

The Sexual and Reproductive Health of Young Victorians

A Collaborative project between:

Family Planning Victoria

Royal Women's Hospital

Centre for Adolescent Health

Foreword

Foreword

We are very pleased to present this report on the sexual and reproductive health of young Victorians. We intend the report to be used by communities, educators, health professionals, policy makers and agencies who work with young people to inform their practice, program and policy development.

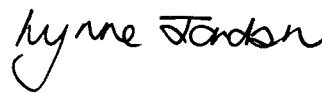
We believe this report is particularly timely given recent public and political debate around confidential health care to minors, sexually transmitted infections, teenage pregnancy, contraception and abortion services, and school-based sexuality education. This debate has stirred considerable interest in the project and has encouraged enthusiastic input from those working with young people.

This project has provided insight into how much is known, how much is already being done, where there are gaps in information and policy, and how we can improve education, services and ultimately the health status of young people. In particular we believe that an overarching policy approach could increase the effectiveness of efforts already being made.

This report is the result of a collaboration between our three organisations, based on the input of the many individuals and agencies who took part in the project's consultations. We greatly appreciate the generosity and commitment of all who participated, particularly those who gave formal presentations at the workshops. In bringing these perspectives together in this report, we are convinced that much more could be achieved through greater coordination and ongoing integration of everyone's efforts.

The passion and enthusiasm of Geraldine McDonald as project officer, supported by Angela Steele, has been central to the implementation of this project and we warmly acknowledge their contribution.

We trust this report will be a useful resource to all who work with young Victorians.



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The goal of the project was to further the community's understanding of young Victorians' sexual and reproductive health - and to propose ways in which it might be improved

In 2004, Family Planning Victoria (FPV), the Royal Women's Hospital (RWH) and the Centre for Adolescent Health (CAH), Royal Children's Hospital, formed a multi-agency collaboration that embarked upon the Young People's Sexual and Reproductive Health Project (YPSRHP).

The collaboration arose from a half-day forum held at the Royal Women's Hospital in late 2002, at which a number of health services met to discuss aspects of sexual and reproductive health in young people. While many different issues were raised, widespread concern was expressed about deteriorating sexual and reproductive health in young people, as evidenced by rising rates of sexually transmitted infections and high conception rates. Concerns also focused on the lack of reliable data about young Victorians' sexual and reproductive health.

The goal of the project was to further the community's understanding of young Victorians' sexual and reproductive health - and to propose ways in which it might be improved. In particular, we wished to summarise the available evidence base and to identify gaps in current practice and policy in order to provide direction for future program and policy development that will improve sexual and reproductive health outcomes in young people. The three participating organisations were well placed to address these issues given their engagement with clinical care, education & training and research.

At the start of the project, discussions took place with various stakeholders working within health, education, research and government settings. As a result of these discussions and our review of the literature, we identified three major themes for the project. These themes were:

Data

- what Victorian data currently inform programs and policies?
- what data could better inform future programs and policies?
- who is responsible for monitoring these data sets?

Education

- how are young people educated about sexual and reproductive health in schools?
- how could this education be improved?

Clinical practice

- what are the opportunities and challenges for clinical services in relationship to sexual and reproductive health care in young people?

Three half-day consultations were then held, each focusing on one of the above themes (see Appendix 1). At each consultation forum, the first half consisted of a series of formal presentations that framed a series of issues and questions. The second half consisted of in-depth discussion and debate around these (and emerging) issues with a wide range of participants providing various health, education, research, community and government perspectives. The outcomes of these in-depth community discussions assisted the project team to shape this report. This report appears especially timely given the extent of national debate around sexual and reproductive health in young people [1].

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Definitions of sexual and reproductive health

The Sexuality Information and Education Council of the United States (SIECUS) defines sexual health and reproductive health, both of which are complex definitions.

“Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one’s own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one’s own values” [2].

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

“Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents...” (Paragraph 7.3) [3].

At the 1994 International Conference on Population and Development (ICPD) in Cairo, reproductive health care was defined as: “the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases” [4].

Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one’s own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one’s own values [2]

Chapter one

Project description

To separately tackle elements of 'sexual' health such as sexually transmitted infections (STIs) and aspects of 'reproductive' health such as contraception and unplanned pregnancy is at best artificial and at worst inefficient given both of these outcomes strongly relate to early sexual activity

Why sexual and reproductive health?

The definitions cited suggest that sexual health may include aspects of reproductive health or the other way around: these definitions all acknowledge relationships as important and none suggests we should separate or differentiate sexual from reproductive health - or that this might even be feasible. It is for these reasons that we generally refer to sexual and reproductive health in this report.

However, throughout the consultation, concerns were raised about education, practice and policy initiatives that attempt to separate sexual from reproductive health. To separately tackle elements of 'sexual' health such as sexually transmitted infections (STIs) and aspects of 'reproductive' health such as contraception and unplanned pregnancy is at best artificial and at worst inefficient given both of these outcomes strongly relate to early sexual activity and unsafe activity. The same young people who are at higher risk of STIs are at higher risk of early unplanned pregnancy. Furthermore, the same health professionals are likely to be involved. To separate aspects of health promotion, education and health and welfare service delivery makes little sense. There was further concern about the separation of sexual and reproductive health practice and policies from other health issues, such as physical or mental health, with the recognition again of much co-morbidity.

Sexual health issues for young people

The World Health Organisation (WHO) identifies the main issues in adolescent sexual and reproductive health globally as:

- sexual development and sexuality (including puberty)
- sexually transmitted diseases (including HIV/AIDS)
- unwanted and unsafe pregnancies [5]

As stated in the WHO report, Department of Reproductive Health and Research (RHR),

“Adolescents have sexual and reproductive health needs that differ from those of adults in important ways, and which remain poorly understood or served in much of the world. Neglect of this population has major implications for the future, since sexual and reproductive behaviours during adolescence have far reaching consequences for people's lives as they develop into adulthood.” [1]

It might seem obvious to consider the sexual and reproductive health needs of young people in the developing world, where the extent of HIV infection creates an extreme focus for action. However, advocates for adolescent health suggest that the sexual and reproductive health needs of young people as a group, wherever they live, have largely been neglected. One explanation is that adolescent sexual and reproductive health rights and needs remain culturally and politically sensitive topics.

What determines the health of young Australians?

As 19% of the population, there were 935,908 young Victorians aged 12-25 years at the end of June 2004 [6]. Young people enjoy relatively good health in relationship to older Australians [7]. However, it is well established that adolescence is a time of onset of various behaviours and emotional states that have implications for the health of adolescents and young adults, but that also have longer-term impacts on the adult burden of disease.

In much of the literature “adolescence” is usually described in terms of a rite of passage or a transition from childhood to adulthood, which is closely related to the extent of growth and pubertal changes taking place. “The period between childhood and adulthood is a time of profound biological, social, and psychological changes accompanied by increased interest in sex.” [8]

Different definitions reflect different frameworks and contextualisation of adolescence. Within a developmental framework, adolescence is often viewed from the biological standpoint as a time of “storm and stress”, or from a social construction model which views adolescence as an age staged process of negotiating social and cultural influences [9]. Most definitions could be described as “adultist” and commonly characterise adolescence as a time of emotional turbulence, rife with risks. [1]. In contrast Fuller (2002) described adolescence and resiliency as “the happy knack of being able to bungy jump through the pitfalls of life - to rise above adversity and obstacles” [10]. Most definitions acknowledge that the adolescent and young adult years encompass the process of: “...the growth of the individual identity; extension of friendship, relationships and interests outside the family; and the progression towards emotional and financial independence [11].

These changes occur at different ages and rates in different individuals, and a rigid definition of young people is therefore unhelpful. This project has broadly considered young people to be the 20% of Victorians aged from 12-25 years. Focusing on this age group is consistent with the target group in the Victorian Youth Strategy; in some areas we have focused on particular subgroups for which information is available, most commonly those aged 15-19 years.

Adolescence is commonly a time of onset of sexual behaviours. Even though people of all ages are exposed to sexual risks, the consequences of risky sexual behaviour are greater in the young. For example, onset of early sexual activity results in greater risk of unplanned pregnancy and sexually transmitted infections (STIs) during adolescence [12]. Early parenting is a common outcome of socioeconomic disadvantage, but also contributes to continued socioeconomic disadvantage through failure of engagement with education and resultant poverty [12]. Early STIs can have important effects on future sexual and reproductive health, including cervical cancer (human papilloma virus), infertility (chlamydia infection) and recurrent pain (eg herpes simplex virus)

However, the sexual and reproductive health outcomes of young people do not emerge in isolation. Rather, young people who are at risk of poor sexual and reproductive health outcomes are also at risk of a range of other poor outcomes, including higher levels of substance use and abuse and mental disorder [13].

Indeed, throughout the project, there were strong calls to link and integrate approaches to sexual and reproductive health with those wider health and welfare concerns such as mental health, drug abuse and social disadvantage.

Fuller (2002) described adolescence and resiliency as “the happy knack of being able to bungy jump through the pitfalls of life - to rise above adversity and obstacles” [10]

Chapter one

Project description

While 30 years ago, the onset of sexual activity coincided closely with marriage, a dramatic social change in the past 30 years has been the extent of continuing participation in education for both men and women, and the older age at which young people commit to a life partner and have children

Changing timeline of adolescence

Over the past few hundred years, there have been impressive secular trends in the timing of puberty in both males and females. For example, the mean age of first menstruation was 17 years in the mid-19th century but had reduced to 14 years by the mid-20th century. Despite widespread beliefs in the community of a continuing downward trend in the age of onset of puberty in girls, there is little evidence that this trend has continued in the past 30 years in the developed world [14].

In contrast, the age of initiation of sexual intercourse continues to trend downwards, such that the median age of onset of sexual activity in Australia is now 16 years [15].

Barnes (2001) reports: “The lowest median age of Australian mothers in the 20th century occurred in 1971 when it was 25.4 years. Since then the average age of all mothers has been increasing each year to reach the highest level so far at 29.4 years in 2002. Comparative OECD data indicate that the average age of women at first birth in Australia is now amongst the oldest in the world. In 1993 this stood at 28.3 years, behind only New Zealand and Switzerland (OECD 1998). Since then the Australian average age at first birth has continued to rise, reaching 29.1 years in 1998” [16, 17] (see Figure 1).

While 30 years ago, the onset of sexual activity coincided closely with marriage, a dramatic social change in the past 30 years has been the extent of continuing participation in education for both men and women, and the older age at which young people commit to a life partner and have children (see Figure 2 and 3). For example, in 1976 the census living arrangement data showed that 40% of 20-29 year olds were partnered with children, whilst in 2001 only 16% of 20-29 year olds were living with a partner and children [18].

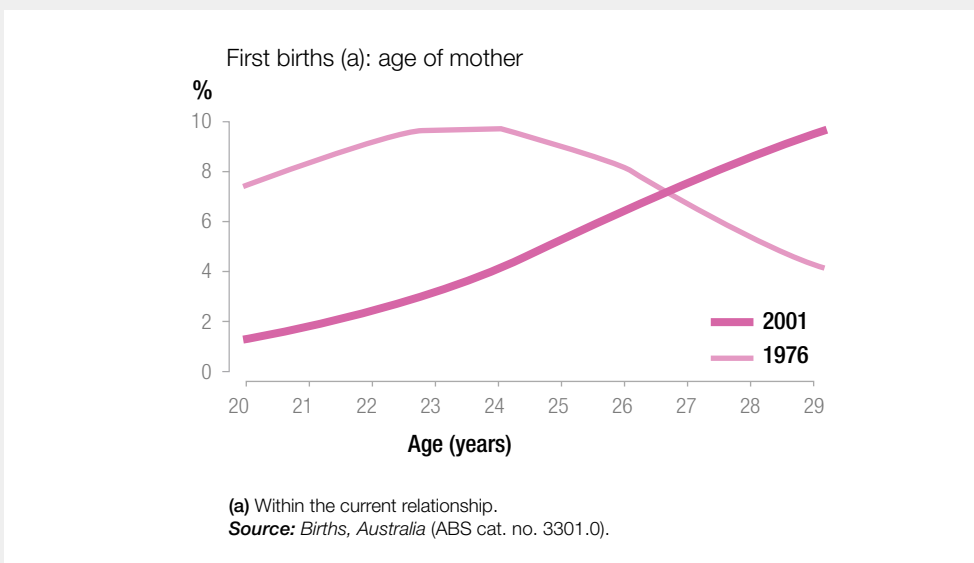
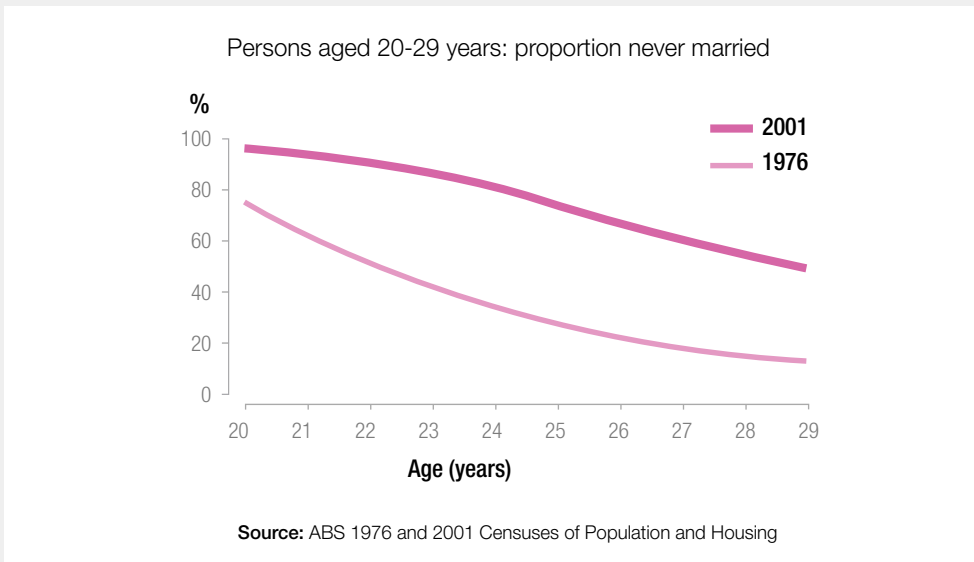
These social changes have taken place concurrently with other changes in sexual conditions such as greater access to sexuality education, greater availability of contraception and legalisation of abortion. Another illustration of the changes in societal attitudes and behaviour is the dramatic decrease in the number of adoptions in Australia, which have dropped sharply from 9,798 in 1971-72 to 668 in 1995-96 [19]. This has been accompanied by an increase in the proportion of births occurring outside a registered marriage, from 17% in 1986 to 31% in 2001 [20].

These changes are likely to reflect a greater acceptance of single motherhood, with a reduction in pressures on single pregnant women to either get married or give up their children for adoption.

These changing social patterns dramatically alter young people’s sexual and reproductive health risks. For example, the sexual and reproductive health risks for young women 50 years ago were quite different to the risks young women face today: sexual activity was more likely to commence within a marital relationship with few repercussions of unplanned pregnancy other than earlier parenthood and little risk of STIs.

In contrast, contemporary young people are not only sexually active at a younger age, but may then experience a period of 10–20 years of sexual activity with a number of different partners before marriage or settling down with a life partner. This greatly increases the risk of unplanned pregnancy and STIs in young people today.

Figure 1



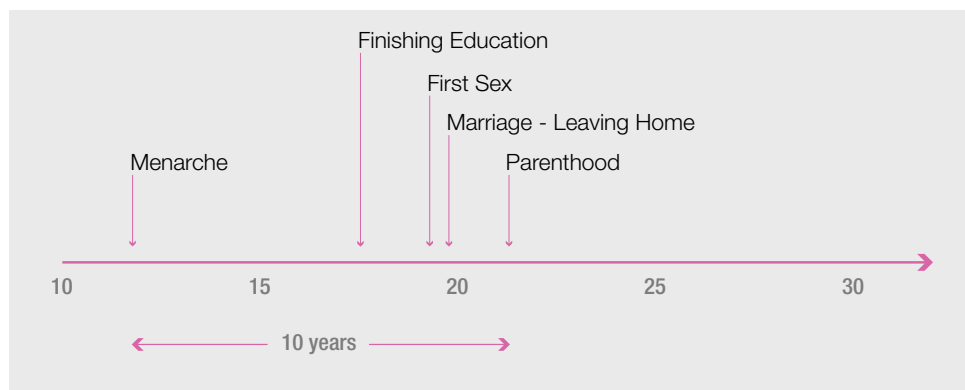
Chapter one

Project description

These changes are schematically represented in the following diagrams [13]:

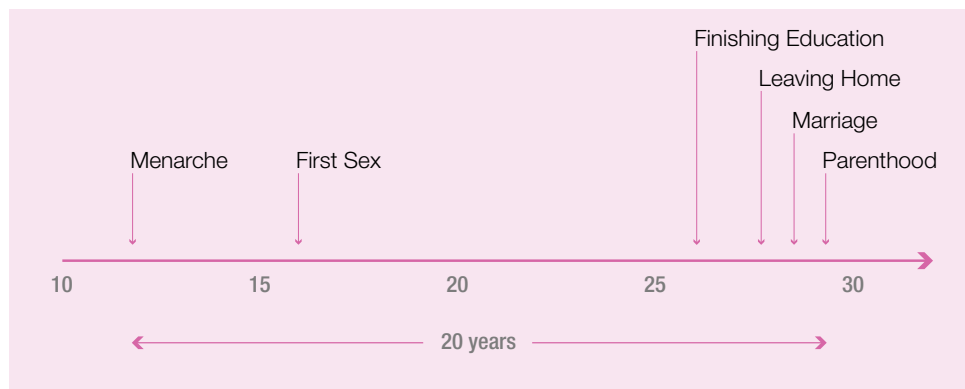
Growing up in 1950s

Figure 2



Growing up in 2000s

Figure 3



19% of the Victorian population is aged 12-25 years. These 935,908 young people are important ^[6]

Chapter two

The state of young people's sexual and reproductive health in Victoria

1 in 4 sexually active students reported that they were drunk or high at their most recent sexual encounter

1 in 5 women and 1 in 20 men report coercion into unwanted sexual activity. In those reporting coercion, half stated this first occurred before the age of 17, with over 80% reporting the first episode of coercion was before the age of 21

One of the 'drivers' of this project was a concern that there was insufficient information to develop the best strategies to improve the sexual and reproductive health of young Victorians. Gaps in data were identified, especially in relationship to the absence of an approach to regular data monitoring. While there is also considerable information available, it is not integrated into a form that makes it readily accessible to governments, other agencies and service providers. This chapter summarises the available information. A detailed analysis is presented of sexually transmitted infections and young people.

Historical changes in sexual development

Between the mid-19th and mid-20th century, the average age of menarche (first menstrual period) decreased remarkably from 17 to less than 14 years globally. There is little evidence of any continued reduction in the developed world in the past 30 years or so [14]. What is more striking is the extent of social changes that have resulted in earlier onset of first sexual intercourse and delayed age of stable life partners, 'marriage' and parenthood, which results in more lifetime sexual partners than in previous generations. As discussed in Chapter One, across their lifetimes, contemporary young Victorians now face a significantly greater risk of unplanned pregnancy and sexually transmissible infections than faced by past generations.

Young people's sexual behaviour

There is no regular survey of the health and well-being of Victorian young people, including sexual behaviours. However some information about young people's sexual behaviour is available from a range of sources, including:

- the Australian Study of Health and Relationships, a national survey of 19,307 people aged 16-59 years, conducted in 2001-2 [21]
- a series of national surveys of secondary students [22]
- the Adolescent Health Cohort Study, a representative study of Victorian young people conducted by the Centre for Adolescent Health (unpublished sexual and reproductive health data from this survey was presented at the first consultation workshop by Professor George Patton).

These studies have found that:

- the majority of older secondary school students have engaged in some form of sexual intimacy
- the median age of first sexual intercourse is now 16 years for Australian women and men. One in 4 year 10 students and 1 in 2 year 12 students have had sexual intercourse
- the median age of first sexual intercourse has been gradually declining. For example, 40% of men and 25% of women born in 1986 report their first sexual intercourse was prior to 16 years, compared to 15% and 10% respectively born in 1941 (see Figure 4)
- ninety percent of Australians use contraception at their first episode of sexual activity. There are lower rates of contraceptive use in young people who report an earlier age of first sexual intercourse

Part two

- ninety percent of young women aged 16-19 who are sexually active but not wanting to conceive use a form of contraception. This is less than the rate of contraception use in sexually active older women
- younger women are more likely to use contraceptive methods with higher failure rates than older women
- onset of sexual intercourse before the age of 16 years is associated with higher rates of sexually transmissible infections, more partners, homosexual experience, non-use of contraception and paid sex
- one in 4 sexually active secondary school students report having had unwanted sexual intercourse, with alcohol being most commonly cited as the explanation
- one in 4 sexually active students reported that they were drunk or high at their most recent sexual encounter
- rates of alcohol use and binge drinking are increasing
- one in 5 women and 1 in 20 men report coercion into unwanted sexual activity. In those reporting coercion, half stated this first occurred before the age of 17, with over 80% reporting the first episode of coercion was before the age of 21.

Young people and sexually transmitted infections

In Australia, notification of sexually transmissible infections (STIs) is mandatory. Monitoring occurs at state and national levels and yields the following information:

- Chlamydia trachomatis is the commonest notifiable STI in Victoria and Australia
- the total number of national notifications for chlamydia trebled between 1994 and 2001
- the rate of increase in national notifications is highest in young women
- Seventy-five percent of Victorian notifications are in under 25 year olds
- notification rates are higher in women than in men in Victoria and nationally
- while less frequent than chlamydia, notifications of gonorrhoea are also commonest in those under 25
- notifications of gonorrhoea are also increasing.

It should be noted that screening for STIs is increasingly encouraged, which may account for some of this increase. The true prevalence of chlamydia infection in Victoria is thus not known. An in-depth discussion of STIs follows.

The total number of national notifications for chlamydia trebled between 1994 and 2001

Chapter two

The state of young people's sexual and reproductive health in Victoria

Young people and sexually transmitted infections in Victoria

Australia, like other comparable developed countries, has witnessed a rise in the rate of many sexually transmissible infections over the last decade [23-26]. This follows a significant decline in the prevalence of STIs in the decade prior to the mid 1990s [23, 24]. The distribution of STIs remains unequal in the community with those under the age of 25 years carrying a disproportionately high burden. This was highlighted by a recent study from the UK that showed that age and number of sex partners is the factor most strongly (and independently) associated with the diagnosis of an STI in the past five years [23]. This study also highlights the importance of core groups in understanding the spread and control of STIs. Core groups are small groups with high rates of STIs that contribute disproportionately to transmission of STIs in the community. Core groups for STIs in Victoria include young people under the age of 25 years, men who have sex with men and sex workers working illegally.

Why do those under the age of 25 years have higher rates of many sexually transmitted infections than older sexually active individuals?

Young people under the age of 25 years have higher rates of STIs for a variety of factors. These include the sexual behaviour patterns of young people, their stage of psychological and cognitive development, as well as anatomical and physiological characteristics of the genital tract [27]. In addition, adolescents appear to be at increased risk of repeat infection from some STIs which may be due to a low level of partner treatment [28]. An additional factor that may be responsible for poor outcomes from STIs includes the fact that adolescents often have difficulty in accessing services, resulting in a delay in seeking care for STIs [29]. These latter two factors plus the acknowledged difficulties in providing effective sustainable health promotion programs for young people may be partly responsible for the disproportionately high morbidity of STIs in young people [27, 30].

What data is there?

In Victoria and nationally, most of the understanding of the epidemiology of STIs comes from mandatory notification of STIs in each State. Specific Victorian legislation requires the notification by medical practitioners and laboratories of certain STIs to the Victorian Department of Human Services.

Chlamydia trachomatis is now the commonest notifiable STI in Victoria and in Australia [26, 31]. In addition, the number of notifications in Australia is increasing and has trebled in the period from 1994 to 2001 [26]. Young women under the age of 25 years, continue to have the highest rates of notification for chlamydia with 75% of the cases notified in Victoria being in those under the age of 25 years [32]. This is similar throughout Australia, and nationwide data suggests the rate of increase in chlamydia notifications in the period 1995 to 2002 has been highest amongst young women [26].

Notification and prevalence data in Victoria

As chlamydia is commonly asymptomatic in both men and women, the correlation between notifications and true prevalence of chlamydia in the community is unclear. Notification rates may have been affected in recent years by the increased sensitivity of tests now used widely throughout Victoria by most practitioners. However, work from Sydney suggests that only 16% of the increase in chlamydia notifications in men and 8% of the increase in women in New South Wales is a result of improvements in diagnosis [33]. It is likely that increased awareness of chlamydia amongst health care professionals and the general community has led to more testing, which may have influenced the number of cases of chlamydia identified. This has been recently confirmed in Victoria, where the number of chlamydia tests in the past decade has risen as well as the number of notifications of the disease [34]. However, the proportion of those tested who are symptomatic had not increased over this time. This supports the argument that at least some of the rise in notifications of chlamydia has been as a result of a true rise in the prevalence of infection in the Victorian community rather than just an increase in testing [34].

Notification rates for chlamydia are consistently much higher in women than in men in Victoria and Australia as a whole [32]. This may reflect more testing of women than men, as true prevalence data from other developed countries has demonstrated similar rates among men and women [23, 35, 36]. Data on chlamydia prevalence in Australian men is incomplete. Currently the number of diagnoses in men largely depends on those who attend health care services because of symptoms, those notified by a partner who has tested positive for chlamydia and the small number of asymptomatic 'screening tests' performed. There is no published data from Victoria or Australia on the true community prevalence of chlamydia, although various studies have measured rates in specific target groups [37].

An unpublished prevalence study of Victorian women showed the prevalence of chlamydia in those aged 18 - 24 years who had ever had sex was 3.7% (95% CI 1.2-8.4). In those who had had a change of partner in the past three months the prevalence was 16.7% [37]. Published prevalence rates in specific target groups in Victoria have varied. A rate of 6.2% was reported in young people under the age of 25 years attending a specific sexual and reproductive health service in the central business district [38]. A small study of 163 adolescents presenting to a youth service in Geelong, Victoria demonstrated a prevalence of 5.8% [39]. Women presenting to a public hospital in Melbourne for legal terminations between 1996 and 1997 were found to have a prevalence rate of 2.8% [40]. Unpublished data from the Well Person Health Check conducted in 11 Koori communities in Victoria demonstrated much higher prevalence rates for young indigenous women [41]. This is consistent with prevalence rates of 11% found in indigenous women from other parts of Australia [42].

In view of the asymptomatic nature of the disease, true prevalence data in Victoria will not be available without a chlamydia screening program. Many experts believe such a program is long overdue in Australia and is a necessity to reduce the burden of disease caused by this STI [36, 43-46].

While chlamydia is the STI most commonly associated with adolescence, other STIs are also commoner in younger rather than older individuals [27]. Gonorrhoea is most common amongst men, especially those having sex with other men, but this disease still causes the greatest burden of disease in those under the age of 25 years [31]. The increasing number of notifications of gonorrhoea in Victoria, in addition to the changing patterns of resistance to standard antibiotics, also provides a public health challenge in the control of this STI among young people.

Chapter two

The state of young people's sexual and reproductive health in Victoria

Young women under the age of 25 years, continue to have the highest rates of notification for chlamydia with 75% of the cases notified in Victoria being in those under the age of 25 years [32]

Knowledge and attitudes of sexually transmitted infections and sexual behaviour data in Australia

The Australian Study of Health and Relationships reported on the sexual behaviour of 20,000 randomly selected Australians aged 16 - 59 yrs [47]. This study has provided important information on many factors that are likely to influence the rates of STIs in Australia.

The median age of first intercourse has declined over the past 30 years and is currently 16 years for both men and women [48]. For those born in 1986, about 40% of men and 25% of women reported sexual intercourse before the age of 16 years. In comparison, for those born in 1941, 15% of men and 10% of women reported engaging in vaginal intercourse before the age of 16 years [48] (See Figure 4). Earlier age of first sexual intercourse is associated with poorer reproductive and sexual health outcomes. These outcomes include increased lifetime risk of being diagnosed with an STI, increased number of lifetime sexual partners and pregnancy under the age of 18 years [49, 50]. The number of individuals reporting the use of a contraceptive method at this first episode of sexual intercourse has also increased over the past 30 years. More than 90% of both men and women who had vaginal intercourse for the first time in the year 2000 report the use of some contraception compared with those who engaged in intercourse for the first time in 1955, in whom this figure is 35% for women and 20% for men [48] (See Figure 5). This is good news, but does not tell us about the method of contraception used or the consistency of use over time, both of which are important factors influencing the rates of STIs and unplanned pregnancy.

Adolescents with a history of sexual assault are known to be at risk in regard to poor health outcomes. The Australian Study of Health and Relationships reported that 5% of men and 20% of women have at some stage been coerced into having sex against their will

[51]. In addition, 1 in 6 women aged 20 - 29 years reported having a pregnancy whilst a teenager (34). Fifteen percent of women and 9% of men reported experiencing feelings of sexual attraction that were not exclusively heterosexual [52].

The knowledge, attitudes and practices of samples of Australian secondary school students in years 10 and 12 have been reported in successive surveys published in 1992, 1997 and 2002 [53, 54]. The most recent survey, published in 2002, included private and Catholic schools as well as public schools for the first time [54]. These surveys show that changes over the time period include increased sexual activity among year 12-students with more than 50% reporting sexual intercourse in the 2002 survey. In addition to intercourse, other sexual activities are common among students including oral sex (45.5%), deep kissing (80%) and genital touching (67%). Condom use remained inconsistent and was more commonly reported as 'always being used' by year-10 students than year-12 students. Sex was reported to occur commonly when under the influence of alcohol. Injecting drug use remains rare. There was an increase in those reporting binge drinking; this was reported by 59% of year 10 female students in 2002, as opposed to 43% in 1997.

Young people report confidence in saying 'no' to unwanted sex. However, 28% of young women and 23% of young men report unwanted sexually activity. The commonest reported reasons for this were the influence of alcohol or pressure from their partner.

Knowledge of STIs over the decade 1992 to 2002 has improved but is still poor about chlamydia and its potential to affect fertility. Knowledge of HIV transmission has decreased over the decade whereas knowledge of hepatitis A, B and C, although still poor, has improved since 1997. Students' attitudes to those who are infected with HIV are positive, as are attitudes to peers who are gay or lesbian.

Sources of information include school sexuality programs, friends and parents. School programs appear to be highly valued and while the internet is accessed for many reasons by young people, it is not highly valued as a source of sexual health and reproductive health information. Young men in year 10 have been highlighted as being particularly vulnerable to poor sexual and reproductive health outcomes as they report poor knowledge of STIs, high rates of partner change, high rates of sex with someone they have met for the first time, high rates of binge drinking and a high chance of being drunk at their last sexual encounter.

To improve the sexual and reproductive health of young Victorians, public health policy must be informed by accurate data on the sexual behaviour of young people. An understanding of the factors influencing these behaviours and reliable data on the epidemiology of STIs in this demographic group is also necessary. Reliable data are available on knowledge, attitudes and behaviours of young Australians. However, investing in repeat serial studies provides important information on changes with time. Notification data for STIs in Victoria are adequate but true prevalence data are currently lacking. Implementing a chlamydia screening program and enabling all young people at risk of chlamydia to access testing (both male as well as female) would provide important information on the epidemiology of chlamydia, and would also be an important public health initiative likely to improve long-term health outcomes for Victorian young people.

Figure 4

Sexual Intercourse in Australia <16 years

Australian Study of Health and Relationships, ANZ Journal Public Health 2003

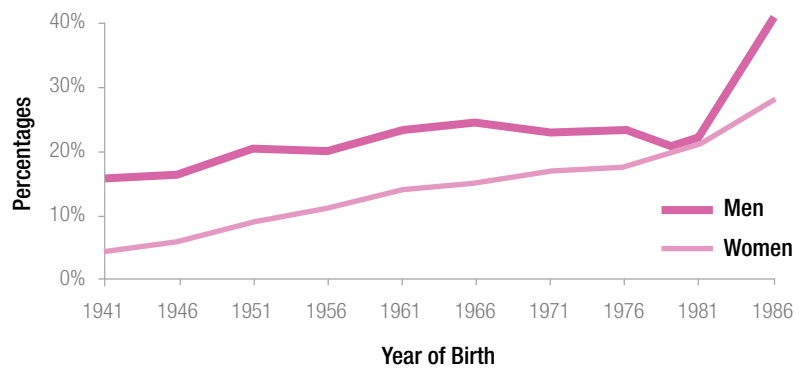
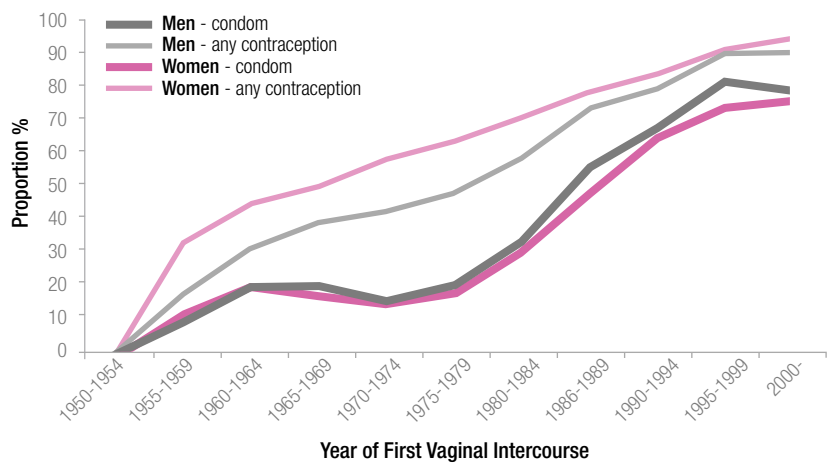


Figure 5

Likelihood of Contraceptive Use at First Sexual Intercourse

Australian Study of Health and Relationships, ANZ Journal Public Health 2003



Chapter two

The state of young people's sexual and reproductive health in Victoria

There has been a gradual decline of births to teenagers as a proportion of all births from 4.4% in 1986 to 3.1% in 2002

The proportion of teenage births in 2002 was 4.8% nationally compared to 3.1% for Victoria, which has the lowest proportion of all states and territories

Teenage birth rates in Victoria

Data are collected on all births in Australia and reported by the Victorian Perinatal Data Collection Unit and the Australian Institute of Health and Welfare. Comprehensive information is reported.

For Victoria:

- there were 1900 births to women aged 15-19 years in 2002
- the proportion of teenage women among all women giving birth is steady at 3.1-3.3%
- there has been a gradual decline of births to teenagers as a proportion of all births, from 4.4% in 1986 to 3.1% in 2002
- the proportion of teenage births varies in different parts of the state. For example, the proportion ranges from 6% in some rural areas to 1.4% in the eastern metropolitan region
- among indigenous women, 22% births are to teenagers.

Nationally:

- the proportion of teenage births in 2002 was 4.8% compared to 3.1% for Victoria, which has the lowest proportion of all states and territories
- the proportion of teenage births to indigenous women is consistently much higher than for the population as a whole
- the number of teenage births fell by 10.2% in the 10 years to 2002.

Teenage abortion rates in Victoria

There is no formal monitoring of abortion in Victoria or nationally [55, 56]. There is however, mandatory reporting of all abortions in South Australia, which is regularly reported [55].

A paper presented to the first consultation workshop of this project by Dr Julia Shelley provided data derived from Victorian Medicare data and public hospital admissions. It estimated that:

- approximately 18 per 1000 women aged 15-19 had an abortion in the 2001-02 year, a total of approximately 3000 abortions
- approximately 12% of all abortions in Victoria were performed on teenagers
- Victorian abortion rates are lower than similarly derived rates for New South Wales, Queensland and Western Australia
- it is probable that there has been a steady and gradual decline in the rate of teenage abortion since 1994-95 [57].

These data are consistent with recently published systematic estimates [55].

The Victorian Department of Human Services has recently made available data (from the Victorian Admission Event database) on terminations up to and including 19 weeks gestation for the 2002-03 year, recording that 3729 (18.8 per 1000) women aged 15-20 had abortions. Accurate data are not available about the majority of procedures that were performed privately for prior years.

Unpublished data from the Australian Research Centre for Sex Health and Society (ARCSHS) show that higher proportions of younger than older women having an abortion travel more than 50 kilometres and or are away from home overnight, suggesting that access to abortion may be more difficult for this group [58].

Where systems exist for mandatory notification of abortion such as in South Australia and the United Kingdom, information is available on:

- age distribution by year
- gestation (South Australian teenagers have a higher proportion of later abortions, including second trimester abortions, than older women)
- the number of previous pregnancies and abortions
- the relationship of abortion rates to geographical areas and indicators of social deprivation
- the proportion of all pregnancies ending in abortion (in South Australia this is 56% for women under 20 years of age and 35% for those in the 20-24 year age group).

Other relevant data about young people and pregnancy discussed within this project included:

- seventeen percent of Australian women aged 20-29 years in 2001 reported at least one pregnancy in their teen years [59]
- six percent of Australian secondary students have ever had a pregnancy [59]
- access to emergency contraception (the 'morning after pill') does not reduce young people's use of more reliable forms of contraception
- teenage mothers in general are more likely to live in areas of disadvantage, be single, be unaware of the gestation of their pregnancy, experience higher levels of psychological distress, engage in substance abuse and endure domestic violence, poverty, children in care, educational problems, be out of education, experience sexual abuse, mental health problems, be themselves the children of teenage mothers, have greater exposure to crime, and be ignorant about sex [60, 61, 62]
- educational attainment is reduced by unplanned teenage pregnancy [63, 64]
- family connectedness, good parent-child communication and sex education protect against teenage pregnancy [65]
- teenage pregnancy rates in Australia are probably comparable with those in Canada and the United Kingdom, lower than those in the United States but substantially higher than those in many European countries such as the Netherlands
- teenage fathers are a neglected group.

Teenage mothers are more likely to live in areas of disadvantage, be single, be unaware of the gestation of their pregnancy, experience higher levels of psychological distress, engage in substance abuse and endure domestic violence, poverty, children in care, educational problems, be out of education, experience sexual abuse, mental health problems, be themselves the children of teenage mothers, have greater exposure to crime, and be ignorant about sex

Chapter two

The state of young people's sexual and reproductive health in Victoria

Long term outcomes are better for young mothers who are able to continue their education

Other relevant data about young mothers that was discussed within this project included:

- long-term outcomes are better for young mothers who are able to continue their education [66]
- interventions during pregnancy and following birth can increase knowledge and use of contraception and delay subsequent pregnancy [67]
- subsequent pregnancy for teenage mothers substantially increases the risk of being dependent on long-term welfare support [67]
- social disadvantage may both contribute to and result from young age at parenting [62]
- young mothers are significantly more likely to be daily smokers than those who are not parents [13]
- adolescent mothers are more likely to live in areas of social disadvantage, be single, be unaware of their gestation and have fewer antenatal visits. They are more likely to experience higher levels of psychological distress, be substance users and endure domestic violence. However, there is some evidence to suggest that mental health of young mothers may actually improve during and after pregnancy if they are well supported [64, 63, 13]
- while some young mothers and their babies do well, on a population basis, there are significant associations with a wide range of indicators of poor health and wellbeing [12].

Other aspects of young people's health that are important to consider include:

- a higher incidence of sexual risk-taking behaviours is reported in young people with mental health problems and drug use [68]
- mental health disorders, including drug and alcohol dependence and depression, constitute the leading component of the burden of disease for young people aged 15-24 years, with intentional and unintentional injury the second most important in scale [11]
- thirty three percent of males and 27% of females aged 14-19 years were regular alcohol drinkers in Australia in 1998 [11]
- agencies that are funded to manage young people with mental disorder or substance use will also see young people with high levels of sexual risk behaviours – and vice versa
- multiple agencies have identified mental health, drug and alcohol use and poor sexual health as major issues for young people [69, 70, 71].

Monitoring provides a stronger basis for planning interventions to reduce unplanned pregnancy and abortions, allows for targeted interventions for communities and populations at greatest risk, and facilitates appropriate service planning.

Recommendations

A clear picture of where we've come from and how we might progress requires regular monitoring and reporting of young Victorians' health. We recommend:

The health of young Victorians should be monitored and regularly reported

- monitoring should include a range of sexual and reproductive health outcomes of interest, including STI notification rates, birth rates and abortion rates. Monitoring should also include other important sexual health indicators, such as frequency of contraception use and method of contraception, including use of emergency contraception
- this information should be integrated into a single report to be circulated annually to relevant communities, agencies and health professionals
- this information would be most useful if sexual and reproductive health data was able to be cross referenced with wider indicators of health and wellbeing such as mental health indicators, drug and alcohol use, school attendance and homelessness.

A monitoring process should be established for abortions in Victoria

- the Department of Human Services is to be commended for its efforts to accurately record the number of abortions in Victoria, together with other available demographic data. Continuation of this monitoring should be supported by government
- the Department of Human Services and the Royal Women's Hospital (RWH) should work together to establish a pilot project to voluntarily monitor abortions in a manner similar to that undertaken in South Australia and the United Kingdom. Around one-sixth of the state's abortions are performed at the RWH: they will not be representative of the state as a whole because of the high proportion of public patients treated at RWH and the hospital's orientation towards the needs of those facing particular social disadvantage. However, such a pilot would establish the feasibility of such data collection and provide a basis for developing ongoing more comprehensive state-wide monitoring
- a health regulatory framework would facilitate the routine monitoring of this complex health issue.

A population screening program should be established to determine actual chlamydia prevalence rates in Victorian young people

Young people's voices should be included in the development of sexuality education resources

School communities, including parents and students, believe that schools have a responsibility to provide comprehensive sexuality education in schools. The challenge for all is what to provide, when to provide it, and how best to support it. Comprehensive sexuality education programs, commonly referred to as 'Sex Ed' aim to delay the initiation of sexual intercourse while encouraging young people to be sexually safer once they do become sexually active.

Reassuringly, there is no evidence that comprehensive sexuality education increases sexual activity nor encourages early initiation. Specifically, there is no evidence to support claims that discussing sexual intercourse, STIs or contraception encourages sexual activity [62]. Indeed the reverse is true: there is evidence that **comprehensive sexuality education can delay the onset of sexual activity and promote safer sexual activity once it is initiated**. There is no evidence that programs that simply aim to delay the onset of sexual initiation (abstinence only programs) are effective [72].

What do young people say they want?

Family Planning Victoria has held a number of consultations with secondary school students over the past few years to determine what young people want from sexuality education in schools [73]. Young people state the following points are important:

- more time needs to be given to sexuality education within the school curriculum
- there need to be comprehensive sexuality education programs from years 7 to 12
- trained, professional educators are required to deliver sexuality education
- there should be a range of methods and technologies for providing information and support to young people
- young people's voices should be included in the development of sexuality education resources.

What are the principles underpinning comprehensive sexuality education programs in schools?

A set of critical factors have been identified for successful sexuality education programs in schools [74].

These factors include:

- adopting a whole school approach
- acknowledging young people as sexual beings
- addressing and catering for diversity
- appropriate and inclusive curriculum context
- identifying and acting on appropriate professional development needs for the school community
- adopting a developmental-based approach to curricula
- adopting a multi-dimensional approach to sexuality and sex education
- avoiding generalisations about adolescence
- ensuring programs are gender inclusive
- incorporating peer education strategies
- introducing sexuality education early
- involving parents and communities
- providing sexuality educators with appropriate training and support
- working at a systems level as well as at an individual level.

These factors support the need to shift the focus within sexuality education programs from fact-based knowledge to focus more closely on real life situations and the associated factors that influence decision making [74]. They also highlight the need to move beyond considering the role of sexuality education programs in isolation from the role of whole school interventions that promote positive sexuality while reducing the negative consequences of sexual activity.

Most of the literature about young people's sexual and reproductive health focuses on the identification of sexual behaviours and associated reproductive health outcomes such as pregnancy and STIs. This work identifies that many factors predict the timing of first sexual intercourse as well as early first pregnancy, including socioeconomic status, parental and peer attitudes, lack of engagement within education, being the child of a teenage mother, as well as ignorance about sex. Importantly, teenagers who do well in school are more likely to delay sexual initiation [75]. School-based programs are only part, albeit an important part, of the solution.

No 'abstinence only' program has been shown to reduce sexual behaviour.

The most successful curricula-based programs to reduce teenage pregnancy have 10 characteristics in common [76].

Successful programs:

- focus on specific behavioural goals
- are based on theoretical approaches
- deliver clear messages about sexual activity and/or contraceptive use
- provide basic information about risks associated with teenage sexual activity and methods to avoid pregnancy and STIs
- address social pressure toward having sex
- provide activities to practise communication and refusal skills
- incorporate multiple teaching methods and personalise information to individual needs
- are tailored to participants' age-level, culture, and level of sexual experience
- are long enough to cover all information and activities
- provide appropriate training for teachers or peer leaders who are committed to the program.

Translating our knowledge of sexually risky behaviours into effective prevention programs has been less well studied [77]. Kalmuss and Davidson developed eight points to consider when designing specific programs that aim to reduce risky sexual behaviours in teenagers [78]. Many of these points overlap with the points outlined above. These include:

- programs should begin early and target younger adolescents
- new programs for minority teenagers need to be developed
- risk reduction programs need to be systematically linked to other youth programs that directly address socioeconomic disadvantage

- programs need to understand that many youth lack the skills to practise safer sex
- programs need to effectively address the influence of peer groups, social norms and pressures to have sex
- programs for adolescents should not assume that sexual behaviour is volitional
- programs should not assume that sexual activity among teenagers is limited to vaginal sex
- programs cannot assume that teenagers are unambivalent about preventing pregnancy.

Delaying first sexual activity

No 'abstinence only' program has been shown to reduce sexual behaviour. A common misapprehension is that these programs have been largely responsible for lower rates of unplanned pregnancy in the United States rather than the more likely scenario of increased use and availability of contraception [62]. 'Abstinence only' programs would be more likely to be effective in delaying first sexual intercourse if they were implemented in conjunction with programs that involve equipping young people with skills to make informed decisions about their sexuality. A detailed review of 'abstinence only' programs is reported by Manlove et al and is available at www.teenpregnancy.org/works/pdf/NotYet.pdf

Key findings from this report include:

- there has been increasing focus in the US on 'abstinence only' programs in the absence of any literature supporting the efficacy of these programs when run alone
- promoting abstinence in conjunction with comprehensive sexual and reproductive health programs that include information about contraception and STIs has been shown to be effective.

There are no minimum standards or certified courses for teachers of sexuality education in Victorian schools

There are many reasons why it is beneficial to delay sexual intercourse [80]:

- teenagers who begin having sexual intercourse at younger ages are more likely to express regret about their first sexual experience than are older teens
- teenagers who have sex in their early teens have more sexual partners, are less likely to use contraception, and are more likely to get pregnant
- teenagers who first have sex at an early age are more likely to have older partners
- teenagers in families with higher education and income levels are more likely to delay first sexual intercourse
- higher quality parent-teen relationships help delay sexual initiation
- attitudes about sex and peer norms affect timing of first sex
- having a steady, romantic relationship is associated with an earlier age of sexual initiation.

The Victorian experience

The Victorian Essential Learning Standards (VELS) sets the standards of the content to be covered throughout a child's school education. The Victorian Curriculum and Standards Framework II (CSF II) is a curriculum guide within these standards. Individual schools are responsible for the implementation of VELS and CSF II while the Department of Education and Training is responsible for implementation of the policy [79]. A range of issues became apparent from discussion within the consultation forum about sexuality education within Victorian schools, some of which are now starting to be addressed. These include:

- sexuality education has been taught within the framework of health and physical education. This is perhaps one explanation why the focus of much sexuality education continues

to be about the biology and anatomy of sexual health and reproduction, rather than on broader aspects such as sexual decision making and the effects of alcohol and drugs or physical and emotional safety within relationships

- there has been no recommended curriculum for sexuality education in either primary or secondary schools until recently. There are now two recommended curriculum resources for sexuality education in secondary schools: 'Catching On' and 'Talking Sexual Health'. While some primary schools currently address sexual education, there is little consensus about the appropriateness of sexuality education for younger students, and little integration with later teaching in secondary school
- participants considered that sexuality education was generally not integrated into a range of wider approaches beyond curriculum-based components. There are many opportunities for schools to integrate sexuality education within other subjects such as English or Media Studies, or to link with whole school approaches to gender or sexuality-based bullying, or to broader frameworks of building social confidence and self-esteem.
- there are no minimum standards or certified courses for teachers of sexuality education in Victorian schools
- the value placed on providing a comprehensive sexuality education program largely depends on each individual school community. As with other components of the curriculum, individual schools have considerable flexibility in how they interpret the CSF in relationship to comprehensive sexuality education. There is wide variation between schools in their approach. While there are some superb 'best practice' examples, there is little evidence that such examples are widely implemented.

Chapter three

Education

There is wide variation between schools in their approach to sexuality education. While there are some superb ‘best practice’ examples, there is little evidence that such examples are being more widely implemented

In summary, parents have the major responsibility for the sexuality education of their children. However, the extent of unplanned pregnancy and rising rates of STIs in young people, together with the fact that over 50% of young people are sexually active by 16 years of age, underscores the importance of ensuring that young people acquire the attitudes and skills to make safe sexual choices. This requires more comprehensive approaches to sexuality education in schools than simply teaching the anatomy and physiology of sex and reproduction.

Case studies

A Scottish perspective: Comprehensive teacher training is possible

Margaret Palmer described the development and implementation of a teacher training intervention to provide sexuality education in a region in central Scotland (population base of approximately 280,000) which, prior to the intervention, had one of the highest rates of teenage pregnancy in the world.

A review of sex education in the region's schools had highlighted a lack of teacher competence and confidence in delivering sexuality education. A comprehensive training program was developed as a result.

The program aimed to develop the competence of teachers who were already delivering sexuality education, and to empower each teacher with confidence and enthusiasm to deliver sexuality education.

As a result of the positive evaluations from both teachers and students of this pilot program, a uniform approach to teaching sexuality education was subsequently introduced in Scottish schools. Sexuality education is now mandatory within the school curriculum and teachers are required to be trained in order to deliver a minimum standard of sexuality education [80].

Northcote High School: Implementing a sexual diversity program

It is estimated that up to 1 in 10 young people are same-sex attracted [81]. These young people commonly experience negative effects of homophobia which may contribute to the higher rates of poor health outcomes in same-sex attracted young people, such as emotional and mental disorder.

Youth participation models can offer powerful protection against the experience of homophobia, (whether internalised or externalised). Youth participation models are based on the notion that young people who are provided with active opportunities to participate and contribute, and to make decisions in support of themselves, will develop greater competence, coping and resilience.

Kerryn O'Rourke described the development of a successful program at Northcote High School that aimed to reduce homophobia in the school through a youth participatory process. A further aim was to enhance young people's safety. The program was supported by a proactive coordinator, with explicit commitment to the program by teachers, parents and the community. Informal evaluation suggested that participating young people felt greatly supported by the program [82].

Plumpton & Corio High Schools: Quality support for women who parent young

There is a lack of practical support and encouragement for young women who are parenting to stay at school and complete their education [83]. Plumpton High School in NSW and Corio High School in Victoria are exceptional in the extent of support and childcare that is provided to young women who parent while at school.

Kay Boulden described that continued engagement in education provides a dramatically different trajectory to the usual experience of teenage parenting. More young women completed their secondary education and increased their opportunities for tertiary education or employment. Furthermore, reconnectedness with education also reduced the likelihood of subsequent unplanned pregnancies [66].

Summary

The features of effective comprehensive sexuality education programs are well described.

There are many successful examples of comprehensive sexuality education programs. While adapting programs to individual school environments requires local commitment, there is no evidence that designing or funding more pilot programs is indicated. Rather, consideration of how best to implement successful universal and targeted programs (eg, to support young parents) is required.

Implementation of successful sexuality education programs, including a whole-of-school approach, will require a commitment by government to resource development and teacher education.

Recommendations

To ensure we are educating our young people to make informed decisions about sexuality and safe sexual and reproductive health choices, we need to implement comprehensive sexuality education programs in Victorian schools. We recommend:

- an audit of all Victorian primary and secondary schools is undertaken to identify what is taught to Victorian students in sexual and reproductive health education
- an audit of teachers of sexual and reproductive health education is undertaken to identify their level of knowledge and level of comfort with teaching sexual and reproductive education
- setting minimum standards for teachers running comprehensive sexual and reproductive health education programs
- information about successful existing programs and pilots should be included in the proposed annual report of young people's sexual and reproductive health (see Chapter 2).

Chapter four

Service delivery to young people

Access to confidential health services is an important component in young people's decisions to use health services as well as the effectiveness of those services

This chapter identifies some important elements that promote more effective health service delivery to young people which have been consistently reported by young people in multiple studies in many different parts of the world. A number of clinical approaches and models for engaging with young people are also described in this chapter.

Access to services

The published literature identifies access as the most pressing health service delivery issue for young people requiring attention to location, mobile services, outreach via community based workers, cost of services, and training private sector providers to be responsive to the needs of young people [84, 85]. Access was confirmed by consultation participants as critically important.

Confidentiality

Recent debate, literature reports, and discussion during this project have emphasised the importance of confidentiality, including perceived confidentiality, in young people's decisions to use health services and the effectiveness of those health services. This aspect has been recently reviewed in the Australian context [86-88]. The project confirms the importance of:

- acknowledging and respecting the wishes of young people for confidentiality
- discussing confidentiality issues with all young people
- encouraging young people, especially those under 16, to inform their parents or allow their parents to be informed about important issues about their health and health care. However, health professionals are legally required to respect mature minors' wishes for confidentiality
- protecting the confidentiality of young people, including where parents may seek information against the wishes of a young person
- resisting legislative change that would diminish the rights of young people to confidential health services on the basis that this would compromise their access to good care
- supporting changes that would increase access to services by young people; eg, issuing young people with a Medicare card once they reach the age of 16
- ensuring health professionals are adequately trained in this aspect of health service delivery for young people.

er four

Approaches to service delivery

A New South Wales report 'Getting it right: models of better practice in youth health' identified seven key features of best practice in youth health service delivery:

- addressing inequalities
- providing access and participation
- building supportive environments
- balancing approaches including individual and population based, reactive and proactive (preventive)
- coordination of services with collaboration between disciplines
- collaboration between sectors
- building the infrastructure including staff training, support and supervision [89].

An approach involving 'integration of services with a common vision, mission, shared philosophy and agreed protocols and professional practice guidelines' may result in more effective service delivery [90]. However, co-location of services, while popular, is not in itself the solution to improving integrated service delivery to young people. Fragmentation, philosophical differences, differing contractual and funding agreements and standards for working with young people may result in compromise of service delivery. Chesterman Associates (1998), cited in Success Works, (2000), suggest that compatible service delivery philosophies and frameworks, complementary approaches in dealing with clients and a common community of interest are important components of successful co-location projects [90].

Improving youth health service delivery models

A United Kingdom study evaluated sexual and reproductive health services at two satellite sites, one for young people and the other an open-age mainstream clinic. They piloted an alternative approach to running the two parallel services by establishing one quality mainstream service. This service was open to all ages with extended hours, required no appointments and built in a 'drop in' component, combined with targeted outreach to facilitate access to under 25 year olds. The outreach program included developing strong links between schools, youth services, social services and voluntary sector organisations [91].

By establishing a new, single, quality service model with targeted outreach to young people, they saw new patient registrations increase among all age groups almost immediately. The greatest increase was among the younger age groups with a 12-fold increase for those under 16, a three-fold increase for young people between 16-19, and 2.5-fold increase for those under 30 years. The combination of extended clinical hours, drop in and proactive targeted outreach significantly increased the use of family planning services [91].

Chapter four

Service delivery to young people

Many young people are fearful that their parents will find out about their health consultations which inhibits them accessing services. A clinician who focuses on communication, including confidentiality, who can demonstrate compassion without judgment, and is able to provide a service that is sufficiently convenient and affordable, can expect to work more effectively with young people. Attention and responsiveness to the developmental stage of the young person is vital

In 2002, Family Planning Victoria (FPV) undertook an extensive review of service provision to young people [1]. As a result, FPV changed how services were delivered to ensure that the most disadvantaged young Victorians were able to access sexual and reproductive health services. Clinic hours were altered to ensure services were available until 6 pm, appointments were cancelled in favour of a 'drop in' model and satellite services were set up in areas with high levels of socioeconomic disadvantage and large numbers of young people.

Following the changes, while the number of consultations for under 25 year olds stayed constant, the proportion who were marginalised or disadvantaged, as evidenced by holding a Health Care Card or being on a pension, increased from 18 to 31% [92].

Improving clinicians' skills

More specific training for health, welfare and education professionals who work with young people was a theme that was commonly discussed within this project, especially in relationship to sexual and reproductive health [93]. These consultations can be challenging and confronting for clinicians, as well as the young people who access the service; without specific training or experience, clinicians commonly report lacking both confidence and competence when consulting with young people, including aspects of their medico-legal responsibilities [87].

Confidentiality is a central issue: raising and discussing this at the start of a consultation has been shown to be helpful in establishing trust with young people, and makes it more likely that young people will be honest with the treating health professional. Many young people are fearful that their parents will find out about their health consultations, which inhibits them accessing services. A clinician who focuses on communication, including confidentiality, who can demonstrate compassion without judgment, and is able to provide a service that is sufficiently convenient and affordable can expect to work more effectively with young people. Attention and responsiveness to the developmental stage of the young person is vital.

There has been a growing emphasis on the development of training and tools that assist and support clinicians in identifying and responding to young people's health needs. Specific training in adolescent health has been shown to significantly improve service delivery by Victorian general practitioners [94]. This training included use of the HEADSS mnemonic, a prompt for health professionals to question young people around the themes of Home, Education, peer Activities, Drugs, Sexuality, and Suicide in order to identify concerns, feelings, and behaviours that underpin health and wellbeing [95]. The complex interplay between mental health disorders and high-risk behaviors underscores a need for coordinated training for health professionals around communicating with young people, regardless of whether the presenting problem relates to physical, sexual and reproductive, behavioural, social or mental health and wellbeing [68].

Existing services

A wide range of general and specific services deliver clinical care to young people. These include mainstream clinical services such as general practice, community health centres and hospitals, as well as a series of services that target young people. Some models that have been developed in response to local needs assessments are described below.

The Frontyard Youth Service within Melbourne's CBD is a youth-specific service that offers an integrated and comprehensive range of services with a preventive and early intervention focus, helping those that are in need of housing and other supports. It is co-located with eight other services designed to assist those in need of crisis care and longer-term support, including primary health care. These services are Young People's Health Service (Centre for Adolescent Health), Melbourne Youth Support Services, Centrelink, Job Placement Education and Training (JPET), Melbourne Gateway, Reconnect, Youth Transition Model and Youthlaw.

The City of Melbourne has committed to supporting the improved delivery of primary health care services in Melbourne's central business district, including working towards the development of a community health centre in the CBD in partnership with the State Government and services providers [97].

The Clockwork Youth Health Agency in Geelong is a youth agency situated in a youth precinct with art, community, health and eating facilities, with a service design specific for adolescents co-located with mainstream health services [96].

The Centre for Adolescent Health provides a model of delivering 'adolescent friendly' services (including sexual and reproductive health services) to young people in a tertiary environment.

Satellite Community Health Service in a School.

This collaboration between a secondary college, the local Community Health Service, local medical group and Department of Human Services secondary school nursing program was established with the involvement of the School Council and consultation and engagement with parents who were able to opt their children out of the service if they wished.

The school services already included a student wellbeing coordinator, two counsellors, a chaplain, psychologist, social worker and a school nurse. These services form a youth clinic in the school, consisting of a multi-disciplinary team including a community health nurse, a secondary school nurse and a GP from a local medical group. The service is administered by the Community Health Centre with the Department of Human Services secondary school nurse coordinating the student access, providing services, and referring back to the school services or referring to external services as required. The main goal was to augment health education being delivered by the school and to provide more complete primary health care. In this rural region, access to health services is limited by both lack of health care providers as well as lack of bulk billing. The 'Youth Clinic' service has been well accessed, including by young people seeking contraception, pap smears, STI screens and pregnancy tests. Young people are also presenting with more general issues such as mental health concerns.

Chapter four

Service delivery to young people

Positive, supportive non-judgmental service provision can strengthen young people's capacity to advocate for themselves and their children and improve short and long-term outcomes for both mothers and children

Community nursing project in London

A sexual and reproductive health community nursing project in London used local community services to create safe environments for young men to discuss sexual and reproductive health issues. A local barber shop in south-west London that serviced a large population of young African-Caribbean men was used to distribute condoms and recruit to a young fathers group. This project also developed a youth friendly website (www.gettingiton.org.uk) a family-planning service within a sexual health service and provided emergency contraception free to people younger than 19 years across the region. School nurses also provided a sexual and reproductive health drop-in service in local schools.

An important aspect of the strategy was to integrate reproductive health with sexual health issues. Furthermore, while STI checks and safe sex messages were the key focus, the project also worked with the local council housing strategy. One result of this collaboration was the development of a postnatal six-bed housing unit for young single mothers. This unit enabled young mothers access to postnatal care and support that ensured the transition to parenting was as smooth as possible [98].

Services targeted to specific issues: Antenatal care for young mothers

Multidisciplinary age-specific antenatal services have been associated with improved outcomes for young women, including a reduction in the rates of infant prematurity [99, 100].

Positive, supportive non-judgmental service provision can strengthen young people's capacity to advocate for themselves and their children, and improve short and long-term outcomes for both mothers and children. Teenage-specific antenatal services have been shown to detect higher rates of health risks than those detected in general antenatal clinics [99], such as unstable housing, drug dependency and domestic violence that will place the child at risk of abuse and neglect.

The detection of these factors and the ability to offer young mothers greater support and coping strategies has been shown to be positively correlated with better postnatal outcomes for the mother and child [99].

Summary

There is an emerging evidence base about how best to work with young people.

There are many models of health service delivery to young people that can be adapted to other locations and settings. It is noteworthy that all of the successful models reported within this project addressed issues beyond simply sexual and/or reproductive health.

Mainstream primary health care services will continue to provide a central role in the provision of health care to young people. In addition, a variety of youth focussed services have been shown to be more effective in meeting the needs of a diverse range of young people with more complex health care needs or issues.

Substantial benefits can arise from the development of specific strategies targeting the health needs of young people, including their sexual and reproductive health needs. These include:

- a reduction in the spread of chlamydial infection in the short term and of chlamydial infertility in the longer term
- prevention of unwanted pregnancy and delay in subsequent pregnancy for young women
- reduction of prematurity rates for young mothers.

It is more difficult to measure improvements in psychological wellbeing, but it is likely that the effects listed will also be associated with improvement in general health and wellbeing.

Recommendations

To ensure our young people have access to services that address social health and wellbeing, we recommend:

- development and implementation of training for health professionals working with young people, focusing on key aspects of adolescent health such as communication skills, knowledge of adolescent development, and awareness of confidentiality issues, which can promote access to health care
- implementation of universal approaches to health risk screening, including sexual health risks, for young people seen in general practice
- undertake an audit of state-wide youth focussed health services, with a report on orientation towards particular health issues. As part of this audit, gaps in service provision should be identified, including inadequately serviced geographical areas and places where different models may improve service reach and effectiveness
- consider development of youth focussed health services; eg, a series of comprehensive 'one-stop shops' for youth health
- consideration of ways to integrate the multiple issues which often affect young people, such as:
 1. how do we ensure that a young person with a mental health crisis also has their STI risk and contraceptive needs identified and responded to?
 2. how do we ensure that a young woman with an unwanted pregnancy has access to follow up for violence or mental health issues?

Chapter five

Policies and Initiatives prioritising young people in Victoria

This chapter identifies current state and national policies that have some bearing on improving the health and wellbeing of young Victorians. We have included those that principally target young people (without focusing on sexual and reproductive health), those that have some relevance to the sexual and reproductive health of young people (without specifically targeting young people), and those that specifically target young people and their sexual and reproductive health.

A list of the identified policies and initiatives that provide the basis for work with young Victorians is included as Appendix 3. Some of the identified strategies and policies are listed here.

Office for Children

The establishment of the Office for Children in March 2005 in response to The Premier's Children's Advisory Committee report 'Joining the dots' has the potential to bring together the many policies and programs that are working towards the common goal of improving the lives of children in Victoria.

The Office is responsible to the Minister for Children and aims to:

- provide a new focus on Victorian children and their families within the State Government and its departments
- ensure a consistent approach across government, with greater coordination and sharing of resources between related programs

The Office for Children brings together:

- universal early childhood care, education, health and disability programs
- programs to assure the safety and wellbeing of children, including child protection, and to support vulnerable families, including those affected by violence and crime, including sexual assault
- juvenile justice services and other programs to support vulnerable young people
- state concessions programs targeted to lower-income families and individuals [100].

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There are a number of different strategies that include young people and relate to their sexual and reproductive health.

The Victorian Youth Strategy: 2002

Respect: The Government's Vision for Young People. A Framework for Policy and Program Development articulates the State Government's commitment to improving health and wellbeing for young people, defined as those between 12-25 years. This document is intended to set out a framework for policy direction and program development and is based on three key elements: Respect, Diversity and Partnerships. Emphasis is placed on the need for collaboration: The strategy recognises that while government provides an integral role in program implementation and development, partnership building between service providers at all levels of government, young people and their families is necessary for successful implementation of such a shared vision.

The most relevant focus of this report is that of improving access to support services for young people. This report recognises that most young people enjoy health and opportunity and commits to providing those who are particularly vulnerable or 'at risk' with the necessary support structures. It also states that creating supportive environments for young people depends on the provision of high-quality services, education and health promotion. Emphasis is placed on youth participation, community strengthening, connectedness and building resiliency, academic/educational achievement and training for meaningful employment. There is little specific mention of the sexual and reproductive health needs of young people per se in this document, except when emphasising prevention of HIV/AIDS and hepatitis C and when promoting the physical, sexual, emotional and psychological 'safety' of young people. Disappointingly, there are no stated targets for improvements that have been set within these areas, although a future commitment is given to developing school-based gender initiatives to improve relations between the sexes [102].

National Sexually Transmissible Infection Strategy (2005-2008)

The recent release of the National STI Strategy is timely given the rising rates of STIs in Australia and their associated burden of disease. The strategy's main objectives are:

- to improve awareness of STIs, in particular their economic, social and personal effects within the government, medical and community sectors
- to establish a basis for coordinated national action on STIs, now and in the future
- to increase access to diagnosis, treatment and care of STIs
- to minimise the transmission and morbidity of STIs in identified priority groups
- to improve surveillance and research activities in order to guide the development and implementation of prevention initiatives [103].

While the release of this strategy is timely and positive it is important to note that the strategy is not comprehensive, nor does it address broader sexual health concerns [103]. It is suggested that the strategy be read in conjunction with other strategies such as the National HIV/AIDS Strategy and the National Aboriginal and Torres Strait Islander Sexual Health and Blood-Borne Virus Strategy. The STI strategy separates reproductive health from sexual health. Concerns have been repeatedly raised about this approach within the current project, given the link between risk factors for STIs and reproductive outcomes such as unplanned pregnancy, as well as the long-term reproductive sequelae of chlamydial infection. An appropriate next step would be the development of a National Sexual and Reproductive Health Strategy.

Chapter five

Policies and Initiatives prioritising young people in Victoria

Gay and Lesbian Health Action Plan

Whilst Australia does not yet have a comprehensive integrated sexual and reproductive health strategy, Victoria can be considered to lead world best practice in the area of gay and lesbian health initiatives. The Gay and Lesbian Health Action Plan launched in 2003, recommended the establishment of a Health Resource Unit for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. This unit was established in 2004 with the aim of improving the lives of gay, lesbian, bisexual, transgender and Intersex people in Victoria. Activities conducted by the centre include:

- training health care providers and health organisations about GLBTI health needs and appropriate service delivery
- developing health resources for GLBTI communities, in conjunction with mainstream services
- establishing a research and information clearing house as a resource for health care providers, researchers and individuals to use in researching their own health issues
- providing advice to government on the planning and development of future GLBTI programs.

The action plan recognised the particular risks of self-harm and suicide faced by same-sex attracted young people, and its recommendations included implementation of research findings in this area, the development of school-based education initiatives and support groups for gay and lesbian youth.

The Victorian Women's Health and Wellbeing Strategy (2002-2006)

The aim of this strategy is to improve the health and wellbeing of Victorian women, with a particular emphasis on disadvantaged women. There are five areas for action developed for the Women's Health and Wellbeing Strategy which provide a focus for work across the Department of Human Services. The five areas for action are:

- to increase women's participation and leadership
- to increase access that embraces diversity
- to enhance women's safety and security
- to improve women's mental and emotional health
- to extend knowledge of women's health and wellbeing and promote ongoing improvements.

The strategy should be read in conjunction with a number of other State Government reports and is written in the framework that acknowledges the multiple roles and experiences that impact on a woman's wellbeing. The strategy is implemented through a yearly planning and evaluation framework, with a key feature being an annual Women's Health and Wellbeing Forum [104].

The Department of Human Services in Victoria oversees many of the current programs and activities that aim to improve young people's lives by ensuring their safety. In particular, the Youth Homelessness Action Plan, Best Start, Looking after Children, Leaving Care Initiative and Child Protection, to name a few, have a particular focus around risk management and crisis response.

Youth Homelessness Action Plan

The Youth Homelessness Action Plan identified that young mothers require extra attention, stating 'Housing for young mothers needs to have health care nearby, maternity nurses to visit, babysitting vouchers, wide hallways for prams, meals on wheels after the birth and links with other young parents' [105].

Among the population of young Victorians aged 12-24, one in every 104 young men and one in every 62 young women used homelessness services over a 12-month period. Specifically:

- 1 in 1,110 of young Victorians aged 12-13;
- 1 in 270 of those aged 14-15;
- 1 in 61 of those aged 16-17;
- 1 in 48 of those aged 18-19; and
- 1 in 61 of those aged 20-24 used homelessness services [105].

The sexual and reproductive health outcomes of young homeless people reveal higher morbidity and a greater burden of disease than young people in stable living environments. Young mothers appear particularly vulnerable, with poorer postnatal outcomes and greater risks for their children [64].

'New Directions for Victoria's Mental Health Services'

This report identifies as an action area strengthening services to young people aged 15-25 and emphasises the need to enhance service collaboration and integration, including working with agencies addressing drug treatment, disability and homelessness to develop complementary guidelines and protocols.

Chlamydia Strategy for Victoria (2000-2004)

This strategy identifies young women as being particularly vulnerable to risk of chlamydia infection and highlights the potential for schools to implement education programs that improve knowledge around STI prevention, and provide young people with skills that enable them to make safe choices. The report also identifies general practitioners as an important source of information and screening, yet highlight that many general practitioners were unaware that chlamydia was a notifiable disease.

Victorian HIV/AIDS Strategy 2002-2004

This strategy identifies young people, particularly young people who identify as gay, or who are questioning their sexuality, as at greater risk of HIV infection. The strategy identifies schools as an important setting for sexuality education, recognising that "Schools have a responsibility to develop inclusive sexual health programs that meet the needs of all young people, and to take measures to combat homophobia in schools, which can prevent same-sex attracted young people seeking appropriate information and support" [106].

The strategy recommends that key health promotion strategies for sexually active young people develop an intersectoral approach to target sexually active young people in a range of settings.

Chapter five

Policies and Initiatives prioritising young people in Victoria

Inquiry into Issues relating to the Development of Body Image among Young People and Associated Effects on their Health and Wellbeing. (2005)

The recently released report of the Parliamentary Inquiry into Body Image included an environmental scan identifying schools that had accessed the MindMatters professional development program managed by the Australian Principals' Association Professional Development Council and the Curriculum Corporation. MindMatters aims to improve the mental health of young people in schools. This program can be used as professional development for teachers or through consideration of whole-of-school approaches to improving youth mental health in schools. The report acknowledged that, "Within the framework of prevention, intervention and treatment, discussion has focused on how an integrated approach to dealing with body image issues is the best strategic approach. In particular, health-centred rather than weight-centred disorders involve different issues and different solutions"[107]. While it acknowledges eating disorders are suffered by adults as well as young people, the following recommendations and findings are directed particularly at young people:

- that the Centre for Excellence in Eating Disorders be assisted in its production of professional development and training programs for health and allied health professionals, and for counsellors working with youth
- that a day centre proposal be developed as a community-based initiative designed to address a serious service gap in the public health treatment of young adolescents recovering from severe eating disorders
- that a 'one size fits all' approach to the treatment of eating disorders does not adequately cater for the needs of all young sufferers of eating disorders

- that whole-of-school programs that teach and promote physical wellness and self-esteem in primary students result in improvements in student wellbeing and learning
- that the Department of Education, with the Department of Human Services and in partnership with schools, undertake a program of evaluation, monitoring and implementation of whole-of-school health promotion in primary schools.

Summary

A number of strategies identify young people as an important target group. Sexual and reproductive health is commonly absent from more general strategies and policies, including those that target young people. When sexual and reproductive health is considered, sexual health is often viewed as distinct from reproductive health.

Recommendations

To ensure organisations are working together as effectively and efficiently as possible, we recommend:

- a cross-sectoral ministerial advisory committee be established to develop a strategy to improve the sexual and reproductive health outcomes of young Victorians
- an audit be conducted by the State Government to identify what policies, programs and organisations in Victoria have prioritised working with young people, to identify how these programs can work more collaboratively
- program and policy development in the field of sexual or reproductive health should occur within a social model that recognises the inter-relation of sexual and reproductive health, rather than viewing these domains as distinct fields.

Chapter six

Recommendations

A clear picture of where we've come from and how we might progress requires regular monitoring and reporting of young Victorians' health. We recommend:

The health of young Victorians should be monitored and regularly reported.

- monitoring should include a range of sexual and reproductive health outcomes of interest, including STI notification rates, birth rates and abortion rates. Monitoring should also include other important sexual health indicators, such as frequency of contraception use and method of contraception, including use of emergency contraception
- this information should be integrated into a single report to be circulated annually to relevant communities, agencies and health professionals
- this information would be most useful if sexual and reproductive health data was able to be cross referenced with wider indicators of health and wellbeing such as mental health indicators, drug and alcohol use, school attendance and homelessness.

A monitoring process should be established for abortions in Victoria

- the Department of Human Services is to be commended for its efforts to accurately record the number of abortions in Victoria, together with other available demographic data. Continuation of this monitoring should be supported by government
- the Department of Human Services and the Royal Women's Hospital (RWH) should work together to establish a pilot project to voluntarily monitor abortions in a manner similar to that undertaken in South Australia and the United Kingdom. About one-sixth of the state's abortions are performed at the RWH: they will not be representative of the state as a whole because of the high proportion of public patients treated at RWH and the hospital's orientation towards the needs of those facing particular social disadvantage. However, such a pilot would establish the feasibility of such data collection and provide a basis for developing ongoing more comprehensive state-wide monitoring
- a health regulatory framework would facilitate the routine monitoring of this complex health issue.

A population screening program should be established to determine actual chlamydia prevalence rates in Victorian young people.

To ensure we are educating our young people to make informed decisions about sexuality and safe sexual and reproductive health choices, we need to implement comprehensive sexuality education programs in Victorian schools. We recommend:

- an audit of all Victorian primary and secondary schools is undertaken to identify what is taught to Victorian students in sexual and reproductive health education
- an audit of teachers of sexual and reproductive health education is undertaken to identify their level of knowledge and level of comfort with teaching sexual and reproductive education
- setting of minimum standards for teachers running comprehensive sexual and reproductive health education programs
- information about successful existing programs and pilots should be included in the proposed annual report of young people's sexual and reproductive health (see Chapter 2).

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To ensure our young people have access to services that address social health and wellbeing, we recommend:

- development and implementation of training for health professionals working with young people, focusing on key aspects of adolescent health such as communication skills, knowledge of adolescent development, and awareness of confidentiality issues, which can promote access to health care
- implementation of universal approaches to health risk screening, including sexual health risks, for young people seen in general practice
- an audit of state-wide youth specific health services, with a report on orientation towards particular health issues. As part of this audit, gaps in service provision should be identified, including inadequately serviced geographical areas and places where different models may improve service reach and effectiveness
- consideration of the development of youth-specific health services; eg, a series of comprehensive 'one-stop shops' for youth health
- consideration of ways to integrate the multiple issues which often affect young people, such as:
 1. how do we ensure that a young person with a mental health crisis also has their STI risk and contraceptive needs identified and responded to?
 2. how do we ensure that a young woman with an unwanted pregnancy has access to follow-up for violence or mental health issues?

To ensure organisations are working together as effectively and efficiently as possible, we recommend:

- a cross-sectoral ministerial advisory committee be established to develop a strategy to improve the sexual and reproductive health outcomes of young Victorians
- an audit be conducted by the State Government to identify what policies, programs and organisations in Victoria have prioritised working with young people to identify how these programs can work more collaboratively
- program and policy development in the field of sexual or reproductive health should occur within a social model that recognises the inter-relation of sexual and reproductive health rather than viewing these domains as distinct fields.

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Appendix 1

Consultations

Three consultation workshops were held in 2004 around the themes of:

- Evidence: available data about the sexual health of young Victorians
- Education in sexual and reproductive health
- Clinical service provision for young people

Evidence

Where is the evidence?

What are the gaps in the data of young people's sexual and reproductive health?

Presenters

- **Dr Julia Shelley**
Principle Research Fellow, Australian Research Centre for Sex Health and Society (ARCHS).
What do we know about young women and abortion in Victoria?
- **Professor George Patton**
VicHealth Professor of Adolescent Health, Centre for Adolescent Health, Murdoch Children's Research Institute.
Young people's health: What we know, what we need to know?
- **Dr Hennie Williams**
Senior Medical Officer, Family Planning Victoria (FPV).
Sexual and reproductive health data: Filling in the gaps.

The three presenters described what we know from Victorian evidence and data bases. Information about young people's sexual behaviour is available from a national 'Sex in Australia' survey conducted in 2001-2 and from an ongoing cohort study conducted by the Centre for Adolescent Health. Key discussion points from this consultation were:

- birth information is systematically collected and reported nationally and for all states
- comprehensive data about abortion rates have not been collected routinely in Victoria or nationally, but there has been mandatory notification of abortions in South Australia since 1970
- information about sexually transmitted infections comes from ongoing national and state surveillance data

Education: Who's educating whom?

Presenters

- **Mr Steven O'Connor**
Senior Project Officer, Targeted Initiatives Unit Department of Education and Training.
What is the policy agenda set by the Department of Education and Training for sexuality education in schools Victoria?
- **Ms Margaret Palmer**
Health Educator, Alfred Hospital.
Sexual health education: A Scottish perspective.
- **Ms Kerry O'Rourke**
School Nurse Program, Department of Human Services.
Implementing a sexual diversity program at Northcote High School, processes barriers and successes.
- **Ms Kay Boulden**
Author
Teenage pregnancy and school retention rates.

A series of presentations at the consultation workshops described successful projects in education settings:

- a Scottish project in a region with high teenage pregnancy rates introduced a training program to develop the confidence and competence of teachers who were already delivering sexual education, but felt poorly equipped to do this
- a Victorian school developed a project to reduce homophobia, based on the theory that a youth participation model will enhance resilience and protect against risk. The project enablers were a proactive coordinator role and supportive school community, parents and teachers
- two Australian schools provided childcare and support to women parenting young to assist them to complete their education.

Clinical Service Provision

Are we responding to the needs of young people in relation to sexual and reproductive health?

Presenters

- **Dr Lena Sanci**
Postdoctoral Fellow,
Centre for Adolescent Health.
Effective health care for adolescents in
General practice: What are the issues?
- **Associate Professor Julie Quinlivan**
Department of Obstetrics &
Gynaecology, The University
of Melbourne.
Teenage Mothers.
- **Ms Alison Duffin**
Community Sexual Health
Nurse Educator,
Family Planning Victoria.
Meeting the needs of young people in a
sexual and reproductive health service
in Victoria. Comparisons to the United
Kingdom experience.
- **Mr Richard Flanagan**
Department of Human Services,
Secondary School Nurse,
A community health outreach clinic in a
school setting.

A series of approaches, projects and interventions were described in the consultation workshops:

- responsiveness of general practitioners to young people's health needs can be improved by continuing education programs which address legal, confidentiality, and communication issues, recognizing that aspects of these consultations can be confronting to practitioners

- interventions can improve outcomes for teenagers parenting. Specialized antenatal services have been associated with higher infection screening rates and decrease in preterm births as well as increased uptake of contraception. Follow-up multidisciplinary home visits have contributed to better knowledge and use of contraception and delay in subsequent pregnancy
- a United Kingdom case study drew on national policy to support a local project to reach young people using the internet and a community facility. This was contrasted with a Victorian outreach project, which depended on high levels of commitment from interested individuals working in the field and an element of chance in their encountering each other. A variety of local programs exist, but they would be more easily established and effectively sustained in the presence of overarching policy support
- school based sexual and reproductive health clinics are extremely effective in addressing issues around barriers to services due to rural isolation
- a school nurse reported a joint project with a community health centre to improve access for students to health services to overcome geographic and social barriers. It was well supported by parents and school and valued by students.

The workshop strongly supported a comprehensive approach to the health and wellbeing of young people, which considers sexual and reproductive health in the broader context.

Appendix 2

List of forum attendees

Data Forum: July 15, 2004

Organisation	Person
Centre for Adolescent Health	Yasmin Jayasinghe
	George Patton
	Susan Sawyer
	Lena Sanci
	Paddy Moore
Royal Women's Hospital	Chris Bayly
	Julie Quinlivan
	Di Palmer
	Annarella Hardiman
	Andy Morrow
	Angela Steele
	Martha Papaganis
DHS Public Health	Marie Wintle
	Melissa Morgan
Perinatal Data Collection Unit	Michael Batchelor
	Merrilyn Riley
Primary Health	Tracey Slatter
Family Planning Victoria	Lynne Jordan
	Kathy McNamee
	Siobhan Bourke
DHS School Nursing Program	Kerryn O'Rourke
Office of Youth Affairs	Kim Wilson
	Pat Thurgood
Women's Health Victoria	Kerrilie Rice
Deakin University	Helen Keleher
Key Centre for Women's Health	Doreen Rosenthal
	Jan Watson

Education Forum: July 12, 2004

Organisation	Person
Centre for Adolescent Health	Susan Sawyer Ian Seal Paddy Moore Yasmin Jayasinghe
Core of Life	Tracey Smith Debbie Patrick
Department of Education and Training	Lynne Redley John Roberts Kirsten Douglas Maggie Bishop Carol Kelly Stephen O'Conner
Department of Victorian Communities	Pat Thurgood Annette McGowan
Department of Human Services School Nursing Program	Roger Nixon Richard Flanagan Sue Ferguson Maureen Weir Margret Chigros Sarah Balfort
Family Planning Victoria	Lynne Jordan Nancy Leaver Mandy Stevens Claire Maharaj Sharon Davey Siobhan Bourke Emma McKirdy Alison Duffin Mark Camilleri Sally Dooley Luke Atkin Colleen Ivory

Appendix 2

List of forum attendees

Education Forum: August 12, 2004 (continued)

Organisation	Person
Family Planning Victoria (continued)	Geraldine McDonald
	Hennie Williams
	Kwai Chee Ho
Jean Hailes Foundation	Linda Daly
	Mandy Hudson
Marie Stopes International	Rachael Molley
	Julie Mundy
Parents Victoria	Amanda Amrich
Positive Women	Hilary Christmas
	Stephanie Moore
Royal Women's Hospital	Chris Bayly
	Di Palmer
	Julie Quinlivan
	Fiona Lange
	Angela Steele
	Kim Xia
	Roger Short
	Kylie Houltham
Women's Clinic on Richmond Hill	Yasmin Ash
Australian Catholic University	Rozenn Blovin
	Evelyn Carlton
Police Victoria	Lisa Keyte
Primary Schools Principal Association	Phillipa Lovell
	Cath Behan
Melbourne Sexual Health Centre	Vanessa Woods
Melbourne University	Laura Mahony
Youth Affairs Victoria	Paula Grogan
Australian Research Centre for Sex Health and Society	Julia Shelley
	Jason Ferris
	Jenny Walsh
Banyule Community Health Service	Emrana Alavi

Clinical Services Forum: September 16, 2004

Organisation:	Person:
Department of Human Services	Margaret Chigross Kerryn O'Rourke Jenny Taffe
Office for Youth	Pat Thurgood
Western Region Health Centre	Cath Shimmin
Melbourne Sexual Health Centre	Vanessa Wood
Jean Hailes Foundation	Mandy Hudson
Centre for Adolescent Health	Paddy Moore Lena Sanci Dot Henning Tim Fry Alice Ryan
Royal Women's Hospital	Angela Steele Janet Joss Chris Bayly Julie Quinlivan Annarella Hardiman Fiona Cullinane Kylie Houltham Emrana Alavi
Family Planning Victoria	Hennie Williams Geraldine McDonald Lynne Jordan Kathy McNamee Lise Mifsud Cathy Barker Lucy McKinnon Colleen Ivory Nancy Leaver
Core of Life	Tracey Smith Debby Patrick
Key Centre for Women's Health	Jan Watson
Westgate Division of General Practice	Mike Williams

Appendix 3

Current policies and programs addressing the health of young Victorians

Strategy	Area of Focus
Youth Homelessness Action Plan	Homelessness
Best Start	Child development
Looking After Children	Out-of-home care
Creation of the Office for Children	Whole of health and wellbeing for children
Office of the Children's Safety Commissioner	Child protection and safety issues
Integrated Strategy for Child Protection and Placement Services	Child protection
Strategic framework for the Maternal and Child Health Service	Maternal and child health
Child Death Review Committee	Child protection
Victorian Indigenous Family Violence Taskforce	Aboriginal issues, Child protection
High Risk Adolescents Service Quality Improvement Initiative	Child protection and placement, homelessness
Leaving Care Initiative	Child protection, placement, juvenile justice, homelessness
Falconer Report (Leave arrangements)	Juvenile justice
Victorian Juvenile Justice Rehabilitation Review	Juvenile justice
The Australian Clearinghouse for Youth Studies (ACYS)	Adolescent health
Gatehouse Project	Adolescent health
Gay and Lesbian Health Strategy	Gay and Lesbian health
Positive Spin	Adolescent Mental health
Implement opportunistic testing pilot for chlamydia to 10 health centres and improve hepatitis B prevention in prisons – source Departmental Plan 2005-06 (unpublished)	Disease prevention
Data	Web Address
Births in Victoria	http://www.health.vic.gov.au/perinatal/pubs.htm
Sexually transmissible infections	http://www.health.vic.gov.au/ideas/downloads/annual_rpts/SNID2002_Complete.pdf
Australian Bureau of Statistics	http://www.abs.gov.au/
Australia's Young People their Health and Wellbeing 2003 AIHW	http://www.aihw.gov.au/publications/index.cfm/title/9569
Sex in Australia: 2003	http://www.latrobe.edu.au/ashr/
Profile of Young Australians: Facts, Figures and Issues. 2004	http://www.youngaustralians.org/profile/home.htm
Secondary Students and Sexual Health	http://www.latrobe.edu.au/arcshs/schoolsurvey.html



FAMILY PLANNING VICTORIA

THE ROYAL



WOMEN'S
HOSPITAL



Centre for
**ADOLESCENT
HEALTH**