low expectations on young men to take responsibility.³⁹ Additionally, it suggests the difficulties young people can experience in communicating about sexual health (as opposed to fertility).

Gender norms and behaviours

Studies from Australia and the US have observed cultural pressures on young women to appear sexually inexperienced, but also to go along with sexual situations which they may not like – a combination which can lead to harmful outcomes. Many young women are uncomfortable with carrying condoms, fearing damage to their reputations, a concern likely to be more intense in rural communities, and compounded by social media.⁴⁰

To make this worse, vulnerable young women, at risk of being stigmatised for using contraception, can also be expected to carry sole responsibility for it. In the 2007

study of young mothers in rural Victoria, only two out of the 21 young women interviewed said their male partners accepted some responsibility for contraception. While the young women resented this, they also felt powerless; for many, unsafe sex and pregnancy were things that 'just happened.' Comments included:

- *'We had no conversations about contraception ... cause we'd only just met'*
- *'We didn't actually ever talk about contraception'*
- *'Just using condoms would be a lot easier, but then again, you don't always use those. You've just gotta count on your lucky stars too.'*⁴¹

Similar comments were made in a 2009 study of young Indigenous people. Here, many young mothers characterised pregnancy as something that 'just happened' – not necessarily unwelcome, but not considered or planned in any active way.⁴²

In contrast, one US study found that adolescent girls' behaviour around condom and contraceptive use was related to their general sense of self-efficacy; they appeared more likely to make positive choices around safer sex or abstinence if they had a high sense of personal control and confidence across the board.⁴³

Emergency contraception and family planning

It is possible that the higher rate of young motherhood in rural and regional Victoria does not point to higher rates of pregnancy alone. It may also reflect more restricted access to emergency contraception, fertility counselling and terminations.

In 2012, the Women's Health Association of Victoria undertook a research project with regional women's health services to gather data about access to family planning services. They surveyed 225 workers from community health, local government, school nursing, family support services, and general practice.⁴⁴ Findings included:

- When asked how living in a rural area impacted on access to emergency contraception, the most common barriers mentioned were availability (30.7%), privacy (30.7%) and travel (17.3%). Some respondents commented that not

all local pharmacies would sell emergency contraception to young people, or that their limited opening hours posed a problem.⁴⁵

- 15% of respondents said there was no local option for pregnancy counselling. The greatest barriers to options counselling were listed as travel (18.9%), availability (17.5%) and privacy (14.7%).⁴⁶
- Only 3.5% of respondents said they had an option for referring women for a termination (up to 12 weeks) within their local community.⁴⁷ The biggest barriers identified were lack of public service providers and lack of access to medication abortion.⁴⁸
- Most respondents said they knew medical professionals who would refer women for terminations, but 45% said they were aware of professionals who would not.⁴⁹ (For a young patient, with fewer transport options and less life experience, such a refusal could have a more serious impact.)
- Almost half of respondents said they did not know whether medication abortion was available in their communities, and 29% said it wasn't.⁵⁰
- 39% of respondents said their service did not work with women with 'additional needs'. This included young women, women from Indigenous or culturally and linguistically diverse backgrounds, same-sex attracted women, or women who were homeless or had a disability or mental illness.⁵¹ (As all these groups face particular dangers and inequalities in relation to sexual and reproductive health, this seems highly concerning.)

One respondent from Barwon South-West remarked 'it seems that a lot of women are "shipped off" to Melbourne ... they have to find their own way to appointments'.⁵² Another commented 'Lack of support from family / partner is huge, with some women continuing with pregnancies they don't want due to significant pressure from family – particularly younger women pressured by mother / sister.'⁵³

Service providers from the Hume region, interviewed by Women's Health Goulburn North-East in 2011, also highlighted concerns about long GP waiting lists, young people not knowing they could access bulk billing (and surgeries not advertising this fact), and the need for GPs to increase their competence in communicating with young people, and addressing issues of discrimination and cultural difference.⁵⁴

In a 2012 doctoral thesis about women's access to family planning services in the Grampians, service providers nominated similar issues: lack of local services, distance from metropolitan services, fears about confidentiality, and judgemental service providers. Service barriers included a shortage of female doctors, lack of choice about which doctors a patient could see, and the stress and costs of navigating services in a distant city. Some service providers gave anecdotal accounts of GPs withholding information and referrals for women until an early termination was no longer possible (forcing them to either proceed with a pregnancy or face the costs, barriers and distress of a later termination), and about pharmacists refusing to sell emergency contraception to young women.⁵⁵ Young women were seen as especially vulnerable to pressure – sometimes to terminate a pregnancy, more often to continue with one. One practitioner commented:

*'If teenagers come to a GP pregnant and want a termination, it's not going to happen – it's as simple as that. Teenagers are probably the group who face the most barriers such as being able to afford the service and subsequent costs with travelling to Melbourne ... limited support in making the decision and finding out about and accessing a service'.*⁵⁶

Violence against women

In order to reduce rates of STIs and unwanted pregnancies and promote sexual health, it is also necessary to address the problem of sexual violence, and to promote and support respectful relationships.

Violence against women is an abuse of human rights which has severe impacts on the health and wellbeing of individuals and the community, and exacts significant costs to the economy. The Burden of Disease data for Victoria (DHS, 2005) estimates that intimate partner violence is responsible for 9% of the burden for women aged 18-44; it has a greater impact than any other risk factor on the health of women in this age cohort.⁵⁷ In 2009, KPMG estimated that the annual cost of

violence against women to the Victorian economy of \$3.4 billion. Costs relate to health care, mortality, absenteeism, damaged property, police, courts, counselling, support programs and child protection. Without further interventions, this is predicted to rise to an annual cost to Victoria of \$3.9 billion. For every woman whose experience of violence is prevented, over \$20,000 in costs can be saved.⁵⁸

This relates to sexual health in important ways. Young women who have been exposed to partner violence are more likely to experience unplanned pregnancy, termination or miscarriage. They are slower to make contact with health services for antenatal care than women who have not been exposed to violence; they are also more likely to have an abnormal result on a pap smear or to report a vaginal or endocervical infection.⁵⁹

A disturbingly high percentage of young people have experienced sexual violence or coercion. The 2008 study of Australian secondary students found that 38% of the young women reported having experienced unwanted sex, as did 19% of young men. The most common reasons given were being drunk (17%) and pressure from a partner (18%).⁶⁰

The 2006 ABS Personal Safety Survey found that 1.6% of Australian women reported having experienced sexual violence at least once in the previous 12 months, as had 0.6% of Australian men. 58,100 Victorians reported having experienced sexual violence in the past 12 months. 17% of women reported having experienced sexual violence since the age of 15.⁶¹

Other studies indicate that the figures may be higher still, that the proportion of Australian women who have experienced sexual violence or coercion may be between a quarter and a third, with at least 5% of men also experiencing this. Young women aged under 25 are an especially vulnerable group. A 2011 study by the Institute of Criminology into children's exposure to domestic violence in Australia found that one in seven girls and young women had experienced rape or sexual assault, and that one in twenty young people thought forcing a partner to have sex (as well as other forms of physical aggression) was part of 'normal conflict' rather

than relationship violence. Anastasia Powell notes that interviews conducted with young women demonstrate the extent to which sexual coercion is experienced as being part of 'normal' relationships, where a woman is expected to meet her male partner's wishes in order to feel loved and worthwhile.⁶²

Thus, when promoting young people's sexual health, it is vital to support their development of respectful, non-violent relationships.

This is especially important for rural communities. In the ABS Personal Safety survey, 33% of people who reported experiencing sexual assault in the past 12 months lived outside of a capital city.⁶³ The National Rural Women's Network notes that rural women who have experienced violence face particular barriers to getting help, including physical isolation, lack of public transport, lack of specialised services, fears about confidentiality, and sometimes conservative local attitudes.⁶⁴

Alcohol and 'boredom'

Efforts to promote young people's sexual health also must take into account the impacts of alcohol consumption. In the 2008 survey of Australian secondary students, almost a quarter of sexually active students reported having been drunk or high at their last sexual encounter.⁶⁵ Possibly this issue is more pressing than average in rural and regional communities, as the VCAMS Adolescent Community Profiles showed a higher rate of alcohol consumption amongst teenage young people there, compared to most metropolitan regions. With the exception of the Hume region, rural students aged 12-14 and 15-17 were more likely than their metropolitan peers to report having drunk alcohol in the past 30 days.⁶⁶ The *State of Victoria's Children report* also noted that rural young people were more likely than their metropolitan peers to report recent binge drinking, to agree that alcohol was easy to get hold of, and to have obtained alcohol from their parents.⁶⁷

In the 2007 interviews with young mothers from north-eastern Victoria, many linked rural young people's boredom to their higher rates of sexual activity, assuming there

would be more to do socially in Melbourne, and more opportunities for education and jobs. Many also connected boredom and sexual activity to heavy drinking.⁶⁸

It is worth interrogating the idea of boredom a little further, however. While there is often less to do socially in small rural communities, 'boredom' can also point to a deeper sense of powerlessness and lack of future options. Some of the young women in the above survey commented that they already felt disengaged, with few options for the future, prior to becoming pregnant.⁶⁹ Anecdotal reportage suggests some rural young women are more likely continue with unplanned pregnancies due to a sense that they have few other life choices.⁷⁰

Education

The 2008 study of Australian secondary students found that while there had been an improvement in knowledge of STIs since 2002, knowledge about chlamydia, hepatitis and HPV remained poor.⁷¹ Meanwhile, a number of surveys of young people have confirmed that school-based sex education is not meeting students' needs, with many young people stating they wanted to learn more about topics including communication, relationships and social pressures.⁷² In a large recent survey by the Australian Youth Affairs Coalition, young people nominated topics they wanted more information about, including healthy relationships, how to access services, HIV / AIDS, emergency contraception, body image, sexual pleasure, the impacts of pornography (around three quarters of 16-17 year olds report having seen pornographic websites), sexual diversity, and cultural considerations. Over half the respondents who identified as GLBTIQ said that the sex education they received in school was irrelevant to them. (This is especially concerning as sexually- and gender-diverse young people seem to have a higher than average rate of unsafe sex and unplanned pregnancies.) Over two-thirds of the survey's respondents expressed a preference for sexual health educators to be brought into schools from community organisations, and almost three quarters of respondents expressed a preference for young adult educators, rather than older ones.⁷³

Meanwhile, young people experiencing disadvantage can find it especially hard to access sexual health information. Their school attendance may be poor, and they can be especially vulnerable to things like alcohol and drugs, abusive relationships and discomfort in accessing health services. Large, coeducational sex education classes can also seem embarrassing and inappropriate to young people from Indigenous and CALD backgrounds.⁷⁴ A 2008 study of 112 young people experiencing disadvantage found that they preferred sexual health messages which were short and clear, used images, straightforward language and minimal text, were relevant to their cultural backgrounds, and were delivered through media such as television, cinema, posters, billboards, and advertising on train tickets and social media sites.⁷⁵

Health promotion and prevention

The Centre for Excellence in Rural Sexual Health (University of Melbourne) lists the following characteristics of rural sexual health promotion:

- Based on understanding of local context and cultures
- Works from a strong, acknowledged values base, with principles of equality, justice and diversity
- Takes an integrated, comprehensive approach to respectful relationships, violence prevention, and sexual health promotion
- Engages proactively with issues of difference and diversity, and confronts discrimination and exclusion
- Addresses the sexual health risks faced by priority / vulnerable populations, while also addressing the social and structural reasons *why* some people are especially vulnerable, rather than focusing only on individual knowledge and behaviours
- Uses a range of actions
- Works through partnerships between different sectors
- Coordinates service provision, linking health promotion to clinical services.⁷⁶

In the related field of preventing violence against women, a primary prevention approach is one which:

- Aims to challenge and change behaviours that enable violence
- Is implemented before violent behaviours and attitudes occur
- Aims to reduce or eliminate the factors that place people at risk of using or experiencing violence
- Targets the broader population, not just 'at risk' groups
- Promotes gender equality and respectful relationships between men and women..⁷⁷

Primary prevention programs can take the form of:

- Education and training delivered directly in a range of settings, like schools or workplaces
- Community awareness and advocacy campaigns
- Legislative and policy reform
- Research and information gathering
- One-off or regular events, like White Ribbon Day..⁷⁸

In a study of violence prevention programs in schools by DEECD and VicHealth (2009), detailed criteria for good practice were identified. These included:

- A whole-school approach, including:
 - Takes into account local needs and issues
 - Reinforced through extracurricular activities, through partnerships with organisations and clubs
 - Includes education for teachers on issues such as the links between sexism / gender roles and violence, responding to disclosures of abuse, and developing students' skills in behavioural change

- Involves connections and partnerships between schools and community agencies, such as domestic violence and sexual assault services..⁷⁹
- A program logic and framework, including:
 - An appropriate theoretical framework for understanding violence, drawing on relevant feminist research to address the links between gender, power and violence..⁸⁰
- Relevant, inclusive and culturally sensitive practice, including:
 - Consultation with representatives and leaders of local population groups..⁸¹
- Effective curriculum delivery, including:
 - Delivered by teachers / educators who have adequate skills, capacity and support
 - Sufficient duration and intensity to produce change
 - Addresses behaviours, relationships and wider contexts, not just attitudes
 - Avoids focusing only on strategies for minimising personal risks of victimisation
 - Fosters an atmosphere of respect for self, others and the community
 - Teaches bystander skills for effective intervention..⁸²
- A comprehensive evaluation process, including:
 - Pre- and post-intervention assessment and long-term follow up, measuring both attitudes and behaviours
 - A process for disseminating program findings..⁸³

The report noted that while there had been some very good violence prevention programs operating in Victorian schools, their effectiveness was often hindered by the lack of a whole-school approach, short duration of programs, and insufficient evaluation..⁸⁴ Other common weaknesses included:

- Lecturing young people, without interaction or participation
- Taking action only after violence has occurred

- Focusing wholly on secondary or tertiary interventions, with young people already perpetrating or living with violence, or at high risk of this
- Focusing solely on the production of a resource such as a DVD or poster, without addressing how it will be used or its results
- Ignoring the wider social and school contexts in which violence occurs
- Using programs which are unsustainable due to teacher capacity, policy context, or lack of institutional support
- Not including partnerships with stakeholders.⁸⁵

However, what evaluation had been conducted showed that if done well, prevention education programs could produce lasting results in the lives of young people.⁸⁶ It is concerning, therefore, that while CASA House receives specific funding for the delivery of sexual violence prevention programs in secondary schools in north-west Melbourne, comparable funding has not yet been made available in regional Victoria (or in some other parts of Melbourne).

The above report commented: 'While violence prevention programs that take place outside school settings and have been evaluated are rare, there are sound reasons for complementing universal, school-based efforts with others focused on at-risk populations and environments and using non-school settings such as families, community and faith-based organisations, and media.'⁸⁷ Here, there are some particular opportunities for the Office for Youth to be involved.

Recommendations

- Support young people to become community leaders in sexual health and respectful relationships, utilising the opportunities provided by:
 - The Engage program, which supports young people's economic, social and civic participation in their communities.
 - Program guidelines already state its aim of improving young people's support networks and connections to family and community, and engaging young people facing particular barriers. An additional item explicitly encouraging projects promoting respectful relationships and social / economic determinants of health would seem a good fit.
 - The Be Heard program, which trains rural young people in radio broadcasting and related technologies.
 - Health promotion campaigns are often keen to engage young people through multimedia strategies, and the Be Heard grants encourage applicants to think about specific groups who might benefit from the program, and how it would enable discussion of issues important to young people. It might be valuable to investigate (or explicitly encourage applicants to investigate) how these grants could be used to promote young people's health and wellbeing, possibly in collaboration with other campaigns, to add value to both.
 - The FReeZA program, which supports young people to run music and cultural events in their communities.
 - Guidelines already ask applicants how they will ensure the safety of participants and make events inclusive of all young people. There might be an opportunity here to encourage applicants to consider more explicitly whether their program could have benefits for respectful relationships and population health, perhaps in collaboration with other campaigns.

- Support the implementation of long-term, sustainable, whole-of-school sexual assault prevention programs in every region of Victoria. A whole-school approach should include staff training, assistance for schools to develop policies and procedures, and support for schools to run the programs sustainably in the future, although they should be enabled to partner with community providers initially where appropriate. One example of such a program is that developed by CASA House, profiled on p.31.
- Support initiatives for making condoms freely or cheaply available in a range of public, anonymous settings with after-hours access in rural communities. This should be done in collaboration with local health services and local government. It should draw on the findings of work being undertaken by the Centre for Excellence in Rural Sexual Health (University of Melbourne) and their partner organisations in north-eastern Victoria. Placement of machines should be decided through consultations with young people. Evaluation should consider numbers of condoms purchased, any vandalism of machines, and feedback from local government and health services about the cost and ease of maintaining them.
- Support the development and promotion of a statewide pregnancy information service, with capacity to assist women in all rural, regional and remote communities in Victoria. This service should provide timely, professional, accessible and comprehensive information, counselling, referral and advocacy for women about options, including safe, legal abortion and referral to services providing this. Young rural women should be informed about this service, including via school nurses and sexuality education programs.
- Consult with the Centre for Excellence in Rural Sexual Health (University of Melbourne) to apply findings from their pilot programs to other rural settings. Approaches which have proven valuable in some communities, and which might be developed to suit the needs of others, include:

- Working with young people to produce music, films, art and theatre about sexual health and respectful relationships, in ways which build and celebrate their skills, introduce young people to service providers, and welcome young people from diverse backgrounds
- Developing and distributing youth sexual health referral cards, for use at doctors' surgeries to reduce embarrassment, and educating GPs, nurses, receptionists and young people about their use
- Introducing young people to supportive health providers, youth services and pharmacists through fun school-based events, performances or 'Amazing Race'-style challenges
- Distributing 'condom wallets' with pictorial information and contact details for emergency contraception, local health services and TESTme (profiled on p.36)
- Building the capacity of services to work with Indigenous young people and communities to promote sexual health.

Evaluations should measure changes to organisational practice and community participation, as well as young people's behaviours, knowledge and outcomes. There should also be capacity to measure unexpected or 'side' benefits, such as increased use of health services by young people for other problems, or reduction of social isolation.

- Support the further promotion of the TESTme initiative through school sexuality education classes, youth work settings and support programs for AOD, mental health and young parents.
- Work with rural businesses such as supermarkets and pharmacies to make purchasing condoms easier for young people. Strategies might include installing a self-service checkout, or placing condoms in locations which young people have indicated they prefer (existing research indicates that the front counter is *not* ideal). This process should involve local health services and local government. Success could be evaluated through sales figures and perhaps through surveying young people before and after.

- Increase promotion of respectful relationships programs, resources and networks through the Office for Youth. Resources to promote include the Domestic Violence Resource Centre's 'Sex, Love & Other Stuff', 'Bursting the Bubble', and the Partners in Prevention network.
- Provide further support for programs promoting respectful relationships and prevention of violence, in settings such as rural TAFEs, community VCAL, sporting clubs, volunteer settings and rural workplaces.
- Advocate for a compulsory, consistent national curriculum of sexuality education in secondary schools, including independent and Catholic schools. This could draw upon the models of good practice identified by DEECD in their *Catching On* resources. Modules should be long enough to ensure all information and activities are covered, and should include adequate support for teachers and peer educators. Issues to be addressed should include:
 - Negotiating sexual health and contraception within relationships
 - Practicing communication and refusal skills
 - Gender roles and power, and how these influence sexual health
 - Sexual coercion and violence, including within relationships
 - Sexual diversity, and –
 - Accessing health services, emergency contraception, options counselling and terminations

There should be accountability mechanisms to ensure schools' compliance and use of best practice. Modules should be age-appropriate, and should contain an emphasis on health promotion and positive relationships.

- Extend public health campaigns to promote stronger awareness amongst young people of chlamydia and how to protect oneself and access treatment. Key issues include combating stigma, the fact that young men get infections too, and how to access help, particularly for rurally isolated young people. Young people from rural communities should be engaged in designing these campaigns.

- Ensure that when VCAMs data is collected, the young people surveyed about sexual health are asked about the consistency of their use of condoms and contraception, not just whether they have ever used these.

Examples

Smart and Deadly – Albury Wodonga

In 2010, Aboriginal communities in north-eastern Victoria identified a need for sexual health resources aimed at young people. This led the Centre for Excellence in Rural Sexual Health (University of Melbourne) to plan a collaborative community project in Albury-Wodonga in 2011-12. The aims (successfully fulfilled) were:

- To develop, implement and evaluate a local sexual health promotion project with young Aboriginal people and their families;
- To support young rural Aboriginal people to develop their own creative sexuality education resources; and –
- To develop an audio-visual training resource for non-Aboriginal rural health workers, for engaging with Aboriginal communities.

The project actively engaged over 120 Aboriginal families and community members, and 20 organisations. It produced eight educational YouTube clips and rap songs (over 3800 hits), online resources, and a documentary DVD to support culturally inclusive practice (over 1500 copies distributed around Australia).

An Albury Wodonga Aboriginal Community Working Party operated as the authorising team. The management, events and creative teams engaged multiple local providers and community members. Collaborations involved health services, Aboriginal Corporations, GP networks, secondary schools, LaTrobe University, Wodonga TAFE, DEECD, and the Upper Murray Centre Against Sexual Assault.

Guiding principles included:

- Respect for the authority of Elders, for women's and men's business, and for Aboriginal concepts of health and respectful relationships
- Acknowledging the diversity of Aboriginal opinions and experiences
- Diverse sectorial representation

- Informal processes with room for yarning and story-telling
- Addressing local concerns about confidentiality and ‘shame’
- Taking into account the history of relationships between providers and the community, and –
- Open groups with flexible organising principles.

Inclusive decision making and involving lots of community members were extremely important. This could affect deadlines, but was found to be worth it.

The early planning processes did not involve young people directly, as there was a strong message from the community that there was too much shame around the topic at that stage. Initial planning occurred between older community members and service providers, with young people informally engaged through conversations with Aboriginal workers. Later, young people were engaged extensively as artists, musicians, workshop participants, actors, and makers of short films, on topics including sexual health, what’s involved in going for a check-up, gender and respect. Important elements to engaging young people successfully included: an emphasis on fun creative expression, welcoming young parents and their children, introducing young people to service providers in informal settings, and discussing related topics such as housing and domestic violence. There was an emphasis on building young people’s skills, strengths, interests and decision-making, and promoting a positive, holistic view of sexual health, rather than one focused on negativity and danger.

Positive responses from the community highlighted the successful model of collaboration, higher levels of confidence reported by young Aboriginal people in accessing health services, and the usefulness of the resources in training non-Aboriginal organisations in cultural competency.

It was found that evaluation of such health promotion initiatives should assess not only changes to young people’s sexual health knowledge, behaviours and outcomes, but also the level of community participation, organisational, policy or social changes, and any formal or incidental learning outcomes. Both the products and the

evaluation processes should use a variety of media, as literacy levels vary and the written word is not always preferred.⁸⁸

Sexual assault prevention – Geelong

The Sexual Assault Prevention Program for Secondary Schools (SAPPSS) was first developed by CASA House (the Centre Against Sexual Assault) through programs they ran between 1999-2007. It was adopted by Barwon CASA for use in Geelong secondary schools two years ago. The program aims reduce the incidence of sexual assault and increase schools' capacity to respond to sexual assault.

Barwon CASA had noticed that schools often approached them for support in response to incidents of sexual violence, wanting immediate or one-off assistance. This approach did not seem adequate. Therefore a decision was made to adopt the SAPPSS program, which had already been evaluated and had a strong record in Melbourne. The program is now delivered in Geelong secondary schools through a three-year partnership between schools and Barwon CASA. The curriculum is delivered jointly for the first two years, with schools supported to deliver it autonomously in the future. It was first adopted by North Geelong Secondary College, and has since operated in Catholic schools and a school for students with disabilities.

The program begins by working with the school staff, delivering a training session which all staff are required to attend, about preventing and responding to sexual assault. A 3-day 'train the trainer' module is also provided for those staff members who will work with CASA representatives to deliver the program to students. (By the third year, the SAPPSS sessions have been fully integrated into the curriculum and staff members are expected to run the sessions autonomously.) In addition, CASA provides schools with support in developing policy around sexual violence and harassment. Some schools also request an information session for parents, and there is an option to train Year 10 students as peer educators.

The SAPPSS model comprises a 6-week program for Year 9 students, with one double class per week. These have been delivered in diverse curriculum settings, including health and religion. The sessions focus on issues around relationships, consent and the law, with a focus on preventing sexual assault. They emphasise frank, informal and respectful discussion, where everyone is encouraged to take part, where discriminatory language is not accepted, and where people's opinions can be respectfully explored and challenged. Five out of six sessions are conducted in single-sex groups, after previous evaluations and student feedback demonstrated that this model was preferred by most students. Single sex groups tend to be experienced as providing a more comfortable environment where students of both sexes find it easier to have open and honest conversations. Having single sex classes also recognises and seeks to address gender power imbalances that may impede the equal participation of young women in particular. Students are brought together for the final session, however, which focuses on bystander action. Year 9 was chosen as the age for program delivery, as the point at which issues of sexual violence starts to become apparent.

Evaluations of the program indicated that young people's understanding of sexual assault issues is enhanced, as is their skill and capacity to talk about those issues in an honest, respectful way. Comments from students highlighted things they had learned, including the laws around sexual consent, the fact that sexual violence mainly occurs between people who know each other, what to do if you have been assaulted, and respectful ways of treating other people. Many students mentioned appreciating the fun, understanding and respectful atmosphere. Evaluations were conducted through testing about attitudes, knowledge and some behavioural intentions before and after the program, as well as through in-built quizzes within the program and focus groups. Barwon CASA maintains relationships with the schools for ongoing evaluation and support.

Such programs deliver the best results when the schools involved demonstrate certain qualities: openness, willingness, leadership and readiness to commit. Barwon CASA does not run the program in schools which do not yet have the capacity or commitment to support it fully (although support is provided for them to reach this

point). Also valuable is a school culture where respectful behaviour is already being promoted (for students and staff) and where related issues such as homophobia are being addressed. The changes brought about by the program can best be sustained when there are multiple, ongoing initiatives to prevent sexual violence in the school community.

Barwon CASA urges that programs like this be offered in all schools in Victoria. It is important to work with young people at formative stages in their lives to prevent violence against women and children. Perpetration of violence occurs across all social settings, therefore extending prevention programs to include Catholic and independent schools alongside state schools ensures that all sections of the community (including future community leaders) are reached.

At present, regional CASAs do not receive specific funding to operate violence prevention programs within schools. Those regional CASAs that choose to engage in this work do so with limited resources, often relying on external funding such as philanthropic grants.

Safer Sex in the Sticks: Swan Hill and Robinvale

Funded by the Centre for Excellence in Rural Sexual Health, the 'Safer Sex in the Sticks' (SSITS) project ran in Swan Hill in 2008, receiving the Victorian Public Healthcare Award. It was adapted in 2009 for the rurally-isolated community of Robinvale and the Indigenous community in Swan Hill, supported by the Robinvale District Health Service, Swan Hill Rural City Council, and the Swan Hill Aboriginal Health Service. Positive outcomes included an increase in the number of Indigenous young people using the Youth Sexual Health services at Swan Hill District Health and other health providers.

Key objectives concerned improving STI education amongst young people, improving young people's access to condoms and sexual health services, and building the skills of support workers to assist young people with sexual health concerns.

Interventions included:

- Youth Sexual Health referral cards were developed following consultations with young people, where a large minority said they would like to be able to undertake STI screening but felt uncomfortable asking for it. The referral cards could be handed to a local GP or community health nurse, indicating the patient is requesting a test without them having to ask verbally. All local GPs were educated about this. At the time of evaluation, around 250 cards had been distributed at Swan Hill Aboriginal Health Service, and around 125 at Swan Hill District Health.
- Following the successful placement of condom vending machines in Swan Hill, machines were placed in the leisure centre and public toilets in Robinvale. This was a partnership between local government and the Robinvale District Health Service. It was found useful to keep the cost low and simple: \$2 for 2 condoms. The strong support of the health service, which took responsibility for the machines' stocking and upkeep and tallied the usage, made it easy for council to support the strategy.
- An 'Amazing Race' was held in Swan Hill, involving 30 young people from Swan Hill College, Payika College, and Sunraysia Institute of TAFE, over 90% of whom identified as Indigenous. The young people visited local health services, the library, condom vending machines, and a youth centre, meeting at each location with service providers and getting information about condoms, chlamydia, testing, treatment and how to access information. After the race, the young people and service providers shared a meal. Over 80% of participants said they felt more comfortable accessing health services as a result.
- A performance of Nelly Thomas's 'Condom Dialogs' at Robinvale P-12 College for female year 9 and 10 students, supported by Robinvale District Health Service, and attended by 35 young people. The local pharmacist took part, promoting their free provision of condoms for young people and answering questions – this was found especially useful.

- A poster campaign by young people in Robinvale, about chlamydia, condoms and health testing, with local referral information. Support from the P-12 college principal and school nurse was important here. The posters were created by 39 Year 9 students, after undertaking a health information session with a community health nurse. Their peers nominated the top twelve posters, and the five winning entries were displayed on toilet doors in the public block, the community centre, leisure centre and hotel. Locations were chosen through consultation with the Youth Council and other young people.
- Radio advertising about condoms and STI screening, broadcast 192 times on two local stations. Here, it was found efficient not to 'reinvent the wheel', but to adapt a strong campaign developed by the WA Department of Health.
- Condom wallets were produced, containing 2 condoms, plus lube and instructions, with information about emergency contraception, local health services, and TESTme. These were reworked later, following input from Indigenous workers, to include more pictorial (rather than written) information. They were distributed at local youth events.

Professional development was offered to service providers and teachers, through sessions run by Family Planning Victoria, covering topics including STIs, contraception, handling difficult questions, and referring to local services. 34 people attended, and responses were positive.

A significant issue found to affect the efficiency and success of programs was staff turnover at various services.

Through the successful aspects of this program, and the ones which did not eventuate, some key elements of an effective project were identified. These included:

- Workers taking ownership of the project and committing strongly to it
- Workers having capacity and competency to deal with the sexual health needs of young people

- Stakeholders receiving professional support to build their capacity around sexual health expertise and health promotion planning and evaluation
- Stakeholders identifying this work as a core part of their service delivery, meeting an identified need in the community, and –
- Ensuring agreement with Aboriginal services about what interventions were culturally appropriate, and that they had capacity to deliver these.⁸⁹

TESTme: Chlamydia screening for rural young people

TESTme is a free chlamydia screening service delivered by the Melbourne Sexual Health Centre (MSHC). It began in 2009 as a 12 month pilot funded by the Victorian Government Department of Health. When found to be effective, it was adopted as an ongoing service.

TESTme is available to young Victorians (25 years and under) who live 100 km or more out of Melbourne, as well as rural men who have sex with men, and Aboriginal and Torres Strait Islander people of all ages living in Victoria. TESTme was developed in response to the rising rate of STIs and the difficulties some rural Victorians experience accessing sexual health services.

Young people can order the testing kit online; it is posted to them and they do the test themselves at home. They can also access telephone consultations with a nurse to talk about STIs and contraception. The kits are simple to use and sent in plain packaging, with a reply paid envelope to return them. The TESTme website shows in advance what the kit will contain. Tests can be sent to a young person via a friend's address, a post office or community centre, if they don't want it delivered to their house. If the test comes back positive, a nurse will call the young person, and treatment can be posted to them or MSHC can support the young person to find a suitable health service.

The material provided to young people makes clear that MSHC will not give out information to parents, teachers or friends, explaining the clinic's legal obligations around privacy, and their procedures for ensuring information is kept confidential.

During the 12 month pilot, 24 people accessed and returned the kit. 4 tested positive for chlamydia and had treatment posted to them. Ages ranged from 14-39, and they came from 18 different rural / regional communities.

All the people who responded to the survey during the pilot period (18) reported being satisfied with the service. Most rated TESTme as better than a doctor's consultation; the others said there was no difference. Only a third said they would have gone to their local doctor if TESTme had not been available, citing concerns about access to a female doctor, confidentiality, cost and convenience. (Two-thirds reported that they had had a sexual health concern in the past and had not gone to see a doctor.) While a video consultation option was offered, these young people did not take it up. Reasons included inconvenience, not owning a webcam, and finding video too confronting.

Following the pilot period, a review was conducted, including further consultations with young people. Key concerns identified included young people's discomfort with webcam / phone-based models and concerns about their privacy. As a result, the TESTme service was updated. Confidentiality processes were explained more clearly on the website, and young people were given the option of ordering tests online. Since then, uptake of the service has doubled, with 82 requests for testing so far this year. During the pilot period, very few men accessed the service, but the gender composition now is approximately equal (31 males this year).

At first the service was advertised through multiple media, including Facebook, posters, flyers, business cards, wristbands, newspaper advertisements, student diaries and SMS. However, the majority of clients reported they had learned about TESTme through a health professional. Since the review of the website, higher numbers appear to be finding out about the service through online searches and friends, too. It was concluded that referrals from health services and connections to

other health websites were the most effective ways of reaching rural young people.

90

This seems to raise concerns, however, about young people who do not have a connection to other health services. It suggests the value of promoting TESTme through school sexuality educators, and perhaps community support services, such as AOD or housing support.

Thanks to Barwon CASA, the Centre for Excellence in Rural Sexual Health, CASA House, the Domestic Violence Resource Centre Victoria, the Melbourne Sexual Health Centre, NESAY, the Royal Women's Hospital, VicHealth, Women's Health Goulburn North East, and Women's Health Victoria for their assistance.

¹ World Health Organisation, 'Sexual Health', 2013, http://www.who.int/topics/sexual_health/en/

² VicHealth, 'Burden of disease due to health inequalities: research summary', Melbourne, 2008, www.vichealth.vic.gov.au/healthinequalities

³ VicHealth, 'Burden of disease due to health inequalities: research summary'

⁴ Victorian Government, *Engage, Involve, Create: Youth Statement*, Melbourne, 2012, pp.10, 16

⁵ Department of Health (DOH), *Victorian Public Health and Wellbeing Plan 2011–2015*, Melbourne, 2011, p.14

⁶ DOH, *Victorian Public Health and Wellbeing Plan 2011–2015*, pp.1-3

⁷ DOH, *Victorian Public Health and Wellbeing Plan 2011–2015*, pp. 20-25, 69, 75-76

⁸ DOH, *Victorian Public Health and Wellbeing Plan 2011–2015*, pp.75, 95

⁹ DOH, *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*, Melbourne, 2011, pp.49-51; DOH, *Victorian Health Priorities Framework 2012–2022: Rural and Regional Health Plan*, Melbourne, 2012, pp.42-44, 50, 54

¹⁰ Victorian Government, *Victoria's Action Plan to Address Violence Against Women and Children (2012-15)*, Melbourne, 2012, pp.8-10

¹¹ Anthony Smith, Paul Agius, Anne Mitchell, Catherine Barrett and Marian Pitts, *Secondary Students and Sexual Health 2008: Results of the 4th National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health*, Melbourne, La Trobe University, July 2009, p.1

¹² Australian Youth Affairs Coalition and Youth Empowerment Against HIV/AIDS, *Let's Talk About Sex: Young People's views on sex and sexual health information in Australia*, June 2012 <http://www.ayac.org.au/news/157/67/Let-s-Talk-About-Sex-Young-People-s-views-on-sex-and-sexual-health-information-in-Australia.html> p.6; Jennifer L. Smith, Jennifer Fenwick, Rachel Skinner, Jonathan Hallet, Gareth Merriman, Lewis Marshall, 'Sex, Condoms and Sexually Transmissible Infections: A Qualitative Study of Sexual Health in Young Australian Men', *Archives of Sexual Behavior*, 41.2, April 2012, p.487

¹³ Australian Government Department of Health and Ageing, 'National Women's Health Policy: Sexual and Reproductive Health: Chlamydia', 2010, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/womens-health-policy-toc-womens-health-policy-key-womens-health-policy-key-discussion-womens-health-policy-key->

[discussion-sexual](#); Australian Government Department of Health and Ageing, 'National Women's Health Policy, Sexually transmitted infections', 2011, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/womens-health-policy-toc-womens-health-policy-experiences-womens-health-policy-experiences-reproductive-womens-health-policy-experiences-reproductive-sti>; DOH, 'Surveillance of notifiable conditions in Victoria, Case distribution by sex, age group and year of notification, 1 January to 13 November 2012', <http://ideas.health.vic.gov.au/surveillance/tabulated-summaries.asp>; DOH, Surveillance of notifiable conditions in Victoria, Weekly update: 3 January 2012, <http://ideas.health.vic.gov.au/surveillance/weekly-monthly-reports.asp>; Family Planning Victoria, *PSST!! Partnerships in safer sex and testing: A project implemented by Family Planning Victoria with funding from the Department of Human Services BBV/STI Unit*, Melbourne, 2008 <http://www.fpv.org.au/advocacy-projects-research/projects/completed-projects/> p.5

¹⁴ DOH, '2011 HIV/AIDS, Prepared by the Burnet Institute for the Communicable Disease Prevention and Control Unit, Health Protection Branch', <http://ideas.health.vic.gov.au/surveillance/annual-reports.asp>; DOH, 'Surveillance of notifiable conditions in Victoria, Case distribution by sex, age group and year of notification, 1 January to 13 November 2012'

¹⁵ Department of Human Services (DHS), *Victorian Burden of Disease Study: Mortality and Morbidity in 2001*, Melbourne, 2005, p.3

¹⁶ Department of Education and Early Childhood Development (DEECD), *State of Victoria's Children Report*, Melbourne, 2012, p.47. For VCAMS data gathering, students in years 7, 9, and 11 were sampled from randomly selected government and non-government secondary schools across Victoria, and analysis is based on a final sample of 10,273 adolescents.

¹⁷ Australian Bureau of Statistics (ABS), *3301.0 - Births, Australia, 2011*, table 1.2, Births, summary statistics for Victoria – 2001-2011, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3301.02011?OpenDocument>; ABS, *33010DO005_2011 Births, Australia, 2011*, table 5: Births, Summary, Remoteness Areas—2006 to 2011, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3301.02011?OpenDocument>

¹⁸ DEECD, *Adolescent Community Profile: Barwon South-West*, Melbourne, 2010, p.41; DEECD, *Adolescent Community Profile: Eastern Metropolitan Region*, Melbourne, 2010, p.41; DEECD, *State of Victoria's Children*, 2012, p.49

¹⁹ Australian Government Australian Institute of Health and Welfare, *A Picture of Australia's Children 2012*, Canberra, 2012, p.50

²⁰ DEECD, *State of Victoria's Children*, 2012, pp.7, 48-49. STIs include Chlamydia trachomatis infection, Neisseria Gonorrhoea, Donovanosis, Syphilis Infectious and Syphilis congenital. Original source of data used by SOVC was the Notifiable Infectious Disease Surveillance System 2005–2010, Department of Health; Estimated Resident Population 2005–2010, ABS. Original source of data used by VCAMS was the Department of Health, 2010, Victorian National Infectious Disease Surveillance System, unpublished, ABS, Population by age and sex (Cat. No. 3201.0)

²¹ DOH, 'Surveillance of notifiable conditions of Victoria, regional comparative summary report, 1 Jan – 13 Nov 2012'; DOH, 'Surveillance of notifiable conditions in Victoria, Case distribution by sex, age group and year of notification, 1 January to 13 November 2012'; DOH, Surveillance of notifiable conditions in Victoria, Divisions of General Practice, summaries, 1 Jan – 13 Nov 2012, <http://ideas.health.vic.gov.au/surveillance/tabulated-summaries.asp>; DOH, 'Surveillance of notifiable conditions in Victoria, Local Government Summaries, 1 Jan – 13 Nov 2012', <http://ideas.health.vic.gov.au/surveillance/tabulated-summaries.asp>

²² DEECD, *State of Victoria's Children*, 2012, p.48

²³ Women's Health Victoria, *10 point plan for Victorian Women's Health 2010-2014, developed by Victorian Women's Health Services*, Melbourne, 2011, p.10; Women's Health Victoria, 'Women and Sexual and Reproductive Health', *Women's Health Issues Paper No. 2*, April 2009 http://whv.org.au/static/files/assets/3cc5d436/Women_and_sexual_and_reproductive_health_issues_paper.pdf p.5

²⁴ Winifred A Gebhardt, Margot P van der Doef, Nicole Billingsy, Malou Carstens, and Ingrid Steenhuis, 'Preferences for condom placement in stores among young Dutch men and women: Relationships with embarrassment and motives for having sex', *Sexual Health*, vol. 9, no. 3, 2012, pp.233-239

²⁵ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services* (August 2012) <http://whv.org.au/publications-resources/publications-resources-by->

[topic/post/victorian-rural-women-s-access-to-family-planning-services-survey-report-august-2012/](#)

p.10

²⁶ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.9

²⁷ Women's Health Goulburn North-East, *Rural Women's Access to Family Planning Services – Hume Region*, Wangaratta, 2011, p.6

²⁸ Smith et al, *Secondary Students and Sexual Health 2008*, pp.1, 30. Similarly, a 2009 study of Aboriginal and Torres Strait Islander young people in a Queensland regional centre found that while almost three-quarters had used a condom the first time they had sex, inconsistent use on subsequent occasions was common. See Sarah Larkins, Priscilla Page, Kathryn Panaretto, Melvina Mitchell, Valerie Alberts, Sue McGinty, Craig Veitch, 'Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy: lessons for policy and practice', *Rural Health: The Place to Be*, Cairns, 17-20 May 2009, p.5. A 2005 study found that Australian men use condoms 41% of the time when having casual sex. See B. Sheary and L. Dayan, 'Contraception and sexually transmitted infections', *Australian Family Physician*, vol.34, no.10, 2005, pp.869-872

²⁹ Ed, 'Consistent Use vs. Ever-Use Of Condoms: Which Measure Is More Useful?', *Perspectives on Sexual & Reproductive Health*, Volume 36, Number 4, July/August 2004, pp.171-72

³⁰ Women's Health Goulburn North-East, *A Road Less Travelled: Voices of 21 Teenage Mums from the Country*, Wangaratta, 2007, pp.27-29

³¹ Emily Holcombe, David Carrier, Jennifer Manlove and Suzanne Ryan, *Contraceptive Use Patterns Across Teens' Sexual Relationships*, Child Trends Fact Sheet, Washington, February 2008, http://www.childtrends.org/Files/Child_Trends-2008_02_20_FS_ContraceptiveUse.pdf

³² Holcombe et al, *Contraceptive Use Patterns Across Teens' Sexual Relationships*; Smith et al, *Secondary Students and Sexual Health 2008*, p.31

³³ Holcombe et al, *Contraceptive Use Patterns Across Teens' Sexual Relationships*

³⁴ Suzanne Ryan, Kerry Franzetta, Jennifer Manlove, Emily Holcombe, 'Adolescents' Discussions About Contraception Or STDs with Partners Before First Sex', *Perspectives on Sexual and Reproductive Health*, vol.29, no.3, September 2007, pp.149-57

³⁵ Smith et al, *Secondary Students and Sexual Health 2008*, pp.37-38

³⁶ Larkins et al, 'Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy', p.5

³⁷ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services* (August 2012), p.86

³⁸ Jennifer Manlove, Suzanne Ryan, Kerry Franzetta, 'Contraceptive Use Patterns Across Teens' Sexual Relationships: The role of relationships, partners and sexual histories,' *Demography (pre-2011)*, vol.44, no.3, Aug 2007, pp.603-21.

³⁹ Jennifer L. Smith, Jennifer Fenwick, Rachel Skinner, Jonathan Hallet, Gareth Merriman, Lewis Marshall, 'Sex, Condoms and Sexually Transmissible Infections: A Qualitative Study of Sexual Health in Young Australian Men', *Archives of Sexual Behavior*, vol.41, no.2, April 2012, pp.492-94

⁴⁰ K.A. Fisher, R. Hussain, 'Informal talk: shaping understandings of sexually transmitted infections (STIs) in rural Australia', *Rural and Remote Health*, vol.13, 2013, p.2253., <http://www.rrh.org.au>; Larkins et al, 'Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy', p.6; Jennifer Pearson, 'Personal Control, Self-Efficacy in Sexual Negotiation, and Contraceptive Risk among Adolescents: The Role of Gender, Sex Roles', *Sex Roles*, vol.54, 2006, pp. 617-18, 22

⁴¹ Women's Health Goulburn North-East, *A Road Less Travelled*, p.4, 28, 29

⁴² Larkins et al, 'Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy', p.7

⁴³ Pearson, 'Personal Control, Self-Efficacy in Sexual Negotiation', 617-18, 22.

⁴⁴ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*

⁴⁵ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.13

⁴⁶ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.14

⁴⁷ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.17

-
- ⁴⁸ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.16
- ⁴⁹ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.16
- ⁵⁰ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.20
- ⁵¹ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.21
- ⁵² Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.15
- ⁵³ Women's Health Association of Victoria, *Victorian Rural Women's Access to Family Planning Services*, p.14
- ⁵⁴ Women's Health Goulburn North-East, *Rural Women's Access to Family Planning Services – Hume Region*, Wangaratta, 2011, pp.6, 10, 14, 16
- ⁵⁵ Julie L. Kruss, 'Country women are resilient but....' *Family Planning Access in Rural Victoria*, Victoria University, doctoral thesis, 2012, http://vuir.vu.edu.au/21315/1/Julie_L_Kruss.pdf pp.93-101
- ⁵⁶ Kruss, 'Country women are resilient but....', p.106, also 101, 107
- ⁵⁷ DHS, *Victorian Burden of Disease Study: Mortality and Morbidity in 2001*, pp.3, 91
- ⁵⁸ VicHealth, *Preventing Violence Against Women in Australia: Research summary: addressing the social and economic determinants of mental and physical health*, Carlton, reprinted 2013, p.7
- ⁵⁹ VicHealth, *The health costs of violence: measuring the burden of disease caused by intimate partner violence*, Carlton, 2004, p.23
- ⁶⁰ Smith et al, *Secondary Students and Sexual Health 2008*, pp.2, 31
- ⁶¹ ABS, *Personal Safety Survey, 4906.0*, Canberra, 2006, pp.6-7, 18, [http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02005%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02005%20(Reissue)?OpenDocument)
- ⁶² Family Planning Victoria, Royal Women's Hospital and Centre for Adolescent Health, *The Sexual and Reproductive Health of Young Victorians* (2004) <http://www.fpv.org.au/advocacy-projects-research/projects/completed-projects/> p.13; National Rural Women's Network, *Preventing Violence Against Women Toolkit*, sheet 7, <http://www.nrwn.org.au/toolkits/>; Anastasia Powell, 'Sexual pressure and young people's negotiation of consent', Melbourne University, *ACSSA Newsletter*, no.14, June 2007; Women's Health Victoria, 'Women and Sexual and Reproductive Health', *Women's Health Issues Paper No. 2*, April 2009 http://whv.org.au/static/files/assets/3cc5d436/Women_and_sexual_and_reproductive_health_issues_paper.pdf p.10
- ⁶³ ABS, *Personal Safety Survey, 4906.0*, Canberra, 2006, p.15
- ⁶⁴ National Rural Women's Network, *Preventing Violence Against Women Toolkit*, sheet 4
- ⁶⁵ Smith et al, *Secondary Students and Sexual Health 2008*, p.38
- ⁶⁶ DEECD, *Adolescent Community Profiles*, Melbourne, 2010, profiles for Eastern Metropolitan, Northern Metropolitan, Southern Metropolitan, Western Metropolitan, Barwon South-West, Loddon Mallee, Gippsland, Grampians, Hume, p.42
- ⁶⁷ DEECD, *State of Victoria's Children Report*, 2012, p.52
- ⁶⁸ Women's Health Goulburn North-East, *A Road Less Travelled*, p.4
- ⁶⁹ Women's Health Goulburn North-East, *A Road Less Travelled*, pp.21-3
- ⁷⁰ Kruss, 'Country women are resilient but....' p.113
- ⁷¹ Smith et al, *Secondary Students and Sexual Health 2008*, p.1
- ⁷² AYAC and Youth Empowerment Against HIV/AIDS, *Let's Talk About Sex*, pp.6-10, 18, 21-22, 24; Family Planning Victoria, submission to Australian Curriculum, Assessment and Reporting Authority, *Shape of the Australian Curriculum: Health and Physical Education* May 2012 <http://www.fpv.org.au/advocacy-projects-research/submissions-presentations/> pp.6-7, 12-13; Kruss, 'Country women are resilient but....'; Larkins et al, 'Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy', pp.6-7, 10; Powell, 'Sexual pressure and young people's negotiation of consent'; Women's Health Goulburn North-East, *A Road Less Travelled*, p.26;
- ⁷³ AYAC and Youth Empowerment Against HIV/AIDS, *Let's Talk About Sex*, pp.6-10, 18, 21-22, 24; Family Planning Victoria, *Shape of the Australian Curriculum: Health and Physical Education*; Lynne Hillier, Tiffany Jones, Marisa Monagle, Naomi Overton, Luke Gahan, Jennifer Blackman, Anne Mitchell, *Writing Themselves In 3: The third national study on the sexual health and wellbeing of*

same sex attracted and gender questioning young people, Melbourne, La Trobe University, 2010, pp.35-36

⁷⁴ Family Planning Victoria, *PSST!! Partnerships in safer sex and testing: A project implemented by Family Planning Victoria with funding from the Department of Human Services BBV/STI Unit*, 2008 <http://www.fpv.org.au/advocacy-projects-research/projects/completed-projects/> p.7; Larkins et al, 'Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy', pp.6-7, 10

⁷⁵ D. Keys, D. Rosenthal, H. Williams, S. Mallett, L.Jordan, D. Henning, *Making it real: Sexual health communication for young people living with disadvantage*, Melbourne, 2008

⁷⁶ Centre for Excellence in Rural Sexual Health (CERSH), *Discussion Paper: Current Context of Sexual Health Promotion in Goulburn Valley and northeast Victoria*; Shepparton, University of Melbourne, 2010, pp.8-17

⁷⁷ National Rural Women's Network, *Preventing Violence Against Women Toolkit*, sheet 3

⁷⁸ National Rural Women's Network, *Preventing Violence Against Women Toolkit*, sheet 14

⁷⁹ DEECD and VicHealth, *Respectful Relationships Education: Violence Prevention and Respectful Relationships in Victorian Secondary Schools*, Melbourne, 2009, pp.27-31

⁸⁰ DEECD and VicHealth, *Respectful Relationships Education*, pp.33-34

⁸¹ DEECD and VicHealth, *Respectful Relationships Education*, p.55

⁸² DEECD and VicHealth, *Respectful Relationships Education*, pp.36-55

⁸³ DEECD and VicHealth, *Respectful Relationships Education*, p.57

⁸⁴ DEECD and VicHealth, *Respectful Relationships Education*, p5

⁸⁵ DEECD and VicHealth, *Respectful Relationships Education*, pp.21, 24-25, 46

⁸⁶ DEECD and VicHealth, *Respectful Relationships Education*, pp.19, 22

⁸⁷ DEECD and VicHealth, *Respectful Relationships Education*, p.13

⁸⁸ CERSH, 'Smart and Deadly: Community Ownership, collaboration, and cultural respect for effective Aboriginal sexual health promotion', summary September 2012,

<http://www.cersh.com.au/HealthPromotionActivities/HP-Programs/Smart%20&%20Deadly.html>

⁸⁹ Swan Hill District Health Service, 'Safer Sex in the Sticks & Beyond', Final report, November 2010,

<http://www.cersh.com.au/HealthPromotionActivities/HP-Documents/SSITS%20%20Beyond%20Final%20Report.pdf>

⁹⁰ Deepa G Gamage, Candice A. Fuller, Rosey Cummings, Jane E. Tomnay, Mark Chung, Marcus Chen, Cameryn Garrett, Jane S. Hocking, Catriona Bradshaw, Christopher Fairley, 'Advertising Sexual Health Services That Provide Sexually Transmissible Infection Screening for Rural Young People - What Works and What Doesn't,' *Sexual Health*, vol. 8, no. 3, Jul 2011, pp.407-411; Cameryn C Garrett, Maggie Kirkman, Marcus Y. Chen, Rosey Cummings, Candice Fuller, Jane Hocking, Jane e. Tomnay, Christopher K. Fairley, 'Clients' views on a piloted telemedicine sexual health service for rural youth,' *Sexual Health*, vol. 9, no. 2, 2012: 192-193; Melbourne Sexual Health Centre, 'TESTme: Free and confidential STI testing service', 2012 <http://www.testme.org.au/>