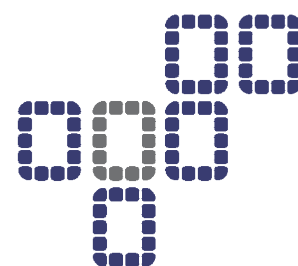
Sexual health education and young people in WA

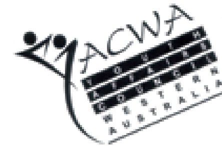
A youth consultation



Acknowledgements

Ms Anne Sorenson, Youth Affairs Council of Western Australia

Dr Graham Brown, Curtin University of Technology



Sorenson A and Brown G. 2007 Report on the Sexual Health Education of Young People in WA. WA Health: Perth.

Published September 2007

"While every endeavour has been made to check the accuracy of the information provided in this document, WA Health takes no responsibility for any errors that may be contained within."

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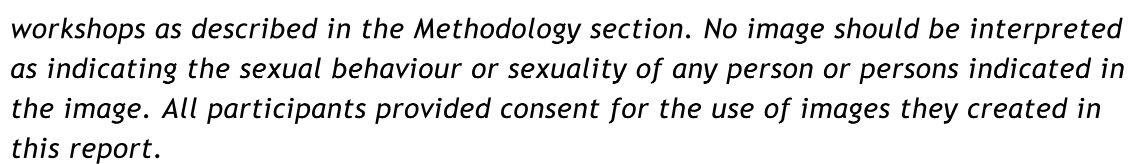
The images included in this report were generated as part of the consultation



workshops as described in the Methodology section. No image should be interpreted as indicating the sexual behaviour or sexuality of any person or persons indicated in the image. All participants provided consent for the use of images they created in this report.

Overview

Introduction

Young people are increasingly sexually active and are experiencing increased rates of sexually transmitted infections. In response to this, the National Sexually Transmitted Infections Strategy of 2005 – 2008 has identified young people under 25 as a priority population (Department of Health and Ageing 2004). The need to effectively educate young people in the area of sexual health and relationships in a holistic and developmentally appropriate way is essential in the prevention of sexually transmitted infections and unplanned pregnancies. In order to inform the continued development of sexual health promotion programs, during 2006 the Department of Health commissioned the Youth Affairs Council of WA (YACWA) to conduct a statewide consultation about where and how young people currently receive their sexual health education and from where and how they would like to receive it.

Methodology

Assembling genuine and honest voices of young people, and gaining insight into their experiences and perspectives, requires very interactive and engaging methodology. This consultation research used a participatory research methodology which consisted of a series of workshops with young people using arts based enquiry, psychodynamic techniques and photovoice approaches. This consisted of 88 young people aged between 15 and 20 engaging in highly interactive workshops. Participants used photography, drama, role-play and discussion to express their experiences and ideas about developing sexual health knowledge and skills. Data from the workshops were collected using digital recording devices, cameras and transcriptions. This information was analysed identifying recurring themes, images, statements and suggestions. A reference group of researchers and educators in the field provided professional and academic support to the consultation process.

Findings

Sexuality and relationships do not occur in isolation to the rest of young people's lives, as evidenced in the experiences, perceptions and opinions of the young people who participated in this consultation research. The young people indicated they learnt about sexual behaviour and sexual health from a range of sources and in a range of contexts.

There were five key themes that were derived from the workshops about

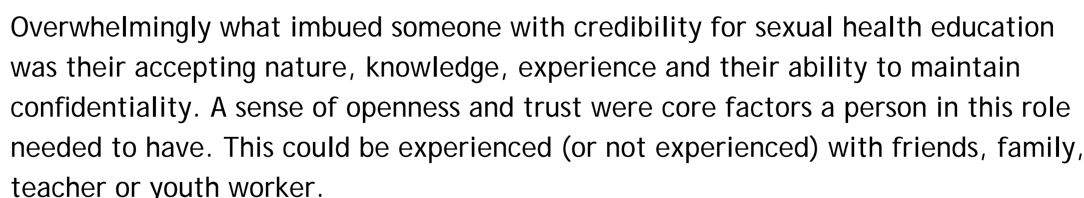
1) from whom and how young people reported they had received their sexual health education; and

2) how they wanted to receive their sexual health education.

These could be summarised as follows:

- peer networks, friends and locations;
- youth friendly and relevant sexual health education including
  - youth friendly and credible sexual health educators,
  - the graduated approach to sexual health education,
  - school settings for sexual health education;
- post or outside of school education;
- family learning and influence;
- media and the Internet; and
- rites of passage events, parties, and alcohol.

Young people consistently spoke about a desire for youth friendly and relevant sexual health education. In describing what 'youth friendly' meant to them, participants emphasised interactive, hands-on and discussion focused approaches as well as safe, trustworthy and non-judgemental environments. Some young people spoke about experiencing this in school, but all young people spoke about learning in this way from friends and peers. Most young people had access to sexual health education and were aware of some of the avenues that exist for them to further this education. However, young people articulated that the method and approach of teaching and the relationship between health educator and young person was crucial to their sense of credibility about and engagement with the education. The consultation process revealed young people's desire to also learn from peers a few years older than themselves, who they tended to view as credible.



Overwhelmingly what imbued someone with credibility for sexual health education was their accepting nature, knowledge, experience and their ability to maintain confidentiality. A sense of openness and trust were core factors a person in this role needed to have. This could be experienced (or not experienced) with friends, family, teacher or youth worker.

Young people identified they were exposed to sexual topics and influences in their day to day lives and considered it dangerous to not be provided with the appropriate knowledge and skills to protect themselves. Workshop participants supported a graduated or age specific approach to sexual health education, but felt this needed to reflect the reality of their social lives. It was felt by the young people that youth friendly sexual health education should be compulsory.

Through the consultation workshops, young people discussed and role-played scenarios that provided insight into their previous and desired experiences about sexual health education not only in school and out of school community settings, but also with family, friends and the media. Young people provided insights to the social and cultural contexts of when and how they gained their sexual knowledge, but also the meanings and expectations of various events in their lives and their association with sexual behaviour. For example the separation of education about alcohol and drugs (particularly in the context of events such as the school ball and high school leavers' celebrations) from education about sexual health was seen as being inconsistent with the experiences of young people.

The need for sexual health education to be positioned within the complex social world in which young people make decisions has been well documented in both research and policy documents (Australian Research Centre in Sex, Health and Society [ARCSHS] 1999; Department of Health and Ageing 2004; Moodie, Edwards & Payne 2003; Smith et al. 2003). Sexual health promotion for young people requires individuals, families, schools and communities to all play their role. This study supports other national and international research (ARCSHS 1999; Australian Health Promoting Schools Association [AHPSA] 2000; UNFPA [United Nations Population Fund] 2003) which advocates key components for the development and delivery of a comprehensive education in schools that focuses on sexually transmitted infections (STIs), HIV/AIDS and blood borne viruses (BBVs).

Sexual health is often depicted as a right and a responsibility. Young people are witness to advertising, education, relationships, media and popular culture that brings sexual health into their reality whether they are developmentally ready or not. Educators and health professionals are continually challenged to create learning environments where young people can safely and openly learn about the complexity of sexual health in relation to their physical bodies and the social reality they live in. This report provides some insight, from the perspective of young people, about solutions to these challenges.

Summary of recommendations

The report's recommendations are presented in the context of a broader Health Promoting Schools Framework and community partnerships approach and a commitment to youth friendly and relevant educational processes. The following is a summary of the key themes contained in the full recommendations listed at the end of this report.

Peer networks, friends and locations

- Promote opportunities to use peer based education and influence models. This includes peer based initiatives to influence young people within school based programs, in informal and out of school settings and through new media and technologies such as the Internet.

Youth friendly and relevant sexual health education

- Ensure the provision of training and policy development for schools and agencies concerning youth friendly approaches to sexual health education, including issues of trust, confidentiality and credibility, to equip young people with socially relevant skills.
- Support the building of partnerships between schools and youth health services.
- Improve training, development and ongoing support for schools to ensure teachers are implementing comprehensive and age appropriate sexual health education confidently throughout all years of schooling.
- Ensure sexual health education is identified as a core component of school health promoting obligations.
- Enhance support for professional development of youth services staff in the implementation of effective, evidence based, interactive and youth friendly sexual health and relationship programs and services.
- Increase resources to evaluate the effectiveness of different modes of outreach programs and services targeting out of school or marginalised young people.

Family learning and influence

- Increase resources to develop effective and achievable ways to engage parents and increase their capacity to support comprehensive sexual health education within a Health Promoting Schools Framework.

Media and the Internet

Support curriculum that increases young people's skills in assessing accuracy and quality of information and images presented in the media, including the Internet.

Rites of passage events, parties, and alcohol

Promote the inclusion of context and relationship issues within alcohol, drug and sexual health education such as: assertiveness; planning healthy behaviour; relationship conflict; sexual assault and consent; social and peer influence; and looking after and supporting peers.

Promote the development and evaluation of outreach initiatives to young people conducted during major celebrations and determine their effectiveness and how complementary they are to school based programs.

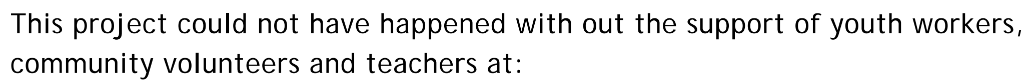
Promote education programs that respond to the linkages between sex and alcohol and drugs in the context of young people's lives.

Acknowledgments

This report was commissioned by the Sexual Health and Blood Borne Virus Program (SHBBVP) of the Department of Health (WA). The research was undertaken by Anne Sorenson, Youth Engagement Officer of the Youth Affairs Council of WA.

Special thanks to the project reference group:

- Ms Maryrose Baker, Senior Policy & Planning Officer, SHBBVP, Department of Health (WA)
- Dr Graham Brown, Lecturer and Researcher, WA Centre for Health Promotion, Curtin University of Technology
- Ms Suzanne Dimitrijevich, Project Officer, School Drug Education and Road Aware Program
- Ms Trish Langdon, Executive Director, AIDS Council of WA
- Ms Karyn Lisignoli, Executive Officer, Youth Affairs Council of WA
- Ms Lorel Mayberry, Lecturer, Sexology Program, Curtin University of Technology
- Ms Shauna Skinner, Project Officer, SHBBVP, Department of Health (WA)
- Ms Noelene Smith, Manager, Education and Training Services, FPWA
- Ms Anne Sorenson, Youth Engagement Officer, Youth Affairs Council of WA.



This project could not have happened with out the support of youth workers, community volunteers and teachers at:

- Bassendean Youth Advisory Council
- Bridgetown Repertory Theatre's Youth Theatre
- Cyril Jackson High School
- Forrestfield Senior High School
- The Freedom Centre
- Kalgoorlie Youth Council
- Lockridge Senior High School
- Millen Street Centre
- Northam TAFE
- Swan City Youth Services
- Trinity Learning Centre.

This research could not have taken place without the cooperation, openness and trust of all the young people who contributed to consultations with their pictures, stories, experiences and opinions about sexual health education. Thank you.

1. Introduction

This study was commissioned to hear the voices of a diverse sample of young people under 20 years of age with a particular focus on:

- male and female youth located in both in and out of school settings, including regional areas; and
- a selection of different relevant sub-cultures including marginalised groups.

The study facilitated participatory workshops to identify young people's perspectives on where and how they received sexual health education and where and how they would prefer to receive sexual health education. The purpose of this report is to complement other research and evidence about effective sexual health promotion and inform government and community policy and program planning in the delivery of youth STIs and BBVs prevention programs.

The report first provides a very brief background to the context of the research. This is followed by an overview of the aim and methodology, including details of the approach used in the highly interactive consultation workshops. A description of the five key themes is provided, highlighting the implications for practice and relevant recommendations. An overall discussion is then followed by a listing of the recommendations.

2. Background

Young people and sexually transmitted infections

In Western Australia, the incidence of notifiable STIs has been increasing. The total number of chlamydia notifications increased more than six-fold from 808 cases in 1993 to 5428 cases in 2005. The increase in 2005 alone was 25% compared to the previous year. The total number of gonorrhoea notifications doubled from 797 to 1576 cases in the same time period. Young people are disproportionately represented within these statistics (Department of Health 2006a; Atthowe et al. 2006), and so young people are listed as a priority area for the prevention and control of STIs at state and national levels (Department of Health and Ageing 2004; Department of Health 2006a).

A national survey on the sexual health of 2388 Years 10 and 12 Australian secondary school students (Smith et al. 2003) conducted in 2002 included the following findings: the majority of Years 10 and 12 students are sexually active in some form and there is a trend over the past 10 years towards increased sexual activity;

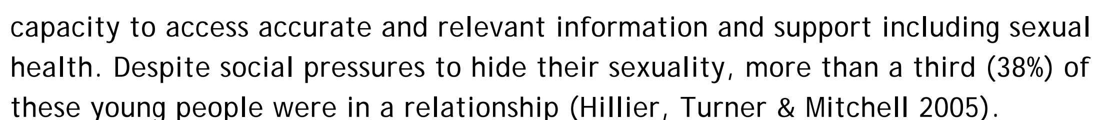
- 25% of Year 10 students and 50% of Year 12 students have had sexual intercourse;
- condoms are used for contraception rather than prevention of STIs and are used inconsistently;
- rates of condom use have not changed over time and condom use decreases with age, with proportionately more Year 10 students reporting using condoms than Year 12 students;
- 23% of sexually active young men and 17% of sexually active young women had three or more partners in the previous year; and
- knowledge of HIV transmission had declined and knowledge of other STIs such as chlamydia was poor.

Smith et al. (2003) showed secondary school students identified school based relationship and sexual health education as credible and the most used source of information. Students placed high value on school based sexual health education and approximately 50% of students identified school based sexual health education as the most-used source of information. Students also reported parents, friends and siblings as important sources of information. However, students reported low levels of confidence in discussing sexuality or contraception with parents (Smith et al. 2003).

Particular groups of young people, such as Aboriginal youth and same-sex attracted youth, were overrepresented in STI statistics and experienced special challenges in developing good sexual health knowledge and skills (Department of Health 2006a). These two groups are discussed in more detail below.

Same-sex attracted youth

Western Australian, national and international studies have found that same-sex attracted youth (SSAY) were up to six times more likely to attempt suicide than their heterosexual peers, with SSAY living in rural areas at an even greater risk of suicide. These young people also experienced low levels of access to relevant and appropriate sexual health education (Cochran et al. 2002; Edwards 2005; Hillier, Turner & Mitchell 2005; Howard et al. 2001; Russell 2003; Savin-Williams and Ream 2003). In 2004, an Australian national report on the sexuality, health and wellbeing of same-sex attracted youth found that 16% had been physically abused, 44% had been verbally abused and 74% of this abuse had occurred at school. The cultural climate of schools has a profound influence on the coming-out experiences of SSAY and their



capacity to access accurate and relevant information and support including sexual health. Despite social pressures to hide their sexuality, more than a third (38%) of these young people were in a relationship (Hillier, Turner & Mitchell 2005).

Aboriginal youth

High-risk sexual behaviour amongst young Aboriginal people is of particular concern given the very high rates of STIs and a consequent increased threat of HIV/AIDS to the Aboriginal community. Much higher rates of Aboriginal teenage pregnancies are also a concern due to the adverse long-term health and social consequences for the mother and baby as a result of an unplanned pregnancy. The Western Australian Aboriginal Child Health Survey (Zubrick et al. 2005) reported that Aboriginal youth had sex at a younger age compared to the general population, with 48.6% of Aboriginal youth reporting sex before the age of 16 compared with 20.4% of youth in the general population. Sexual health education at school was cited by 41% of young Aboriginal people aged 12 – 17 years as the only source of information about HIV/AIDS and STIs.

Future direction

Priority action is required to ensure that sex education addresses issues of sexual and reproductive health in a holistic and developmentally appropriate way.
This includes information and support for delaying commencement of sexual activity until young people are sufficiently mature and well informed (Department of Health and Ageing 2004). The challenge therefore is to find the most effective means of educating young people about these risks and equipping them with the necessary skills to deal with them.

This study was undertaken as a result of a recommendation by the Western Australian Committee on HIV/AIDS and STIs (WACHAS) to conduct a statewide consultation with youth to ascertain their perceptions about and preferred means of the delivery and receiving of sexual health information and education, with particular attention to out of school elements and marginalised young people who may be underrepresented in other studies. This research complements key studies conducted in Australia such as the Smith et al. (2003) study by the Australian Research Centre in Sex, Health and Society.

3. Research Aim

The aim of this study was to investigate from the perspective of young people (aged 15 – 20) in WA:

- where and how young people currently obtain their education and information about sexual health;
- where and how young people would prefer sexual health education and information about STIs/BBVs to be delivered;
- from whom young people would prefer to receive this information;
- when the best time is to receive information about sexual health and STIs/BBVs; and
- what information/education about STIs/BBVs should look like/involve.

To achieve this aim, it was proposed the consultation would need to:

- include marginalised young people who are not always well represented in youth consultations;
- draw on sexual health education expertise within the Perth community; and
- use a highly interactive participatory methodology to ensure the full context and complexity of the issues could be explored.

The goal of the recruitment was not to have a statistically representative sample of all young people in Western Australia, but to include the perspectives of a broad range of young people including those who may not have participated significantly in other consultations or research.

4. Methodology

Methodological approach

This research used a participatory research methodology, conducting a series of workshops with young people using arts based enquiry, psychodynamic techniques and photovoice approaches. This consisted of young people engaging in highly interactive workshops where participants could use photography, drama, role-play and discussion to express their experiences and ideas about developing sexual health knowledge and skills. Such participatory and interactive research approaches are well documented in the health and education sciences literature (Cornwall & Jewkes 1995). The following section provides an overview of the theoretical framework for this methodology.

Arts based enquiry

Arts based enquiry employs a range of activities designed to suit a wide range of learning styles and allows for an exploration of issues by encouraging freedom of expression and inclusiveness. The arts have been tied to increasing accessibility and communication in education, particularly among young people considered 'at risk' for failure or who feel constrained by the written word or by the English language (Packard 2004).

Psychodynamic techniques used in consultation workshops

Psychodynamics analyses how human thought processes respond to patterns and influences. The approach, utilising the language of movement, gesture and image, can assist young people to break out of their habitual patterns of responding to consultation by engaging them in movement, gesture and image to evoke responses that are a true reflection of their experiences and culture (Bainbridge Cohen 1993). This approach allows young people to offer conscious and unconscious responses to photographs and questions. Two approaches were used in the consultation workshops: drama and dialogue.

Drama uses a language of action and reflection and as such allows the young people to challenge and question their experiences through symbolic play and dialogue. Symbolic play occurs when participants recreate their reality through role-play. It offers a method through which young people can present their culture and experiences and examine its meaning (Hawkes 2001; Conrad 2004).

Dialogue refers to a process of active listening and talking. It deepens understanding and creates empathy (Holloway 2004). For dialogue to engage young people it must involve trust, confidentiality, acceptance, respect, a balance of talking and listening, full participation and mutual support. Contemporary qualitative methods suggest that the process of gathering young people's views may be better facilitated when there is a collaborative bond or trust between the researcher and the participants (Bryman 2004; Cornwall & Jewkes 1995).

Photovoice

Photovoice is an image based research method used for starting the process of engagement with direct stakeholders about various issues and concerns (Prosser & Schwartz 1998; Strack, Magill & McDonagh 2004; Wang & Burris 1997; Wang 2003). In the context of this project photos were used to promote critical dialogue through small group discussions of the photographs, a process known as photo elicitation (Hurworth 2003) or photo interviewing (Collier & Collier 1986; Harper 2000). This sort of image based research follows the tradition of visual anthropology (Collier & Collier 1986; Harper 2000; Packard, Ellison & Sequenzia 2004).

Potential limitations of participatory and interactive methodology

Participatory methodologies produce rich sources of data that are developed and reflected as part of the workshop. There is potential for the process to influence the data as it is highly interactive and guided by the facilitator (Cornwall & Jewkes 1995). However this is limited by the ideas and concepts being presented back to young people as part of the interaction to be affirmed or challenged by the group. The number of workshops conducted across a range of young people, using an experienced facilitator, and the reflection on the themes and ideas with the reference group during the data collection process also reduce the potential for bias.

Implementation of methodology

There were five phases to the research conducted during 2006, with a reference group providing advice and support to each phase as shown in Figure 1.

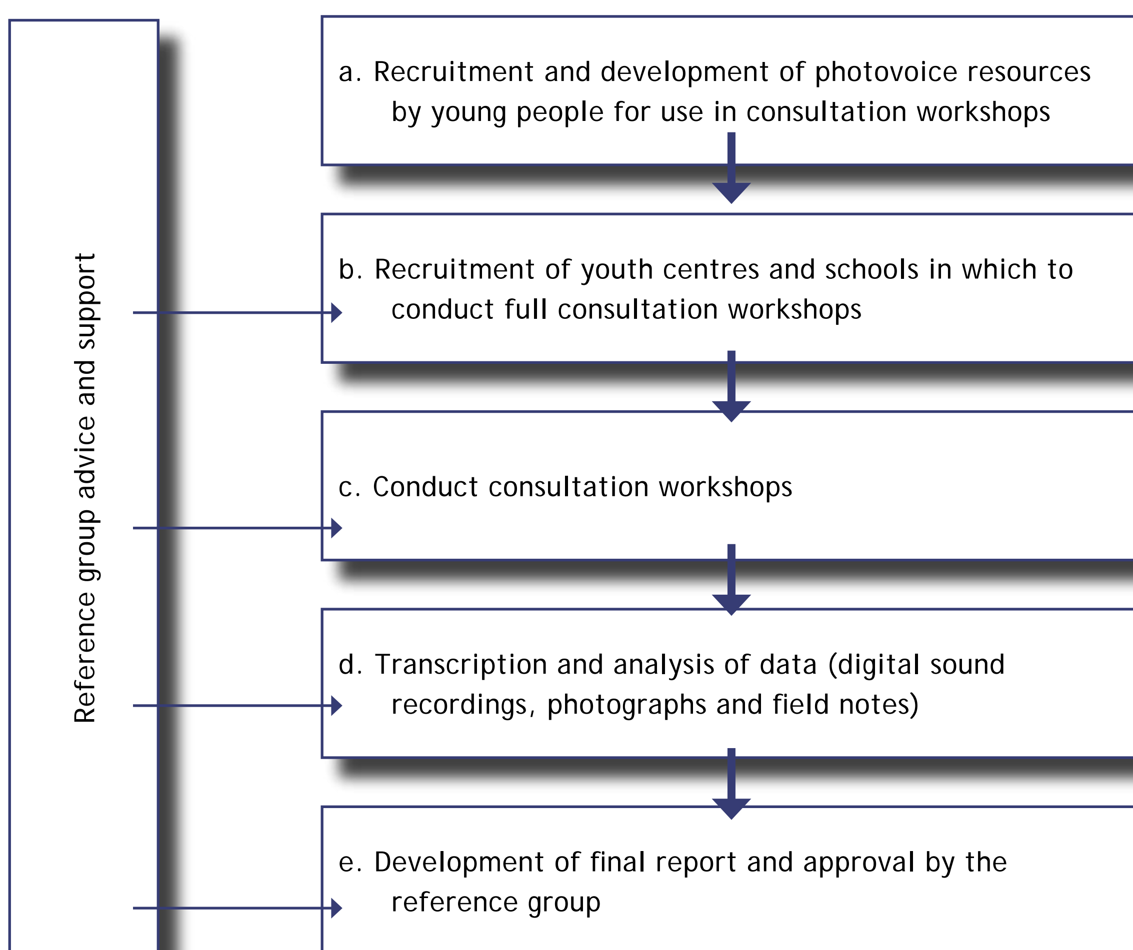


Figure 1: Overview of research approach

Reference group

At the commencement of this study a reference group was established to oversee and provide input to the design of the consultations, the implementation of the photovoice aspect of the methodology and the final report writing. Those on the reference group who provided input for this project were:

- Ms Maryrose Baker, Senior Policy & Planning Officer, Sexual Health and Blood Borne Virus Program, Department of Health (WA);
- Dr Graham Brown, Lecturer and Researcher, WA Centre for Health Promotion, Curtin University of Technology;
- Ms Suzanne Dimitrijevich, Project Officer, School Drug Education and Road Aware;
- Ms Trish Langdon, Executive Director, AIDS Council of WA;
- Ms Karyn Lisignoli, Executive Officer, Youth Affairs Council of WA;
- Ms Lorel Mayberry, Lecturer, Sexology Program, Curtin University of Technology;
- Ms Shauna Skinner, Project Officer, Sexual Health and Blood Borne Virus Program, Department of Health (WA);
- Ms Noelene Smith, Manager Education and Training Services, FPWA; and
- Ms Anne Sorenson, Youth Engagement Officer, Youth Affairs Council of WA.

The reference group provided a forum for discussion at each stage of the research, and advice and support for the methodology.

Development of photovoice resources

Resources for the consultation aspect of the project were collected through a photovoice activity with a group of nine young people recruited through the Bassendean Youth Advisory Council. Young people were briefed about the project in an introductory session and asked to carry a single use camera with them for a week. Specifically, they were encouraged to follow this instruction: ‘Use the camera creatively to take pictures of where or how you learned what you know about sexuality and relationships’.

The majority of photographs suggested magazines and friends as important sources of information about sexual health. Seventeen photos were of peers and 12 were of magazines. The next most frequently appearing item in the photographs was pamphlets. Other people or places represented in the photographs were: parents, school based health services (including chaplains), classrooms, youth centres, places where young people hang out (e.g. parks, shopping centres), youth events and the Internet. The selection of photos was reviewed and supplemented where appropriate by the reference group. No photos were removed or omitted by the reference group.

A variety of magazines were photographed including men’s and women’s lifestyle and fashion magazines along with sexually explicit magazines such as Playboy.

The majority of photos indicated friends as a significant source of sexual health eduaction.

Recruitment of workshop participants

Member agencies of YACWA were approached to assist in recruiting young people who were accessing their services. Groups of young people that were already established were preferred in order to engage with an already present group dynamic and a sense of trust among participants. Young people were informed of the research and the activities before being asked to sign a consent form to participate in the research, or withdraw from it. The recruitment was directed towards young people who were either marginalised or identified as 'at risk' through ethnicity, experience, sexuality or geographic location.

As discussed earlier, the aim was not to recruit a representative sample of all young people in Western Australia, but to include the perspectives of a broad range of young people including those who may not have participated significantly in other consultations or research.

Males	32
Females	56
Total number of young people participating in consultation workshops	88

Table 1: Workshop participants gender distribution

The YACWA Youth Engagement Officer conducted ten consultative workshops of up to two hours in length. Workshops were conducted in the metropolitan area (where six workshops were held) and in three regional areas (where four workshops were held). Participant numbers ranged from 6 – 15 young people. Table 2 provides a summary of the diversity achieved within the sample.

Group	Number of participants	Groups with same-sex attracted young people	Groups with at risk young people	Groups of rural young people	Indigenous group (rural)	Groups with young parents	School based groups	Groups with post compulsory school aged young people
Bridgetown Repertory Theatre's Youth Theatre	14							
Cyril Jackson SHS	7							
Forrestfield SHS	15							
Freedom Centre	7							
Kalgoorlie Millen St Centre	6							
Kalgoorlie Youth Council	8							
Lockridge SHS	10							
Northam GATE	6							
Swan City Youth Service	9							
Trinity Learning Centre	6							
Total	88							

Note: ● indicates characteristics included in each group

Table 2: Summary of the diversity of workshop participants

Consultation workshops data collection

Young people were shown the photos generated from the photovoice aspect of the project. The data collection purpose of the photos was explained to each group of young people. Participants of each group were then asked to respond to questions about whom or where they learned about sexual health by physically moving towards photos that expressed their answer.

Following discussions regarding their responses, young people were then encouraged to respond to more questions and to express their answers through creative movement activities. This included creating a physical timeline and physically expressing their responses to the questions using props, costumes and role-play drama activities. Semi-directed interview techniques facilitated discussion throughout consultations allowing for deeper exploration of the issues raised and presented in the activities.

Photographs were taken of the final images that young people constructed to represent their ideal education model. These images were then used as additional data in identifying common themes.

Potential bias of the facilitator's interpretation was reduced through the facilitator presenting the ideas and concepts back to young people as part of the interaction to be affirmed or challenged by the group. See Appendix 1 for an overview of the workshop schedule and questions.

Transcription and data analysis

Data were recorded via digital sound recordings, photographs taken during workshop activities and field notes. Sound recordings were transcribed in annotated format. Common themes indicating how, where and from whom young people learn, and want to learn about sexual health were identified and compared within and across the different workshops. Early analysis was presented to the reference group and discussed to ensure accuracy of analysis.

Timeline activity asking, 'At what age should people learn about sexual health?'

A selection of sexual health 'props' included condoms, femdoms and dams (prophylactic used for oral sex).

The condom demonstrator was a source of endless fascination and play at every consultation.

A box of props and costumes was used to encourage young people to create an image of what they would like sexual health eduaction to look like.

A young mother describes how she learned about STIs from her first pap smear.

Role-playing characters of different genders occured in many of the workshops indicating the creation of a safe and fun space.

Some of the items in the props box.

At all the consultations young people played with the sample condoms.

5. Findings

There were five key themes that were derived from the workshops that provided insight into from whom and how young people reported they received, and suggested they wanted to receive, their sexual health education. These included:

- peer networks, friends and locations;
- youth friendly and relevant sexual health education including:
  - youth friendly and credible sexual health educators,
  - the graduated approach to sexual health education,
  - school settings for sexual health education, and
  - post or outside of school education;
- family learning and influence;
- media and the Internet; and
- rites of passage events, parties, and alcohol.

Each theme is discussed in turn in the following sections.

Peer networks, friends and locations

Many of the pictures of young people returned from the photovoice project indicated friends as a source of knowledge about sexuality and relationships. The responses to questions and activities in the consultation workshops indicated most young people turned to their friends and other people who supported and accepted them when wanting to learn about sexual health. The informal discussions that occurred on the bench in the shopping mall or at sports club training sessions were presented as significant times of sharing and learning about sexual health.

Examples of the statements made by participants included:

> *'Young people listen to young people.'*
>
> *'They [friends] are the only ones who would talk to me about it if I wanted to talk about it.'*
>
> *'The footy girls—I started when I was 14 and I really didn't know who I was. They let me be who I was and they just supported me.'*

The quality of the relationship, including confidentiality, trust and non-judgemental interaction, were common factors presented as prompting young people to feel safe

and comfortable to discuss issues of sexual health with their friends and peers.

Throughout the workshops young people created images and expressed different ways they approached and made connections with other young people a few years older than themselves who they felt had sexual experience or knowledge, and who could offer support and guidance as they explored and discovered their sexuality. Listening, watching and asking other young people to share their stories through discussions appeared to be how young people were being taught by friends. The following quote provides the clearest description of this common theme.

> *'People our age and a bit older who can talk about their experiences and help each other. Like our own peers so we don't feel intimidated.'*

This was reinforced through several role-plays generated by young people that demonstrated how they sought the knowledge and experience of friends a few years older than themselves when wanting to learn about condoms. It was noted that young women preferred conversational models of learning. Being able to sit and chat around food and magazines played an important part in their sexual health education. Most

An image representative of discussion with peers (the mannequin represents a friend). The informality is indicated by the inclusion of coffee, chocolates and cigarettes. Magazines and DVDs represent the use of print media and visual media as sources of information.

Image from a role-play demonstrating how young men either did or wanted to turn to men a few years older than themselves to learn about how to use condoms.

girls reached for the magazines and coffee as props to create their 'ideal model' of sexual health education occurring among friends. Young men's role-plays tended to be more directive, asking older peers questions or, as discussed later, accessing literature or the Internet on a more individual basis.

However, a peer of the same age who was seen as sexually experienced was not necessarily respected. The young people consulted considered overtly sexual behaviour in other young people, particularly young women, negatively. The following quote indicates how actual or assumed sexual behaviour in young people, particularly young women, can be negatively labelled by their peers at an early stage and stereotypes perpetuated about young women and sexual behaviour.

> *'When I got to high school there was a group of Year 8s who were the slut homeys—they were already having sex.'*

Same-sex attracted young people found it more difficult to find same-sex attracted friends at school. Many of the young people consulted, regardless of sexuality, agreed that only 'straight sex' was discussed in the classroom at school. In their experience the lack of acceptance of same-sex attraction in schools leads to a suspicion of being harassed and victimised by other students in the school environment. They spoke of their feelings of connection and relief when finding other young people in their community who were also same-sex attracted and how this contributed to their knowledge and understanding of sexual health.

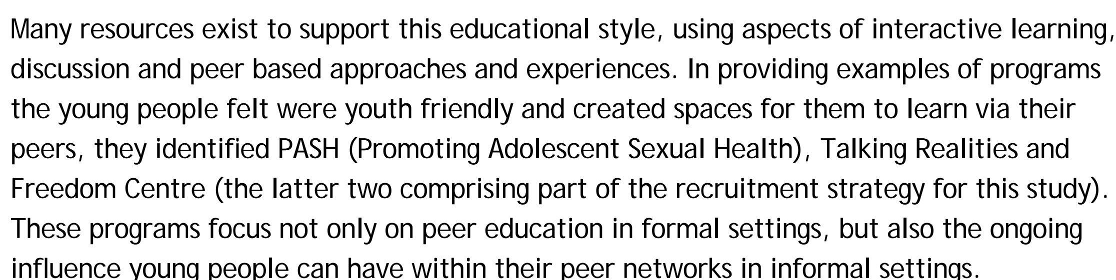
> *'I learned it from my best friend, me and this gay guy who nobody liked and I was like, there's something about you I love, and then he said, "I'm gay" and I was like, so am I!'*

Same-sex attracted youth saw their social isolation in schools as a factor that contributed to young people keeping their same-sex attraction or gender diversity to themselves. This forced them to seek other sources of information to find out about their sexuality.

> *'I remember burrowing into the library in my first year of uni in the women's gay and lesbian section; that's where I learned about relationships and stuff.'*

Implications for practice

The literature on the influence of peers and peer networks on sexual health education is well established (Mellanby et al. 2001; Moodie, Edwards & Payne 2003; Pearlman et al. 2002; Shiner 1999; Turner 1999). The challenge is to effectively tap into this process where it is already occurring and create environments where this can occur in an accurate, safe and supportive way.



Many resources exist to support this educational style, using aspects of interactive learning, discussion and peer based approaches and experiences. In providing examples of programs the young people felt were youth friendly and created spaces for them to learn via their peers, they identified PASH (Promoting Adolescent Sexual Health), Talking Realities and Freedom Centre (the latter two comprising part of the recruitment strategy for this study). These programs focus not only on peer education in formal settings, but also the ongoing influence young people can have within their peer networks in informal settings.

School based programs that have been developed with similar approaches (but not specifically identified by young people in the consultation) include Growing and Developing Healthy Relationships (Department of Health 2002) and Talking Sexual Health (ARCSHS 1999). These programs are currently used in schools and are consistent with the models of peer education the young people described.

While the issues of peer influence and the Internet did not arise together in the consultation, both were raised as key sources of knowledge. With the development of user-created content and websites being a key part of contemporary youth expression, it is likely that this developing medium will increase in its role in peer influence among young people.

Recommendations

Improve awareness of, access to and use of effective peer based education models by:

- increasing schools' access to professional development and resources about teaching of sexual health and relationships;
- facilitating peer education strategies; and
- enhancing the capacity of non-government youth services to promote greater awareness of programs and resources.

Invest in research to:

- determine the effectiveness and value of peer based initiatives to influence young people in informal and out of school settings; and
- monitor the development of peer influence through new media and technologies such as the Internet.

Youth friendly and relevant sexual health education

In general, sexual health education was interpreted as education about sex. Nearly all of the young people considered penetrative sex as mostly what sexual health was about. Only a few young people spoke of education and skills for healthy relationships.

This section discusses four interrelated aspects of this theme:

- what young people meant by youth friendly and credible sexual health educators;
- a summary of the discussions concerning the graduated approach to sexual health education;
- an insight into young people's views on school based education; and
- experiences of post or outside of school education.

Youth friendly and credible sexual health educators

When young people described a desire for youth friendly educators or facilitators for sexual health education, they were asked to elaborate what this really meant in practical terms. Young people responded with descriptions that included having a non-judgemental attitude, respectful listening, responding to questions and someone they felt they could relate to. A facilitator's honesty and ability to listen, accept and respond to young people's enquiries in a value free way was described as youth friendly. Some youth workers that the young people in this sample had been in contact with were given as examples and described as trustworthy and able to keep confidence.

The blend between seriousness and play was articulated by many of the young people at consultations as being characteristic of youth friendly environments or approaches.

> *'They need to be able to laugh at jokes. They need to not take things so seriously. They need to be really fun instead of everything being serious. Have a bit of serious, have a bit of fun, then a bit of serious.'*

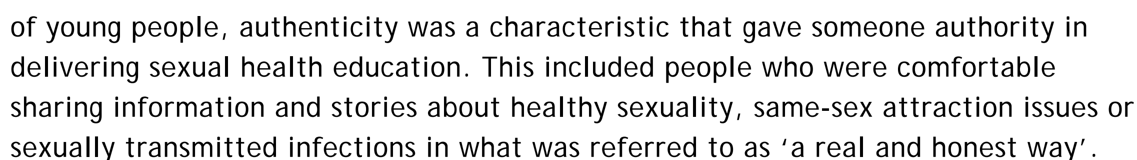
> *'Funny, interesting and appealing to youth. Someone independent, like a youth worker, independent of school, informal dress, every day clothes.'*

> *'Teachers that are funky, down to earth, open and made it fun.'*

Being introduced as a sexual health educator did not necessarily imbue authority or credibility. It was important for the facilitator to have knowledge, but to also share experience based stories that were socially relevant to the issues they were discussing. For example, in one activity a young person included the following written statement in a representation about sexual health education.

> *'No old nuns telling you stuff. Instead have young cruisy people (not teachers) who are easy to approach and communicate with.'*

This statement is an indication of the assumptions young people made about the perspective of their sexual health and relationship educators, and the desire to feel a connection with both the content and the educator. From the perspective



of young people, authenticity was a characteristic that gave someone authority in delivering sexual health education. This included people who were comfortable sharing information and stories about healthy sexuality, same-sex attraction issues or sexually transmitted infections in what was referred to as 'a real and honest way'.

An important aspect of young people's definition of youth friendly and credible was the concept of safety and confidentiality. Being able to engage with young people was not enough—there needed to be the creation of a space and environment where young people felt safe and could trust the educator or facilitator. Stories of how educators created value free and non-judgemental opportunities to explore sexual health were described by some of the young people indicating that such environments could be promoted successfully in schools by trained youth friendly practitioners.

'I had a groovy teacher where we were allowed to go to her office and chat at any time about anything.'

Young people gave examples of a range of activities and approaches that they saw as indicators of being youth friendly. These generally included activities that respected young people's desire for confidential enquiry such as a question box where young people place questions anonymously into a box. The questions were then answered by the teacher in a classroom situation. Young people at one of the school based consults indicated it was their choice to participate in PASH and the personality of the facilitator along with the informal nature of the sessions were the reasons they enjoyed it and considered it friendly and accessible. However young people also gave examples of environments that were not youth friendly or safe, such as poorly facilitated classroom settings.

> *'When you ask a risky question in class, if the teacher doesn't take you seriously the class will tease you.'*

Throughout the consultations young people raised the issue of access to condoms. Many young people did not have concerns about purchasing condoms in the community but many young people still in school were keen to be able to access condoms though sexual health instructors.

> *'She's cool. She gives us condoms.'*

The process of providing condoms was more than providing easy access to condoms (an important issue for young people in rural areas who were uncomfortable to purchase condoms from the chemist or other places), but also reinforced the perception of a non-judgemental approach among the young people.

Contributing greatly to the confidence of some young people to openly question and investigate issues during their sexual health education was the sexual health educator

being considered an anonymous source of information. For example, for some young people, communicating openly with a teacher in the school environment was accompanied by feelings of embarrassment, shame and mistrust.

> *'Sometimes it's shame at school but sometimes it's not.'*

> *'Don't have teacher present [sic], children can feel comfortable asking a stranger questions.'*

Many young people indicated that if the facilitator was from beyond the circle of people they interact with, they would feel less at risk talking to them. Young people were concerned that things they may wish to ask or disclose could affect the ongoing relationship they had with a teacher. Confidentiality issues and fear of judgement were the contributing factors to this desire. This was more prevalent in regional WA and with the Indigenous young people. It was the actions, not the words, of educators that proved to young people that non-judgemental, confidential and youth friendly approaches would be maintained.

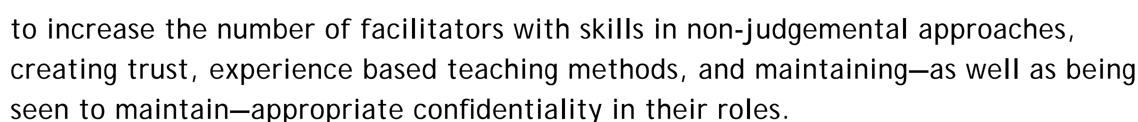
Implications for practice

The term 'youth friendly' is often used to describe a range of services and programs. However the meaning and practicalities of the term can vary. Youth friendly as defined by young people in this consultation referred to facilitators who were not only skilled in addressing youth health issues in an open and relaxed manner, but who also:

- facilitated discussion of stories, experiences and scenarios in a real and contextualised way;
- offered socially appropriate information to young people in order to normalise their experiences; and
- generated confidence and trust in their non-judgemental and confidential approach.

The fact that young people recommended both personal sharing in groups and confidentiality may seem contradictory. However the underlying theme was about reality, relevance and credibility in the stories and activities. Using stories and scenario based activities generated by and for young people that engage, but do not normalise risk behaviour or personalise experiences, could still generate credible and effective learning situations.

This report recognises there are many skilled and knowledgeable sexual health educators delivering accurate and up to date information to young people in WA, as was evidenced by some of the experiences of young people in the consultation. However the young people expressed inconsistency in these experiences, and a need



to increase the number of facilitators with skills in non-judgemental approaches, creating trust, experience based teaching methods, and maintaining—as well as being seen to maintain—appropriate confidentiality in their roles.

While training and development is a key part of achieving a youth friendly and credible education process, equally important is ensuring the school community supports the approach and the facilitators. Building trust and confidence is as much about the school policies, ethos and community as it is about what happens in a classroom or workshop.

Recommendations

Ensure training and policy development for schools and agencies in utilising resources that:

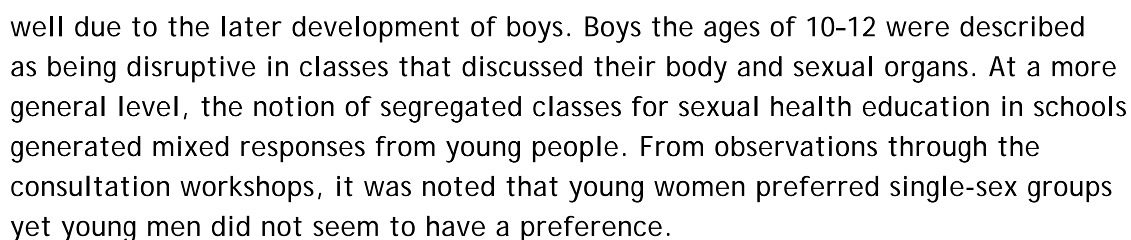
- reiterate the importance of establishing a safe educational environment;
- promote a youth friendly approach to sexual health education that includes trust and confidentiality;
- lead to relevant and credible discussions with young people about their experiences and equip young people with socially relevant skills;
- promote young people's trust with the school or agency as a whole and not just with individual staff; and
- support the building of partnerships between schools and youth health services in facilitation and promotion of sexual health education and services.

The graduated approach to sexual health education in schools

The discussion with young people about relevant sexual health education led to discussion about the age at which they considered it appropriate to learn about sexual health. The responses were very consistent across all the consultation workshops.

All the young people felt it was important to teach young children about protective behaviours such as 'good touch, bad touch'. It was indicated that learning this in lower primary school allowed children to be aware of inappropriate sexual behaviour between themselves and others.

Puberty and the physiological changes associated with sexuality were seen as correctly placed in the school curriculum in upper primary. Young people all agreed that learning about their changing body before or whilst it was changing was appropriate. There were suggestions that same-sex classes at this age would work



well due to the later development of boys. Boys the ages of 10–12 were described as being disruptive in classes that discussed their body and sexual organs. At a more general level, the notion of segregated classes for sexual health education in schools generated mixed responses from young people. From observations through the consultation workshops, it was noted that young women preferred single-sex groups yet young men did not seem to have a preference.

The majority of young people agreed that the transition to secondary school included a greater exposure to sexuality.

> *'Everything happens at high school.'*

In all the consultations the majority of young people indicated safe sex and STI education should be taught from Year 8 onwards. Only one young person raised the fear of exposure to sexuality in classrooms as something that encouraged young people to engage in sexual activity. One young woman believed, 'When you start to learn things you get curious and then you want to try them.' However, this was not supported by the majority of the other young people who identified problems with delaying education about sexual health and safe sex. Most young people felt that exposure to sexual behaviour was easy through the Internet, media, movies and television, and to deny them accurate knowledge was considered dangerous.

> *'But what if they have sex and they don't use protection?'*

> *'By the time you get to 13 girls start to have older boyfriends. If they don't know about this stuff … '*

Most young people were particularly vocal about earlier access to information regarding STIs in schools.

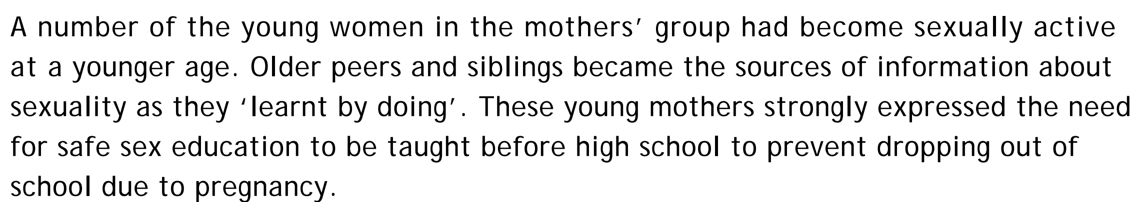
> *'They teach you about sex but they don't teach you about STDs until you get to 14 … You don't know what a condom is until you get to 14.'*

> *'They don't really teach you about STIs until later. They put a big issue on the pregnancy side. They don't give enough weight to STIs.'*

> *The workshop with young mothers (under 18 years) revealed strong views drawn out of their experiences at school, and leaving school when they became pregnant.*

> *'I didn't make it through high school because I got pregnant.'*

> *'I got taught about pregnancy at the end of Year 11 and I was already pregnant.'*



A number of the young women in the mothers' group had become sexually active at a younger age. Older peers and siblings became the sources of information about sexuality as they 'learnt by doing'. These young mothers strongly expressed the need for safe sex education to be taught before high school to prevent dropping out of school due to pregnancy.

It was reported that in school there was not an open and honest dialogue about those issues of sexual health and sexuality that were deemed more personal and private, such as masturbation, gender diversity, relationship support and domestic violence. In response to education surrounding these issues that young people considered 'mature' issues, it was suggested they needed to be discussed from 15 years onwards (Year 10). Many young people felt that before 15 years, young people would have limited capacity to talk openly about such topics in a classroom.

The role of families and parents in deciding at what age young people should learn about sexual health in schools was discussed during consultations. Some young people believed that it should be up to families to decide what information was taught and when in school based sexual health education. Other young people felt their parents might be too restrictive in what could be taught. However the majority of young people indicated that sexual health education should be compulsory if conducted in a youth friendly way.

Implications for practice

Young people identified they were exposed to sexual topics and influences in their day to day lives and considered it dangerous to not provide them with the appropriate knowledge and skills. It was also felt by the young people that youth friendly sexual health education should be compulsory. The young people in the consultation workshops overwhelmingly recommended that, by Year 8, young people should have good basic knowledge and skills in safe sex and the prevention of STIs. Young people also wanted to see more mature or complex topics directly engaged with during high school.

A graduated, age appropriate and sex positive approach to sexual health education has always been part of a comprehensive sexual health education framework. A sex positive approach recognises that harm minimisation approaches are most appropriate and encompasses a range of positions including the support of abstinence choices through to explicit safety advice for those who are sexually active (Mitchell 2005).

The recommendations from young people in this consultation were consistent with the age appropriate approach of programs such as Growing and Developing Healthy Relationships (Department of Health 2002) and Talking Sexual Health (ARCSHS 1999). The consultation was also consistent with other research (e.g. Smith et al. 2003) that indicates there may be times when single-sex classes would be seen as a safer and more useful spaces for young people learning about sexual health and relationships.

Recommendations

- Ensure comprehensive education and skills development in the prevention of STIs and pregnancy throughout high school.
- Consolidate and improve ongoing training, development and support to ensure teachers are implementing comprehensive and age appropriate sexual health education confidently throughout all years of schooling.

School settings for sexual health education

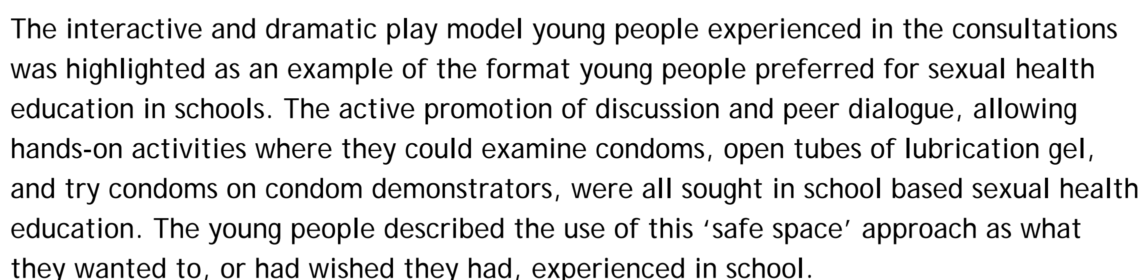
There was a diversity of experiences of school based sexual health education reported across the consultations. However most young people expressed their frustration at school based education as focusing on what they described as only puberty, procreation and penetration. Through discussion they described school based education as not including topics such as how to enjoy your body, abstinence, non-penetrative sex, or same-sex sexual relations. In the opinion of some young people, school based sex education was only about a penis and a vagina with a condom in between.

> *'I remember getting years and years of menstrual cycles but no information about real sexuality—issues like foreplay, non-penetrative sex, masturbation.'*

Young people expressed their desire to see sexual health as a subject on its own rather than as part of science, health education or physical education. This was linked to young people's desire for sexual health to be in a context that they felt related to their lives, to transition times and the school community generally. The discussion was about creating the right setting and approach within the school environment and not simply fitting sexual health education into a setting more appropriate for other subjects.

A group of young women meeting in a small group to share experiences and discuss sexuality.

Condom packets and pamphlets support the discussion.



The interactive and dramatic play model young people experienced in the consultations was highlighted as an example of the format young people preferred for sexual health education in schools. The active promotion of discussion and peer dialogue, allowing hands-on activities where they could examine condoms, open tubes of lubrication gel, and try condoms on condom demonstrators, were all sought in school based sexual health education. The young people described the use of this 'safe space' approach as what they wanted to, or had wished they had, experienced in school.

> *'I think things like this are good, casual, where you can discuss things, where you all feel comfortable to ask questions.'*

Young people repeatedly linked fun and play to learning and overcoming their embarrassment about sexual health topics. Many young people indicated that the class being fun was a key factor in retention of information.

> *'Fun…you learn more when you have fun.'*

> *'You don't remember boring stuff—you always remember the fun stuff.'*

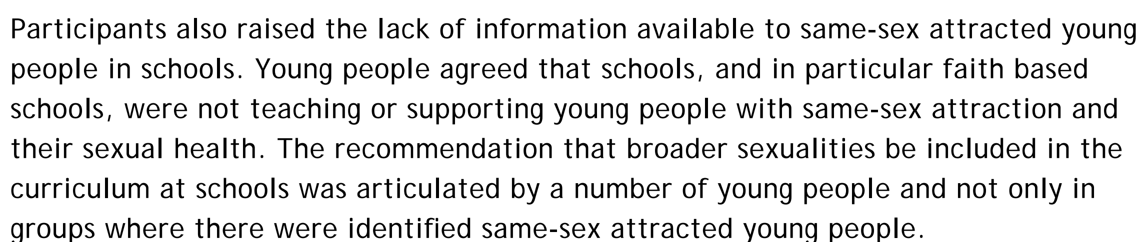
When schools created informal settings young people felt this contributed towards their learning from peers. Being able to relax and feel comfortable was something young people felt facilitated the discussion and contributed towards a deeper understanding and confidence about sexual health.

The images and role-plays young people created in the workshops showed how small group discussions in school based sexual health classes were seen as informal. Small group discussions that arose from the stimuli of the pamphlets, props and packets guided the direction of the discussion in these learning environments. The teacher was presented as a facilitator who responded to queries as they arose and facilitated genuine enquiry into healthy sexuality.

> *'Do it in an easygoing environment. Relaxed, not sitting at a desk. Outside, under a tree or on the oval.'*

Young Indigenous women described a small group model they felt worked in association with their schooling, where young people attended a youth health clinic for a course in sexual health. The interactive and multi-stimuli nature of the learning environment was noted as being what contributed to the interest of these young people and young people in general.

> *'After school we have a girls' youth group and we talk to one youth lady and she teaches us about stuff. She takes us to a clinic/hospital and teaches us and we look at pictures and stuff.'*



Participants also raised the lack of information available to same-sex attracted young people in schools. Young people agreed that schools, and in particular faith based schools, were not teaching or supporting young people with same-sex attraction and their sexual health. The recommendation that broader sexualities be included in the curriculum at schools was articulated by a number of young people and not only in groups where there were identified same-sex attracted young people.

In contrast, in some groups when there were no young people identified as same-sex attracted, a photovoice image of two young men kissing was responded to with disgust and the use of derogatory terms, particularly among the young men. This reinforced comments by other young people that harassment and bullying on the basis of assumed sexuality was still a major issue within the school environment, and there was a need for such issues to be directly responded to at a curriculum and school policy level.

Implications for practice

This research indicates that sexual health education may benefit from small well-facilitated classes that allow for discussion and exploration. Conducting this in an environment different to a classroom may facilitate a breakaway from the norm and an opportunity for teachers to use alternative resources and skills to create safe and supportive spaces that promote free expression and discussion. The safety of the group and trust in the facilitator enabled young people to question, discuss and discover information about sexual health. A fear of repercussions from peers, the school or from family often prevented effective sexual health education.

The findings speak strongly to the issue that creating these supportive environments is a whole school community issue. If discrimination, harassment and bullying around gender, sexuality or assumed sexual behaviour is not responded to within the school community then it will be difficult to create a safe space in which sexual health and relationships can be effectively explored and promoted.

The Health Promoting Schools Framework provides a useful model in which to position sexual health and relationship education within the broader school based resources and goals for student health. The framework mobilises the whole school community to engage in the promotion of health, including: curriculum, teaching and learning; school organisation, ethos and environment; and partnerships and services (AHPSA 2000).

While professional development and curriculum support materials are founding elements for good sexual health and relationship education, this foundation needs to be supported and enhanced through effective school based policies and engagement with the broader school community.

Recommendations

- Ensure sexual health education is identified as a core component of school health promotion obligations.
- Continue and enhance support for professional development of teachers in the implementation of effective, evidence based, interactive and youth friendly sexual health and relationship curriculum and health promotion approaches.
- Prioritise school policy processes that:
  - support the implementation of sexual health curriculum;
  - promote acceptance and support diverse sexualities at a curriculum, policy and school community level; and
  - encourage collaborations and partnerships with youth health services in the school's community.
- Ensure resources are allocated to support the continued development and evaluation of youth centred sexual health education models that include dialogue, multimedia, and interactive and participatory approaches.

Post or outside of school education

Many young people identified youth centres and youth health services as preferred sources of health education outside of school, particularly those who felt isolated or marginalised from mainstream education. Those young people who had accessed them regarded programs such as PASH and other interactive peer based workshops positively. They reported gaining skills and confidence through these programs. Mobile outreach clinics were praised and reportedly utilised regularly by these young people. The health professional at these mobile clinics was described as being proactive when seeking out young people to attend appointments, get tests and retrieve results. This was described as a key factor assisting young people outside of school to stay sexually healthy.

Young people also discussed general practitioners (GPs) as sources of information specifically about STIs and contraception. This was not always considered a confidential service with rural young people talking of attending GPs in the city to avoid small town gossip. Same-sex attracted young people expressed their desire to find gay identified doctors and how word of mouth contributed towards locating gay friendly doctors.

Young people also described accessing useful information through pamphlets and recommended broader and easier access to these resources. While young people felt there was easy access to these resources in youth centres outside of school, it was suggested these pamphlets should be more readily available in places such as libraries and schools.

Implications for practice

The importance of continuing sexual health promotion beyond and outside of school is well recognised. Young people post school acknowledged and highlighted this need for accurate information, awareness of where to go for help, and medical services to support their sexual health. These young people also identified a value in programs that allow for the informal dialogue and peer education discussed previously in this report. Young people placed a high value on those programs they felt were meeting them 'where they were at', such as mobile and outreach programs and services that provided a range of services with a youth friendly approach.

Young people access information and support through programs run at youth centres.

A response to creating a model of sexual health education included one where young people could access pamphlets and read about the realities of STIs. This model was closely linked to a medical model, suggested by the inclusion of medical STI testing equipment.'

A display of pamphlets near the entry at one youth centre was praised as an effective mehtod of young people discreetly accessing information regarding sexual health.

Recommendations

- Continue to enhance support for professional development of youth services staff in the implementation of effective, evidence based, interactive and youth friendly sexual health and relationship programs and services.
- Ensure youth friendly pamphlets about sexual health and relationships are more widely accessible in the community and schools.
- Provide increased resources to evaluate the effectiveness of different modes of outreach programs and services targeting out of school or marginalised young people.
- Continue to support and develop effective outreach/mobile health clinics and mobile support services for young people, staffed with medical professionals, trained sexual health educators and youth workers.
- Support the collaboration between the various Divisions of General Practice (locally based associations of general practitioner doctors), youth health services and school health programs to improve youth friendly and sexuality sensitive training for GPs and clinicians and increase awareness of youth support services.

Family learning and influence

Many young people spoke of family members and their important role in educating young people about sexual health. A range of positive and negative stories was shared indicating successful and unsuccessful ways parents teach young people about sexual health.

> *'If you have a good relationship with your mother then you can tell her anything.'*

> *'My dad was too embarrassed to tell me.'*

> *'They [family] are the biggest influence on me.'*

> *'I had the talk with my dad. I didn't like it. He yelled at me and said, "If you ever knock a chick up your life will be ruined, especially by me".'*

Indigenous young people listed family members as authorities and sources of information about sexual health. The young women in the workshop listed other female family members such as grandmothers, cousins, aunties and sisters as people they turn to for support and information.

A number of young people indicated that they did not benefit from parental education in sexual health and would welcome an opportunity for parents to learn communication skills and sexual health facts. Young people also acknowledged that even if parents and family members did not appropriately model healthy sexuality, that young people could still learn from their mistakes.

Young people raised the challenges of the conflict between schools and parents about sexual health. For example, one young person described how she had asked her teacher for information about oral sex. The young person felt the teacher had answered her questions in a respectful and mature fashion. When the young person shared with her parents that she had been taught about oral sex, the parent rang the school to complain. This demonstrated not only the potential conflict between creating a youth friendly and open environment and the diverse expectations of parents, but also that young people are aware of this potential conflict and can be caught in the middle.

Implications for practice

Parents and family members are the primary sex educators of children and an integral part of the school community and the Health Promoting Schools Framework. Increasing the capacity of all school community members, including parents, to play an active and supportive role appears to be supported by young people in this consultation.

Being culturally sensitive to sexual health education in regards to the diverse cultural heritage of students in school based education can be challenging but is generally improved by effectively facilitated parental input. Recognising that family and family support structures can be the very effective sources of sexual health and relationship education should be supported and nurtured. Providing accessible support and education for parents and strengthening connections between parents, young people, schools and community support services may increase opportunities to create open and informed discussions with young people about sexual health.

Recommendations

- Provide increased resources for developing effective and achievable ways to engage parents and increase their capacity to support comprehensive sexual health education within a Health Promoting Schools Framework.
- Promote and support programs that enhance the skills and knowledge of parents and family members to support in school and out of school sexual health programs.

The human body book appealed to young men during many of the workshops.

Along with the human body book, young men agreed posters and pamphlets were effective sources of information.

Media and the Internet

The role-plays and discussions in the consultations highlighted the significant role of the messages and information young people draw from the community and media around them. Young people spoke not only about traditional media such as teenage magazines and sexually explicit adult magazines, but also of new media such as the Internet and interactive media.

As discussed earlier, the young women in the consultation cited sitting and chatting around food and magazines as an important part of their sexual health education. 'Dolly Doctor' and other women's magazine articles and columns that discussed sex were a media authority young women turned to for information.

The young men, however, reached for the human body book or photographs representing sexually explicit magazines. The young men role played gathering in small groups looking at pictures and reading with minimal discussion or sharing. Young men also indicated more than young women did that the Internet was a source on sexual health. The ease of access to confidential and anonymous sexually explicit materials was described by many of the young men in the consultations as contributing greatly to their sexual health knowledge. The advantages of access to such anonymous and explicit materials were weighed against their scepticism about the accuracy of the information.

Implications for practice

The input that popular culture and mainstream media has on young people's sexual health knowledge is significant. Young people learn about sexual health from magazines, the Internet and pornography without their parents, teachers or even friends' knowledge. Acknowledging these visual mediums, educators need to be skilled to address and respond to explicit materials in an educational and appropriate way. This is the context in which sexual health educators need to complement (or counter) this information with accurate information and a non-judgemental approach.

The clear differences in learning styles of young women and young men may be an argument for same-sex classes for sexual health. However, young people presented many arguments for and against this approach.

As discussed earlier, with the development of a user-created/user-controlled youth culture on the Internet, it is likely that this medium will increase in its role and influence within youth culture.

Recommendations

- Ensure teachers are appropriately trained and resourced to use popular culture and media materials as educational resources for sexual health.
- Support curriculum that increases young people's skills in assessing accuracy and quality of information and images presented in the media, including the Internet.
- Support the development of sexual health guidelines to support youth magazines and youth websites to contribute to effective sexual health promotion.
- Support Internet monitoring software that, while barring pornographic websites, does not bar accurate, educationally sound websites about sexual health.

Learning about health, sexuality and safe sexual practices before the school ball was seen as important to a number of young people.

A role-play of a young woman getting ready for her school ball whilst her mother gives her 'the talk' about practicing safe sex.

Rites of passage events, parties, and alcohol

Young people in the consultations described a number of events in their social lives which they felt were culturally connected to issues of sexuality and relationships. These events included significant social events such as the school ball, as well as other celebrations such as high school leavers' celebrations. These events could be described as rites of passage or times of transition. These celebrations and parties were often culturally associated with significant levels of alcohol use and an expectation of sexual behaviour.

Many young people chose the school ball as a role-play scene to indicate how they learned about sex. The suggestion was that it was often before the school ball that parents had a 'chat' about sex with them. Young people spoke about events like the school ball and other significant events as being a time when young people had expectations about and engaged in sexual activity.

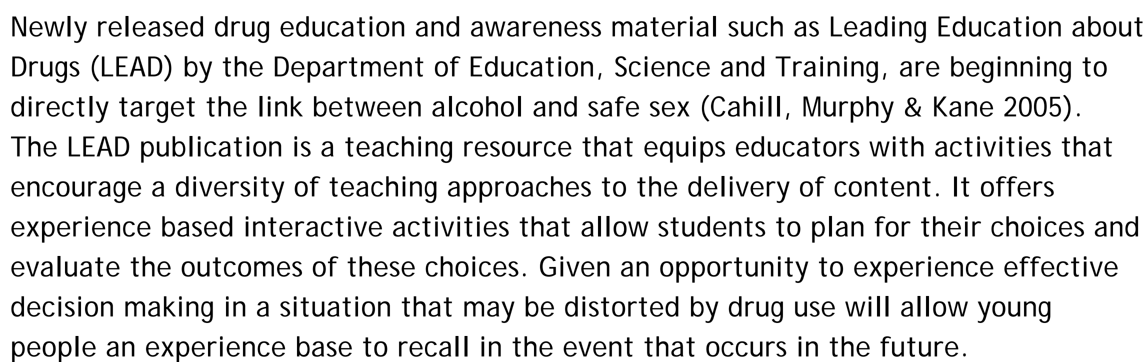
Young people also spoke about parties that were not positioned as significant events, but nonetheless involved expectations of alcohol and sexual behaviour.

Young people spoke of their desire to see education that highlighted the dangers of having sex whilst under the influence of alcohol, drugs or medication. This included drug interaction issues, such as one young mother's experience of how she became pregnant whilst being on the contraceptive pill. She felt no one had explained to her the effects of alcohol or antibiotics on the effectiveness of the contraceptive pill. Considering young people often mix alcohol, drugs and sex, young people found it surprising that alcohol education and sexual health education in schools and the community did not cross over as much as they do in their own culture.

Implications for practice

The separation of alcohol and drug education from sexual health education, as reported by young people in this consultation, may not be consistent with the experiences of young people. For example, young people have positioned significant events such as a school ball and leavers' celebrations to have culturally specific meanings and the status of a rite of passage. Dressing up, drinking and going 'all the way' with their partner was part of the culture surrounding these events.

Drug awareness and the dangers and harm associated with misuse dominates the drug education young people receive. The realities of increased arousal from ecstasy, lowered inhibition from alcohol, difficulties in using condoms when under the influence of alcohol or drugs, and the interaction between substances and medication are all associated with drug use. Domestic violence, relationship breakdown and abuse are frequently linked to alcohol and drugs. Young people wanted to understand how to respond in these situations and how to realistically reach out for support.



Newly released drug education and awareness material such as Leading Education about Drugs (LEAD) by the Department of Education, Science and Training, are beginning to directly target the link between alcohol and safe sex (Cahill, Murphy & Kane 2005). The LEAD publication is a teaching resource that equips educators with activities that encourage a diversity of teaching approaches to the delivery of content. It offers experience based interactive activities that allow students to plan for their choices and evaluate the outcomes of these choices. Given an opportunity to experience effective decision making in a situation that may be distorted by drug use will allow young people an experience base to recall in the event that occurs in the future.

In addition to school based programs, there have been a number of initiatives to engage with young people during significant celebrations and events. For example, peer based outreach programs before and during high school leavers' celebrations have been conducted over the past number of years in WA. Young people and youth services have also welcomed Internet based information addressing youth health issues and how to assist peers. Effective sexual health promotion engages directly within young people's cultural context to equip them with the skills and capacity to make informed decisions for themselves and support their peers.

Recommendations

- Support education workshops about alcohol, drug or sexual risk behaviour that include interactive activities and scenarios based around significant cultural events in young people's lives and the full social context and pressures that surround these events.
- Include context and relationship issues within alcohol, drug and sexual health education such as: assertiveness; planning healthy behaviour; relationship conflict; sexual assault and consent; social and peer influence; and looking after and supporting peers.
- Support training and resources for teachers and youth services to assist young people to develop socially relevant decision making skills, particularly in the context of celebrations with alcohol or drug use.
- Support further research into the role of significant times of transition and rites of passage and its association with risk behaviour including sexual behaviour.
- Support the development and evaluation of outreach initiatives to young people during major celebrations to determine their effectiveness and complementary role to within school programs.

6. Discussion

Summary

Sexuality and relationships do not occur in isolation to the rest of young people's lives, as evidenced in the experiences, perceptions and opinions of the young people who participated in this consultation research. Young people are learning about sexual behaviour and sexual health from a range of sources and in a range of contexts.

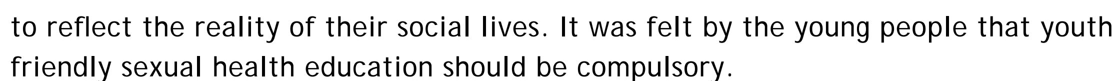
The need for sexual health education to be positioned within the complex social world in which young people make decisions has been well documented in both research and policy documents (ARCSHS 1999; Department of Health and Ageing 2004; Moodie, Edwards & Payne 2003; Smith et al. 2003).

Young people consistently spoke about a desire for youth friendly and relevant sexual health education. In describing what youth friendly meant to them, young people emphasised interactive, hands-on and discussion focused approaches as well as safe, trustworthy and non-judgemental environments. Some young people spoke about experiencing this in school, but all young people spoke about learning from friends and peers. Most young people had access to sexual health education and were aware of some of the avenues that exist for them to further this education. However, young people articulated the method and approach of teaching and the relationship between health educator and young person was crucial to their sense of credibility and engagement with the education. The consultation process revealed young people's desire to also learn from peers a few years older than themselves, who they tended to view as credible.

Overwhelmingly what imbued someone with credibility for sexual health education was their ability to be accepting, their knowledge, their experience and their ability to maintain confidentiality. A sense of openness and trust were core factors a person in this role needed to have. This could be experienced (or not experienced) with friends, family, teachers or youth workers.

Young people supported a graduated or age specific approach to sexual health education, but this needed to reflect the reality of young people's social lives. Young people desired pragmatic dialogue about the realities of sexual health and relationships at an earlier rather than later stage of their education.

Young people identified they were exposed to sexual topics and influences in their day to day lives and considered it dangerous to not be provided with the appropriate knowledge and skills to protect themselves. Workshop participants supported a graduated or age specific approach to sexual health education, but felt this needed



to reflect the reality of their social lives. It was felt by the young people that youth friendly sexual health education should be compulsory.

Through the consultation workshops, young people discussed and role-played scenarios that provided insight into their previous and desired experiences about sexual health education not only in school and out of school community settings, but also with family, friends and the media. Young people provided insights to the social and cultural contexts of when and how they gained their sexual knowledge, but also the meanings and expectations of various events in their lives and their association with sexual behaviour. For example the separation of alcohol and drug education and the meaning of significant social events such as the school ball and high school leavers' celebrations from sexual health education was seen inconsistent with the experiences of young people.

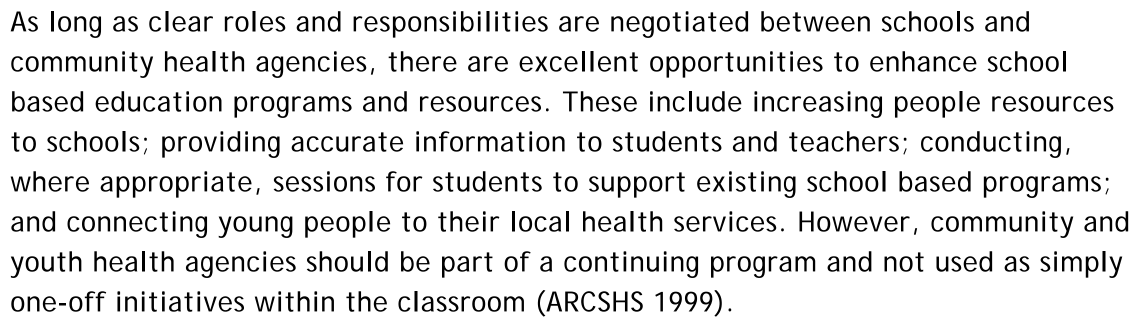
Health Promoting Schools and Partnerships

Sexual health promotion for young people requires individuals, families, schools and communities to all play their role. This study supports other national and international research (ARCSHS 1999; AHPSA 2000; UNFPA 2003) which support key components for the development and delivery of a comprehensive education in schools that focuses on STIs, HIV/AIDS and BBVs. These include:

- taking a whole school or health promoting school approach which includes curriculum and teaching, school organisation, ethos, environment and community links and partnerships (the 'Framework');
- acknowledging young people as sexual beings and the need for age appropriate education throughout their schooling;
- acknowledging and catering for the diversity of all students and the contexts in which they live their lives;
- providing an appropriate and comprehensive curriculum context and the appropriate use of peer and instructor education; and
- acknowledging the professional development needs of the school community.

The findings reveal that strengthening the collaboration between non-government health services and youth services to deliver increased training opportunities for sexual health educators may improve the delivery of sexual health education to young people.

A whole school approach to health promotion provides the capacity and emphasis for school to pursue these goals within a broader community and youth services partnership approach. Students feel more comfortable about using community health agencies when schools have linked these agencies into school-based programs and have set up ongoing links for post school support.



As long as clear roles and responsibilities are negotiated between schools and community health agencies, there are excellent opportunities to enhance school based education programs and resources. These include increasing people resources to schools; providing accurate information to students and teachers; conducting, where appropriate, sessions for students to support existing school based programs; and connecting young people to their local health services. However, community and youth health agencies should be part of a continuing program and not used as simply one-off initiatives within the classroom (ARCSHS 1999).

Educators and health professionals are continually challenged to create learning environments where young people can safely and openly learn about the complexity of sexual health in relation to their physical bodies, their inner world and the social reality they live in. This report provides some insight, from the perspective of young people, about solutions to these challenges.

Table 3 on the following page provides an overview of the key research questions and a brief summary of the findings.

<table>
<tr><th>Study question</th><th>Overview of finding</th></tr>
<tr><td>• Where and how do young people currently obtain their education and information about sexual health?</td><td>• Direct education through school, health services and youth agencies
• Informal discussions and influence from peer networks
• Formal and informal discussions with family
• Self directed searching and informal influence through media and the Internet</td></tr>
<tr><td>• Where and how would young people prefer for sexual health education and information about STI/BBV to be delivered?
• From whom would young people prefer to receive this information?</td><td>• Generally young people requested more information in an informal, relaxed and casual environment where they could ‘just talk about stories and stuff’ with a youth friendly educator willing to share stories and knowledge in non-judgemental and confidential way. In particular young people requested:
o Youth friendly health education and services—defined as relevant, trustworthy, confidential and safe, non-judgemental, and in the context of young people’s lives;
o Appropriate roles for educators with ongoing relationships with young people as well as educators who do not have an ongoing role;
o Engagement with peers who were credible sources of knowledge and experience;
o Parents who were informed and supportive; and
o Detailed information that was accessible, reliable and anonymous</td></tr>
</table>

Study question	Overview of finding
• When is the best time to receive information about sexual health and STIs/BBVs?	• Young people supported a graduated approach that included good safe sex knowledge by Year 8 in high school. They also recommended engagement with other more complex issues concerning relationships, sexual experience, alcohol use and domestic violence during high school.
• What should information/education about STIs/BBVs look like/involve?	• Youth friendly, relevant and contextual to the lives of all young people, including drug use and relationships issues. • Interactive, scenario/story based, and hands-on activities • Use of peers within the learning model. • A positive approach to sexuality and relationships that is supportive of diverse sexualities and experiences. • Confidential and anonymous options.

Table 3: Overview of study questions and findings

7. Recommendations

The following recommendations are presented in the context of a broader health promoting schools and community partnerships approach, and a commitment to youth friendly and relevant educational processes to support and enhance the sexual health of young people.

Peer networks, friends and locations

- Improve awareness of, access to and use of effective peer based education models by:
    - increasing schools' access to professional development and resources for the teaching of sexual health and relationships;
    - facilitating peer education strategies; and
    - enhancing the capacity of non-government youth services to promote greater awareness of programs and resources.
- Invest in research to:
- determine the effectiveness and value of peer based initiatives to influence young people in informal and out of school settings; and
- monitor the development of peer influence through new media and technologies such as the Internet.

Youth friendly and credible sexual health educators

- Ensure training and policy development for schools and agencies in utilising resources that:
    - reiterate the importance of establishing a safe educational environment;
    - promote a youth friendly approach to sexual health education that includes trust and confidentiality;
    - lead to relevant and credible discussions with young people about their experiences and equip young people with socially relevant skills;
    - promote young people's trust with the school or agency as a whole and not just with individual staff; and
    - support the building of partnerships between schools and youth health services in the facilitation of sexual health education and building relationships between young people and the services available to them, in and out of school.

The graduated approach to sexual health education in schools

- Ensure comprehensive education and skills development in the prevention of STIs and pregnancy throughout high school.
- Consolidate and improve ongoing training, development and support to ensure teachers are implementing comprehensive and age appropriate sexual health education confidently throughout all years of schooling.

School settings for sexual health education

- Ensure sexual health education is identified as a core component of school health promotion obligations.
- Continue and enhance support for professional development of teachers in the implementation of effective, evidence based, interactive and a youth friendly sexual health and relationships curriculum and health promotion approaches.
- Prioritise school policy processes that:
  - support the implementation of sexual health curriculum;
  - promote acceptance and support diverse sexualities at a curriculum, policy and school community level; and
  - encourage collaborations and partnerships with youth health services in the school's community.
- Ensure resources are allocated to support the continued development and evaluation of youth centred sexual health education models that include dialogue, multimedia, and interactive and participatory approaches.

Post or outside of school education

- Continue to enhance support for professional development of youth services staff in the implementation of effective, evidence based, interactive and youth friendly sexual health and relationship programs and services.
- Ensure youth friendly pamphlets about sexual health and relationships are more widely accessible in the community and schools.
- Provide increased resources to evaluate the effectiveness of different modes of outreach programs and services targeting out of school or marginalised young people.
- Continue to support and develop effective outreach/mobile health clinics and mobile support services for young people staffed with medical professionals, trained sexual health educators and youth workers.

- Support the collaboration between relevant Divisions of General Practice (locally based associations of general practitioner doctors), youth health services and school health programs to improve youth friendly and sexuality sensitive training for GPs and clinicians and increase awareness of youth support services.

Family learning and influence

- Provide increased resources for developing effective and achievable ways to engage parents and increase their capacity to support comprehensive sexual health education within a Health Promoting Schools Framework.
- Promote and support programs that enhance the skills and knowledge of parents and family members to support in school and out of school sexual health programs.

Media and the Internet

- Ensure teachers are appropriately trained and resourced to use popular culture and media materials as educational resources for sexual health.
- Support curriculum that increases young people's skills in assessing accuracy and quality of information and images presented in the media, including the Internet.
- Support the development of sexual health guidelines to support youth magazines and youth websites to contribute to effective sexual health promotion.
- Support Internet monitoring software that, while barring pornographic websites, does not bar accurate, educationally sound websites about sexual health.

Rites of passage events, parties, and alcohol

- Support education workshops about alcohol, drug or sexual risk behaviour that include interactive activities and scenarios based around significant cultural events in young people's lives and the full social context and pressures that surround these events.
- Include context and relationship issues within alcohol, drug and sexual health education such as: assertiveness; planning healthy behaviour; relationship conflict; sexual assault and consent; social and peer influence; and looking after and supporting peers.
- Support training and resources for teachers and youth services to assist young people to develop socially relevant decision making skills, particularly in the context of celebrations with alcohol or drug use.
- Support further research into the role of significant times of transition and rites of passage and its association with risk behaviour including sexual behaviour.
- Support the development and evaluation of outreach initiatives to young people during major celebrations to determine their effectiveness and complementary role to within school programs.

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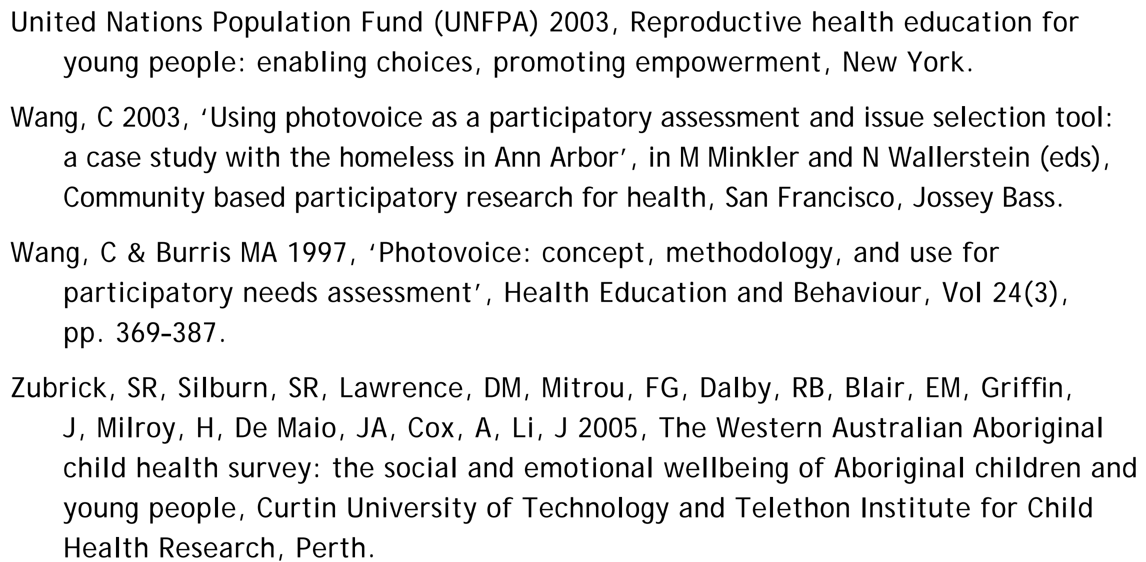

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Appendix 1: Consultation workshop design

Question	Activity	Materials	Data collection
Introductory activities at the start of the workshop will aim to create a sense of trust, warm up the body and will include the World Health Organisation's definitions of 'sexuality' and 'sexual health'.			
1. Where and how did you get your education about sexual health?	Look at pictures on the floor, stand near a picture of a person, place or thing	photovoice pictures	Note-taking, digital recording and transcription.
2. Who do you think are the most authoritative and effective sources of sexual health education and information?	Look at pictures on the floor, stand near a picture of person, place or thing	photovoice pictures	Note-taking, digital recording and transcription.
3. Who would you prefer to teach you or inform you about sexual health?	Discussion		Digital recording and transcription
4. When is the best time to start receiving information about sexual health?	Create physical time line	Age indicators from 11-17 years	Note-taking and photography

Question	Activity	Materials	Data collection
5.) When is the best time to receive information about specific sexual health issues such as puberty, masturbation, same-sex attraction, conflict in relationships, etc?	Create physical time line	Age indicators from 11-17years	Note-taking and photography
6.) Where is the best place to receive sexual health education?	Discussion		Digital recording and transcription
7.) What should sexual health education look like?	In small groups create tableau using props and costumes	Assortment of props and costumes to suggest different roles and different settings	Photography and note-taking
8.) How would you prefer sexual health education to be delivered?	Discussion		Digital recording and transcription
Closing activities will include summary of discussions and distribution of information sheet that includes support services young people can access for sexual health support.			

Notes