



RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

From the President

31 August 2018

Committee Secretary
Health, Communities, Disability Services and
Domestic and Family Violence Prevention Committee
Parliament House
George Street
BRISBANE QLD 4000

Via Email: health@parliament.qld.gov.au

Dear Committee Secretary

Re: Termination of Pregnancy Bill 2018

The Royal Australasian College of Physicians (RACP) thanks the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) for the opportunity to provide input into the Termination of Pregnancy Bill 2018 (the Bill).

The relatively short timeframe for this consultation precludes the RACP's ability to undertake the appropriate internal consultation and develop a more detailed response. Instead, we have enclosed for the Committee's consideration, our previous submission to the Review of termination of pregnancy laws in Queensland and the RACP position statement titled *Sexual and Reproductive Health Care for Young People*, which outline our position with respect to termination of pregnancy.

In essence, the RACP supports uniform access to safe, legal, accessible and affordable abortion services with both medical and surgical options for women who do not choose to continue their pregnancy. This translates to our support for moves to reform the law to decriminalise and regulate abortion in Queensland, particularly the removal of Sections 224, 225 and 226 from the Criminal Code. However, we note that some medical practitioners are opposed to this on conscientious grounds.

The Bill is of high importance to our Fellows who perform surgical or medical terminations, particularly in the case of late pregnancy. The current state abortion law is unclear and confusing, putting medical practitioners at risk of seven to 14 years imprisonment for procuring an abortion. The RACP emphasises that such matters of high public and professional importance require meaningful consultation and adequate time for developing a response, rather than simply ticking the box.

The RACP would welcome the opportunity to provide more detailed feedback to the Committee at the public hearing. Should you require any further information regarding this response, please contact Bella Wang, Policy Officer at [REDACTED] or on + [REDACTED]

Yours sincerely

A handwritten signature in black ink, appearing to read 'Mark Lane', written over a light blue horizontal line.

Associate Professor Mark Lane

Enc: RACP submission to the review of termination of pregnancy laws in Queensland
RACP Position Statement: Sexual and Reproductive Health Care for Young People
(2015)



RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

From the President

9 February 2018

Mr David Groth
Commission Director
Queensland Law Reform Commission
PO Box 13312
George Street Post Shop
Brisbane QLD 4003

Via Email [REDACTED]

Dear Mr Groth

Re: Review of termination of pregnancy laws in Queensland

Thank you for inviting The Royal Australasian College of Physicians (RACP) to provide feedback on the Queensland Law Reform Commission's (the Commission) consultation paper on the review of termination of pregnancy laws in Queensland.

The RACP is supportive of moves to reform the law to decriminalise and regulate abortion in Queensland and particularly the removal of Sections 224, 225 and 226 from the Criminal Code. This position is based upon the fact that the RACP supports uniform access to abortion services for women who do not choose to continue their pregnancy and upon evidence that criminalizing abortion does not decrease abortion but simply increases unsafe practices and the burdens of ill-health experienced by women and children in Australia and internationally.

Furthermore, the RACP believes that access to abortion services should not be open only to women whose pregnancy lies within a specified gestational range, as this may discriminate against women who experience medical illnesses that are only manifest in late gestation, who are in the most difficult of clinical circumstances and/or who lack access to maternal healthcare services. In this regard it is worthy of note that the RACP supports the availability of late term abortions when both the clinicians caring for the patient and the patient believe it to be the most appropriate decision – a position that aligns with The Royal Australian and New Zealand College of Obstetricians and Gynaecologists' (RANZCOG) *Termination of Pregnancy Statement*.¹ In addition, the RACP is also supportive of proposals to reform the

¹ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Termination of Pregnancy Statement*. First developed in March 2005, reviewed in July 2016. Available online: [REDACTED]

law to establish safe access zones prohibiting harassment and intimidation around hospitals and clinics that provide abortion services, as is already the case in Victoria and the ACT.

The RACP is not, however, able to provide a detailed submission to this consultation given the short timeline provided for a response. This is highly regrettable as abortion law reform has been the focus of intense public and professional debate in Australia and, as the experience in the ACT, Victoria and Queensland over the last decade has demonstrated, such reform only succeeds where there is adequate community and professional consultation.

Nevertheless, we have included below the RACP's high level position regarding termination of pregnancy as outlined in the RACP position statement titled *Sexual and Reproductive Health Care for Young People*, a copy of which is enclosed with this letter:

- Termination of pregnancy is a safe procedure for which major complications and mortality are rare whilst the evidence shows that the non-availability of termination of pregnancy services increases maternal morbidity and mortality.
- **The RACP supports uniform access to safe, legal, accessible and affordable abortion services with both medical and surgical options for women who do not choose to continue their pregnancy.**
- Women who opt for termination should be afforded confidentiality, pre- and post-termination counselling and advice on ongoing contraception, when required. These are essential components of care.
- The RACP acknowledges that some medical practitioners have a conscientious objection to termination of pregnancy. In line with guidance from the Medical Board of Australia and the Australian Medical Association, the RACP agrees that personal beliefs should not impede patient access to treatments that are legal and referrals to alternative health professionals should be provided where required.

Should you require any further information about this matter, please contact Ms Claire Celia, Senior Policy Officer, on [REDACTED]

Yours sincerely

Dr Catherine Yelland PSM

Enc: RACP Position Statement: Sexual and Reproductive Health Care for Young People, 2015



The Royal Australasian
College of Physicians

Sexual and Reproductive Health Care for Young People

POSITION STATEMENT

NOVEMBER 2015

145 Macquarie Street, Sydney NSW 2000, Australia

1 300 MY RACP (1 300 69 7227 Australia) (0508 69 7227 New Zealand)

raccp@raccp.edu.au

“Children’s right to health contains a set of freedoms and entitlements. The freedoms, which are of increasing importance in accordance with growing capacity and maturity, include the right to control one’s health and body, including sexual and reproductive freedom to make responsible choices about their sexual and reproductive health. The entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.”¹

United Nations Convention on the Rights of the Child – Committee on the Rights of the Child

“**Sexual health** is a state of physical, mental and social wellbeing in relation to sexuality across the lifespan that involves physical, emotional, mental, social and spiritual dimensions. Sexual health is an inextricable element of human health and is based on a positive, equitable and respectful approach to sexuality, relationships and reproduction that is free of coercion, fear, discrimination, stigma, shame and violence. It includes the ability to understand the benefits, risks and responsibilities of sexual behaviour; the prevention of disease and other adverse outcomes; and the possibility of fulfilling sexual relationships. Sexual health is impacted by socioeconomic and cultural contexts – including policies, practices and services – that support health outcomes for individuals and communities.”²

World Health Organisation

“**Reproductive health** addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.”³

World Health Organisation – Global Policy Committee

ACKNOWLEDGEMENTS

The RACP would like to acknowledge the members of the Position Statement Working Party:

Dr Sarah Martin (Chair)
Associate Professor Rachel Skinner
Dr Bridget Farrant
Dr Andre Schultz
Dr Phil Bergman
Dr Adelaide Withers
Mr Alex Lynch

Suggested citation:

The Royal Australasian College of Physicians 2015. Position Statement: Sexual and Reproductive Health Care for Young People.

CONTENTS

1	INTRODUCTION	5
2	RECOMMENDATIONS	6
2.1	Governments.....	6
2.2	Health professionals and health services	7
2.3	Policy and legislative change	7
3	YOUNG PEOPLE, SEXUALITY, SEX AND RELATIONSHIPS	9
4	SEXUALITY AND RELATIONSHIPS EDUCATION	10
5	YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH CARE	12
5.1	Confidentiality.....	13
5.2	Competence and consent to health care	14
5.3	Young people in rural and remote areas.....	14
6	STI, HIV AND VIRAL HEPATITIS	16
6.1	STI.....	16
6.2	HIV infection	16
6.3	Viral hepatitis.....	17
6.4	STI, HIV and viral hepatitis screening for young people	17
6.5	A public health approach to prevention of STI, HIV and viral hepatitis.....	18
7	CONTRACEPTION, TERMINATION AND TEENAGE PREGNANCY CARE	19
7.1	Contraceptive care	19
7.2	Expanding access to long-acting reversible contraception.....	20
7.3	Ensuring access to emergency contraception	20
7.4	Termination of pregnancy	20
7.5	Teenage pregnancy care	21
8	SEXUAL ABUSE, SEXUAL ASSAULT AND INTIMATE PARTNER VIOLENCE	22
9	SEXUAL AND REPRODUCTIVE HEALTH CARE FOR INDIGENOUS YOUNG PEOPLE	23
9.1	Māori young people.....	23
9.2	Aboriginal and Torres Strait Islander young people.....	23
10	YOUNG PEOPLE WHO ARE SAME-SEX ATTRACTED OR GENDER DIVERSE, AND YOUNG PEOPLE WITH INTERSEX VARIATIONS	25
10.1	Same-sex attracted young men	26
10.2	Same-sex attracted young women	26
10.3	Gender diverse young people	27
10.4	Young people with intersex variations	28
11	YOUNG PEOPLE WITH DISABILITIES AND LONG-TERM HEALTH CONDITIONS	30
11.1	Young people with intellectual disability.....	30
11.2	Young people with long-term health conditions	31
11.3	Young people with physical disabilities.....	31
12	CONCLUSION	33
13	GLOSSARY	34
14	REFERENCES	35

1 INTRODUCTION

This position paper addresses the importance of sexuality and relationships education and sexual and reproductive health care for young people (adolescents and young adults between 12 and 24 years of age) in Australia and New Zealand.

Adolescence and young adulthood are periods of life during which a young person moves through puberty, explores meanings of intimacy and establishes a sense of sexual identity. Young people have the right to age and developmentally appropriate pleasurable and safe sexual experiences, which may include solitary and partnered sexual activities; they also have the right to control their own fertility.⁴

Young people often require support to navigate the physical, emotional and social changes that underpin sexual and reproductive wellbeing. They have the right to information, education and clinical care that supports healthy sexual development and informed choices, and minimises the risk of coercion, unplanned pregnancy, sexually transmitted infection and other unwanted or unintended consequences, including emotional, psychological, social and cultural consequences.

Despite the generally good health enjoyed by young people in Australia and New Zealand, rates of sexually transmitted infection, teenage parenthood, homophobic and transphobic abuse and bullying, and domestic and sexual violence remain significant concerns. Indigenous youth in Australia and New Zealand experience particular inequities in health status, determinants of health and access to health care.⁵ Young people with long-term health conditions or physical or intellectual disability, or who are same-sex attracted or gender diverse, or marginalised due to socioeconomic or cultural factors may require tailored sexual and reproductive health care.

Sexual and reproductive health care for young people is delivered in a range of settings including primary care, community and hospital-based adolescent and young adult health services, community controlled Aboriginal Health Services, Māori health services, sexual health centres and family planning clinics, school-based services and justice health services. Optimal care is culturally, age and developmentally appropriate and delivered from a youth-friendly perspective.

Effective sexual and reproductive health care for young people requires a willingness to ask sensitive questions and provide accurate information. Health professionals are uniquely placed to develop trust with young people, establish meaningful relationships with them and have a positive influence on their health behaviours.⁶ This includes fostering resilience and acknowledging protective factors: individual characteristics, social engagement, healthy beliefs and clear standards for behaviour.⁷

In developing our recommendations, we have reviewed relevant literature, examined key issues, and maintained a focus on young people's voices, their rights, the provision of health education and their interactions with health professionals.

2 RECOMMENDATIONS

The Royal Australasian College of Physicians (RACP) makes the following recommendations.

2.1 Governments

The New Zealand, Australian, State and Territory Governments should ensure:

- Young people have access to the services and knowledge needed to optimise their sexual and reproductive health, and to prevent sexually transmissible infections (STI) and blood-borne viruses (BBV), unplanned/unsupported pregnancy and experiences of sexual violence.
- Access to sexual and reproductive health care for young people is physically and financially feasible, with options for free health care.
- All health professionals providing sexual and reproductive health care to young people have access to appropriate training.
- The needs and perspectives of young people relating to sexuality and relationships education, and sexual and reproductive health care are included in planning, service delivery and guideline development.

Governments should address sexuality and relationships education curricula and health promotion to ensure:

- Sexuality and relationships education is received by all young people, is age and developmentally appropriate and focuses on both sexuality and relationships.
- Curricula are accurate and evidence-based, and delivered by trained and supported personnel, including teachers, school nurses and other health professionals.
- Curricula address respectful relationships (including negotiating positive and respectful relationships and respecting and valuing diversity), sexual and reproductive health, intimate relationships (including gendered power relationships), access to health services, and harm minimisation.

Governments need to continue and expand research into the sexual health needs of young people in relation to:

- The context in which young people negotiate and manage their sexual and reproductive health needs, including the roles of families, schools, peers, social media and health professionals,
- Young people's understanding of the concept of consent.
- Integration of sexual and reproductive health care with other health and supportive care for young people coping with concurrent issues.
- A specific focus on sub-populations including young people of varying sexual orientation, gender identity or intersex variation, and young people with long-term conditions.
- A specific focus on Aboriginal and Torres Strait Islander and Māori young people.
- Enhanced surveillance of STI, including those that are vaccine preventable; unplanned/unsupported pregnancy and its outcomes, patterns of alcohol and other drug use; interpersonal violence; and the management of chronic viral hepatitis and human immunodeficiency virus (HIV).

- The identification of gaps in service delivery across urban, regional and rural Australia and New Zealand.

2.2 *Health professionals and health services*

Health professionals and health services should:

- Recognise that young people have rights to confidential, non-judgemental sexual and reproductive health care, and should:
 - understand their obligations relating to confidentiality, informed consent to health care, child protection and mandatory reporting in their jurisdiction
 - provide clear information to young people on confidentiality and exceptions in accordance with professional practice standards.
- Ensure specific services are available for young people who may face increased discrimination or vulnerability. These include but are not limited to:
 - young people who experience sexual abuse, sexual assault and/or intimate partner violence
 - young people who are same-sex attracted or gender diverse, or live with intersex variation
 - young people with long-term health conditions and physical and/or intellectual disability.
- Provide written policies on confidentiality that are visible to and readily available for young people and their parents or carers.
- Encourage young people to include their parents or carers in their health care decisions, where appropriate.
- Provide coordinated, integrated care that is culturally, age and developmentally appropriate.
- Provide care that follows current Australian or New Zealand clinical guidelines regarding psychosocial screening, immunisation, sexual history taking, prevention, screening and management of STI and BBV, contraceptive advice, cervical screening, pregnancy and unplanned/unsupported pregnancy.
- Recognise the right to a balanced discussion about the options for continuing a pregnancy, adoption, and medical or surgical termination within the legal frameworks of each jurisdiction.

2.3 *Policy and legislative change*

Governments and health professionals are asked to collaborate to:

- Advance multidisciplinary approaches to young people's sexual and reproductive health care.
- Address the significant disparities in sexual health between Indigenous and non-Indigenous populations.
- Review and address barriers to treatment access for young people with gender dysphoria, including gaps in clinician training and clinical service provision, costs of treatment and legislative frameworks.
- Ensure uniform access to safe, legal, accessible and affordable options for medical and surgical terminations of pregnancy.

- Increase efforts to reduce sexual abuse, sexual assault and intimate partner violence experienced by young people.
- Continue investment in comprehensive multidisciplinary support for teenage parents before, during and after pregnancy.

3 YOUNG PEOPLE, SEXUALITY, SEX AND RELATIONSHIPS

We are fortunate to have good data to guide insights into the needs of young people in Australia and New Zealand as they move through puberty, begin to explore meanings of intimacy and consider sexual and gender identity.^{8 9 10 11}

In 2013, the *Fifth National Survey of Secondary Students and Sexual Health* surveyed 2,136 senior students from government, Catholic and independent schools across every jurisdiction in Australia. Forty-two per cent of participating young people were in Year 10, 30 per cent in Year 11 and 27 per cent in Year 12.¹² In Australia, almost one-quarter of Year 10, one-third of Year 11 and half of Year 12 students had had sexual intercourse, and most sexually active students reported positive feelings after having sex. Many of those who had not had sex reported feeling not ready, proud to say no and mean it, and that it was important to be in love the first time they had sex. Almost one in four young people reported an experience of unwanted sex.¹³ Use of social media, including sexually explicit text messages, was common and not limited to those who were already sexually active.¹⁴

Knowledge about STI and HIV varied, as did use of both condoms and contraception, with less than two-thirds (59 per cent) of students who had had either vaginal or anal sex reporting using a condom the last time they had sex. Higher levels of condom use (86 per cent) were reported by students who said a condom was available last time they had sex, suggesting the need to continue to improve condom access amongst young people.

Whilst the majority of students in Australian schools were attracted only to the opposite sex, 8 per cent of young men and 4 per cent of young women reported sole same-sex attraction and slightly fewer young men (4 per cent) and more young women (15 per cent) were attracted to people of both sexes. One in eight sexually active young men reported their most recent sexual encounter was with a same-sex partner, underscoring the need to address safe sex in same-sex relationships within school curricula.

In New Zealand, the *Youth'12* survey invited the views of 8,500 young people aged 12–18 years.¹⁵ From this survey, older students were more likely to have had sex and be currently sexually active. Fifty-eight per cent of sexually active students reported using contraception and 46 per cent reported using condoms all of the time. Most students reported they were exclusively heterosexual, four per cent reported they were same or both sex attracted, and four per cent indicated they were not sure. One per cent reported that they were transgender.

Many of these issues are explored further in later sections of this position statement which starts from the premise that sex, sexuality and gender identity matter to young people, whether they are sexually active or not, and that schools, parents, peers, and community and health professionals all have a contribution to make to the wellbeing of young people as they start to explore sex and intimate relationships.

4 SEXUALITY AND RELATIONSHIPS EDUCATION

Knowledge about sexuality and relationships is essential to support young people to make appropriate and healthy relationship choices and access sexual and reproductive health care.

The RACP believes that all young people should receive age and developmentally appropriate sexual health education that focuses on both sexuality and relationships and is of high quality, scientifically accurate and delivered by properly trained and supported personnel, including teachers, school nurses and other health professionals.¹⁶

Sexuality and relationships education helps young people understand and manage the physical, social and emotional adjustments of adolescence. It helps manage changes to sexual and gender identity, fosters understanding of sexual and reproductive health and health care, and encourages skills that equip young people to manage intimate relationships through promotion of mental health issues, safety, assertive behaviour, managing risk taking in relation to drug use, and respectful relationships.¹⁷

Non-directive sexuality and relationships education encourages adolescents to consider delaying sexual activity and provides accurate, helpful information about physical and emotional safety, contraceptive choices and prevention of STI. In this way, it both supports teenagers to delay sexual activity and allows those who are sexually active to actively consider how to have sex as safely as possible.^{18 19}

Effective school-based sexuality and relationships education programs empower young people by providing them with practical skills that focus on communication and negotiation,²⁰ assertiveness and effective rejection of unwanted sexual advances.²¹ Successful programs often educate through role playing or interactive discussion and promote emotional competence, self-determination and social bonding.^{22 23 24 25}

Sexuality and relationships education is part of the Health and Physical Education curriculum in Australian schools, and revisits key areas as students mature and their ability to understand more complex concepts increases. The 2014 *Review of the Australian Curriculum* was generally supportive of the Health and Physical Education curriculum, but noted the need for greater resource support for teachers.²⁶ At the same time, 50 per cent of young people surveyed in 2013 expressed significant dissatisfaction with sex education in schools, citing irrelevance to their real experiences, lack of relationship advice and lack of discussion of same-sex issues as problems with the education they received.²⁷

There are similar provisions for sexuality and relationships education in New Zealand.²⁸ However, a recent government review noted high rates of STI, unplanned teenage pregnancy and termination of pregnancy, and recommended the development of a coordinated cross-sectoral action plan for providing best-practice, evidence-based sexuality and reproductive health education in all schools.²⁹

Schools, parents and health care professionals can contribute to sexuality education in different, but synergistic, ways.³⁰ Collaboration between teaching staff and health professionals needs to be encouraged so that they share updated information on issues such as hepatitis-related risks associated with body art, new choices in contraception and the latest research on adolescent sex and relationships. Collaboration would also support networking and enhance local-level referral pathways

so that young people know where to access informed, non-judgmental and youth-friendly sexual health services.³¹

Young people benefit from support, guidance, caring and monitoring from responsible adults.^{32 33} Connectedness to trusted family or adults in a position of influence is an important factor in reducing adolescent sexual risk-taking as well as supporting early recognition if sexual risk taking becomes a mode of self-harm.³⁴ Health professionals can offer encouragement for parents to discuss sexuality, contraception and ways in which alcohol and substance use can impact upon decision making, at an appropriate level for the young person's developmental stage, to support reciprocal and honest dialogue between parents and young people.³⁵

Health professionals are well placed to recognise young people at higher risk of early age sexual activity to support timeliness of education.³⁶

Sexuality and relationships education offered by health-care professionals as an integral part of a young person's health care complements education that young people obtain at school and at home. Health professionals who take a sexual history, for example as part of a HEEADSSS (Home and environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression and safety from injury and violence) psychosocial risk assessment, can identify a young person's level of knowledge and health care needs, provide tailored education, and facilitate access to sexual and reproductive health care.^{37 38 39 40}

5 YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH CARE

Youth-friendly sexual and reproductive health care acknowledges a young person's right to pleasurable and safe sexual experiences, free of coercion, discrimination and violence. The transition to becoming a sexually active adult can be emotionally complex. Clinicians need skills training to assist young people to overcome barriers to discussing sexual and reproductive health care needs, whether in specialist medical services, community health settings or primary care.

Services need to be both physically and financially accessible and maintain a focus on providing appropriate care for all young people including higher risk populations. In Australia, adolescents are able to apply for an individual Medicare card from the age of 15 years, and in New Zealand, young people can enrol themselves in a GP practice at 16. This presents a potential barrier to access to medical advice for young people under the age of 15 or 16 years.

“Caring for children and young people brings additional responsibilities for doctors. Good medical practice involves:

- *Placing the interests and wellbeing of the child or young person first*
- *Ensuring that you consider young people's capacity for decision-making and consent*
- *Ensuring that, when communicating with a child or young person, you:*
 - *treat them with respect and listen to their views*
 - *encourage questions and answer their questions to the best of your ability*
 - *provide information in a way that they can understand*
 - *recognise the role of parents or guardians and when appropriate encourage the young person to involve their parents or guardians in decisions about their care*
- *Being alert to children and young people who may be at risk, and notifying appropriate authorities, as required by law.”*

Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. March 2014.

Young people value health professionals who listen, are easy to talk to, are friendly and provide non-judgemental care in a culturally, age and developmentally appropriate manner.⁴¹ Sometimes longer follow-up consultations will be necessary to fully consider a young person's needs. It is important to explore both risk and protective factors for healthy sexual relationships including the impact of alcohol and other drug use on decision-making in relation to sex and relationships. The HEEADSSS assessment continues to be an effective tool to guide risk assessment.^{42 43} A tailored sexual history, including reproductive health, same-sex attraction, and inquiry about intimate partner violence and past sexual abuse, should be the basis for screening, diagnosis and preventive care.

Youth-friendly sexual and reproductive health care services ideally include young people in service planning, delivery and evaluation.

5.1 Confidentiality

Concerns about confidentiality when a young person seeks health care impact both young people and their clinicians. Adolescent concerns about confidentiality can act as a key barrier to health-care access, especially sexual health care.^{44 45 46 47} Fear that a parent may be informed may prevent, delay or interrupt access to information and discussion about protective and preventive health behaviours, contraception, testing and treatment.

It is important to provide clear information on confidentiality. Young people may not be aware that confidentiality is an ethical and legal right for adolescents who are competent to understand their condition and make decisions about their treatment. Adolescents are generally more likely to talk with clinicians about their sexual health needs if they are confident it will not be relayed to their parents without their permission.⁴⁸

“When working with patients under 16 years, you should determine their competence to understand their condition and make decisions about their treatment. If they are competent, they are entitled to confidentiality. In the absence of a concern that the young person is at risk of harm, you should only share information with parents and caregivers with the patient’s consent.”

Medical Council of New Zealand. *Good Medical Practice*, April 2013.

The right to confidentiality is not absolute – exceptions in relation to likelihood of harm to self or others apply to all patients whether adolescent or adult. In caring for young people, health professionals also need to be aware of mandatory reporting responsibilities and legislation in relation to age of consent to sexual activity in their jurisdiction.^{49 50} When mandatory reporting applies, or when advice on the need to report is sought, the overriding concern must be safeguarding the young person, and disclosures to authorities should not be more extensive than is necessary.⁵¹ It is important to identify and affirm protective behaviours that the young person demonstrates, such as actively and appropriately seeking health care and to explore other forms of support such as caring adults whom they know in their community and can access if they are at risk. Wherever possible, a young person should be informed of the reasons for reporting and offered reassurance and encouragement to continue to engage in medical care.

When a young person presents with a parent or carer, it is still important to provide the opportunity for the young person to consult privately for at least part of the consultation.⁵² This can be challenging: in the New Zealand *Youth’12* survey, only 37 per cent of high school students who had accessed health care over the previous 12 months reported having the chance to talk in private. Failure to facilitate privacy may mean a young person is not able to disclose information that is key to accurate diagnosis and/or management.⁵³ Clinicians can still encourage appropriate sharing of information with parents and carers, and there are often benefits in doing so, provided the young person agrees to their involvement.

If a young person decides to disclose issues relating to sexual and reproductive care to their parents, health professionals can play an important role in assisting parents to recognise and respect those needs so that a young person can benefit from their ongoing support.

5.2 Competence and consent to health care

In Australia, anyone over the age of 18 years is deemed competent to make decisions about their medical treatment. Under Common Law, young people under the age of 18 are able to give informed consent to medical care if the health care professional deems them competent, bearing in mind the nature of the treatment and the ability of the young person to understand the treatment. Competence to make medical decisions is primarily a clinical decision, which is based on the adolescent's stage of development and their ability to understand what is being proposed (the mature minor principle).⁵⁴ The level of maturity required to provide consent will vary with the nature and complexity of the medical treatment.

When a young person is 14 years or under, in most instances consent from a parent or guardian is also sought unless the young person objects. In New South Wales and South Australia, additional statutory laws apply; health professionals need to be mindful of legal requirements for consent in their jurisdictions.⁵⁵

In New Zealand, under the Care of Children Act 2004, young people over the age of 16 are regarded as adults for the purposes of determining competence to give informed consent to health care. Young people under the age of 16 are not automatically prohibited from consenting to medical procedures, and judgment is needed to determine competence in each instance. Generally, a competent adolescent is one who is able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment.⁵⁶ The Contraception, Sterilisation and Abortion Act 1977 allows people aged under 16 years to consent to and be given contraceptive information, services and prescriptions.⁵⁷

Health professionals should have a willingness to assess a young person's competence to consent to treatment and to recognise that this may evolve rapidly during adolescence. A young person's capacity to consent to treatment does not preclude encouraging adolescents to include their parents in their health care decisions.

5.3 Young people in rural and remote areas

Young people's access to health services is linked to a number of variables including geography, socioeconomic status, gender and health education.⁵⁸ Distance, expense, service scarcity and a smaller workforce all impact access. In rural and remote areas of Australia and New Zealand, accessing sexual and reproductive health services may be especially difficult.⁵⁹

Difficulties accessing a range of contraceptive options may contribute to relatively high numbers of teenage births in rural communities.^{60 61} Confidentiality concerns (real or perceived) brought about by smaller communities and fewer health professionals also impact access to care.^{62 63}

Referral by health professionals to specific sexual health services is amongst the more successful options available for young people living in rural and remote areas.⁶⁴ Access can also be improved through the use of school-based services, particularly for reducing unplanned pregnancies, and the

willingness of clinicians to provide confidential care in a sensitive way that recognises constraints within small communities.^{65 66}

It is important to promote research into sexual health services in rural and regional areas to establish which programs are most effective, including the role of school nurses, local GPs and practice nurses.⁶⁷

6 STI, HIV AND VIRAL HEPATITIS

Young people are recognised as a priority population in Australia's *Third National Sexually Transmissible Infections Strategy 2014–2017*.⁶⁸ A young person may be at increased risk of STI due to a variety of sociocultural factors including length of time between first becoming sexually active and establishing a long-term partnership, low rates of sustained condom use and variable access or uptake of health services.⁶⁹ For Australian men and women, first sex before the age of 16 years is significantly associated with a greater number of lifetime and recent sexual partners, and a greater likelihood of having had an STI.⁷⁰ Although some form of sexual activity is common in over two-thirds of Australian school students in Years 10, 11 and 12, STI knowledge in these groups remains poor.⁷¹

6.1 STI

After a decade of steady increases in both testing and diagnoses of chlamydia, there has been a levelling off in the number of diagnoses, and even a small decline in the youngest age group. However, chlamydia continues to be the most frequently reported notifiable condition in Australia with 86,136 diagnoses in 2014. Young people continue to be disproportionately affected: 21 per cent of diagnoses were in young people aged 15–19 years, and 57 per cent in those aged 20–29 years. Diagnoses in young women exceed those in young men in every age group. As chlamydia is often asymptomatic, it is essential to routinely offer testing to adolescents and young adults.⁷²

Gonorrhoea and syphilis notifications continue to increase. Gonorrhoea and syphilis are infections primarily of gay men of all ages in urban settings and young heterosexual Aboriginal men and women in remote communities. Young people at risk continue to need tailored prevention interventions and access to testing and treatment.⁷³

The most notable success in STI prevention has been the reduction in human papilloma virus (HPV) infections and associated diseases through school-based immunisation programs. In Australia, this program started in 2007 with vaccination for girls, with a two-year catch up program for young women, and was extended to boys in 2013. Vaccine coverage rates are high at nearly 75 per cent for both girls and boys in 2014. HPV vaccination has resulted in the proportion of young women in Australia aged 21 years or younger diagnosed with genital warts at their first visit to a sexual health centre decreasing from 11.4 per cent in 2007 to 1.1 per cent in 2014.^{74 75} In addition, there have been significant reductions in high-grade cervical intra-epithelial lesions among young women presenting for cervical screening.⁷⁶

In New Zealand, HPV immunisation is available free of charge to all girls and women up to their 20th birthday.⁷⁷ Despite convincing evidence of effectiveness, misperceptions of utility persist, and uptake continues to be low and uneven, with higher uptake in higher socioeconomic groups.^{78 79}

6.2 HIV infection

An estimated 27,150 people in Australia are living with HIV including 1,081 men and women who were newly-diagnosed in 2014.⁸⁰ Sexual contact between men continues to account for over two-thirds of all new HIV diagnoses and the majority of recently acquired infections. In recent years, young men who have sex with men (MSM) have been particularly at risk, with increases in notifications in those aged 20–24 years.⁸¹

The per capita rate of HIV diagnosis in the Aboriginal and Torres Strait Islander population has been similar to that in the Australian-born non-Indigenous population until recently when the Aboriginal and Torres Strait Islander population has had a higher infection rate than the non-Indigenous population (5.9 vs 3.7 per 100,000 in 2014), emphasising the need for a strengthened focus on prevention. There are also important differences in demographics. A substantially greater proportion of HIV infections in Indigenous Australians are attributed to injecting drug use (16 per cent compared with 3 per cent) and heterosexual contact (20 per cent compared with 13 per cent) with women also disproportionately affected (20 per cent compared to 5 per cent).⁸²

In 2014, the first ever Aboriginal and Torres Strait Islander HIV Awareness Week was held, following the launch of the *Eora Action Plan* for HIV.⁸³ The *Eora Action Plan* voices the concerns of Aboriginal and Torres Strait Islander peoples about HIV and its potential impact on communities, and seeks to bring greater attention and efforts to the prevention of HIV, including best clinical care and management of Aboriginal and Torres Strait Islander peoples living with HIV.

HIV prevention in Australia has been and must remain multifaceted. It is important to maintain a focus on testing, treatment and risk reduction that is tailored to risk groups and includes consideration of the specific strengths and vulnerabilities of young people most at risk of HIV acquisition.

6.3 *Viral hepatitis*

An estimated 213,300 people in Australia are living with hepatitis B virus (HBV). In 2014 there were 6,635 people newly-diagnosed with HBV, of which 26 per cent were under the age of 29 years, including 168 diagnoses in adolescents aged 15-19 years.⁸⁴ Evidence is emerging that hepatitis B immunisations programs are beginning to have an impact, with declining rates of new infection, most particularly in younger age groups with the highest rates of vaccine coverage.

An estimated 230,000 people in Australia are living with chronic hepatitis C (HCV) infection. In 2014 there were 10,621 people newly-diagnosed with HCV, of which 20 per cent were under the age of 29 years, with 226 diagnoses in adolescents aged 15-19 years.⁸⁵

As with HIV, data on hepatitis infections underscores the need for clinicians working with young people to be able to identify those at risk and provide prevention, access to harm minimisation strategies and appropriate screening.⁸⁶ Similarly, youth-friendly health care that supports young people to optimise monitoring, treatment uptake and long-term continuation of treatment, or in the case of hepatitis C treatment completion, is crucial.

6.4 *STI, HIV and viral hepatitis screening for young people*

At an individual level, empowering young people to make healthy choices about sex and relationships, with encouragement of both consistent condom use and regular sexual health check-ups are the most effective interventions to reduce STI.⁸⁷

Australian STI Management Guidelines 2014 provide detailed guidance on STI screening and management, including specific guidance for the care of young people.⁸⁸ Young men who have sex with men need additional guideline-based screening and support with HIV prevention. Offering STI screening during non-sexual health-related consultations is acceptable to young people and may increase diagnosis of asymptomatic STI.^{89 90} Access to contraception and cervical screening are

integral to comprehensive health care and are ideally discussed at the time of screening for STI. Addressing barriers to condom access and provision of free condoms will help to support consistent condom use.

All young people who inject drugs need specific tailored interventions, access to harm minimisation strategies including needle and syringe exchange, and regular screening for hepatitis and HIV.

6.5 A public health approach to prevention of STI, HIV and viral hepatitis

Ongoing investment in effective public health interventions to reduce STI, HIV and viral hepatitis infections in young people is needed. Across all settings, programs that foster skills development (such as asking a partner to use a condom) are more effective than knowledge-based programs. Skills-based programs can build self-efficacy and motivation by addressing interpersonal, social and structural issues that a young person faces.⁹¹

Multi-level interventions are necessary. Comprehensive schools-based sexual health programs are likely to have the broadest reach and greatest impact on prevention in the short term for the majority of young people. However, integrated primary care, community and media-based strategies to encourage people to talk about sex, sexuality and sexual health without associated stigma can build on skills and knowledge learnt at school. Social marketing and mass media initiatives without other clinical and community approaches and programs may raise awareness but are unlikely to achieve changes in behaviour.⁹²

In primary care, systematically offering testing to young people aged 15–24 is the most effective way to increase screening rates, and is more efficient than opportunistic screening, but can be difficult to embed into clinical practice.⁹³ One-to-one structured counselling support for sexually active young people where the emphasis is on motivation, self-efficacy and factors that underlie risk-taking can be effective and cost-effective, especially for young people identified as high risk. Technology-based testing and appointment reminders can improve access to testing and increase testing rates in young people, whilst home-based testing for rescreening or repeat testing may be useful options. Targeted outreach screening shows high acceptance and participation in STI screening, but evidence about cost-effectiveness remains inconclusive.⁹⁴

There is good evidence that programs targeted to at-risk and minority youth can be effective in increasing knowledge, attitudes and motivations, and some evidence that these programs can result in changes in behaviour and improved health outcomes. Again, programs that take a broad social context and self-efficacy approach, including health literacy, confidence, communication and life aspirations, can be more effective than programs focused on sexual health alone.⁹⁵

In the case of a cluster of STI or BBV diagnoses in a particular population of young people, outbreak control approaches may be appropriate and effective. These require cooperation between clinicians and community-based organisations and close collaboration with the affected community, including open community discussion and support for peer-led initiatives, to help interrupt transmission of infection through increased testing, treatment and partner notification.⁹⁶

7 CONTRACEPTION, TERMINATION AND TEENAGE PREGNANCY CARE

7.1 Contraceptive care

Young women require access to safe, convenient and affordable contraception, and information that enables them to choose between contraceptive options including long-acting reversible contraceptives (LARC).⁹⁷ Young men also require information about contraception and opportunities to discuss the impacts of unplanned pregnancy. Where possible, couples should be encouraged to attend consultations together to discuss contraception.⁹⁸

For young women who express a wish to conceive in their teen years, or who seem ambivalent about contraception, exploring beliefs about pregnancy and the impacts of pregnancy and parenthood may influence contraception use; however, it may be as important to provide information about the role of good prenatal care.⁹⁹

Ongoing efforts are needed to encourage contraceptive use amongst sexually active heterosexual adolescents. In 2013, in the *5th National Survey of Australian Secondary Students and Sexual Health*, sexually active students most commonly used a condom (58 per cent) and/or the contraceptive pill (39 per cent). The use of LARCs was far less frequent (7.5 per cent). Of concern, 13 per cent of sexually active students reported using no contraception the last time they had sex, 15 per cent used withdrawal and 5 per cent had had sex that resulted in pregnancy. Only 4 per cent of students had accessed emergency contraception, suggesting that emergency contraception is significantly underutilised as back-up after unprotected sex.¹⁰⁰ In the 2012 *New Zealand Survey of the Health and Wellbeing of Secondary School Students*, 58 per cent of sexually active students reported using contraception all of the time to prevent pregnancy, a percentage that has remained fairly stable over the last decade.^{101 102}

Health professionals may be concerned about prescribing contraception to young women without the knowledge of a parent or carer. This may be particularly challenging when providing care for young people from culturally, religiously, ethnically and linguistically diverse backgrounds. It is important to assess competence to consent to health care and to respect the right of a young person to confidential health care.^{103 104} It is also appropriate to encourage young women to involve a parent in health care decisions, as this may help them discuss their decisions and benefit from parental support. However, contraceptive care should not be withheld from a young woman who is able to provide informed consent but is not yet willing to initiate parental involvement.¹⁰⁵

When a request for contraception is made by a very young woman (for instance 12-14 years of age), it is essential to review the basis of the request with the young woman, including a discussion of the sexual activities she is involved in. Consideration should be given to the possibility of sexual exploitation of very young women in such situations. When a health professional considers that sexual exploitation may be present, the safety and wellbeing of the young woman must be evaluated. It may be necessary for the health professional to consider making a child protection notification and/or arranging a discussion with the police.¹⁰⁶ Optimal contraceptive care also includes opportunities to discuss STI prevention and the importance of condoms, as well as STI and cervical screening in accordance with Australian and New Zealand guidelines.

7.2 Expanding access to long-acting reversible contraception

Long-acting reversible contraceptives are safe for young women, including as a first-time contraceptive option, and have both cost and efficacy benefits.¹⁰⁷ However, since insertion must be done by a trained clinician, access may be limited in areas with few trained clinicians.

In Australia, LARC use has been rising more slowly than in other developed nations, with less than 10 per cent of women at risk of pregnancy using intrauterine and implant LARC options.^{108 109} Increased use of LARCs by young women, in particular etonogestrel implant and hormonal intrauterine systems or copper intrauterine devices (IUD), has significant potential to reduce unintended pregnancy, termination and repeat termination rates.¹¹⁰ Depot medroxyprogesterone acetate, whilst longer acting, is not usually a first line option as it is less effective than implant or intrauterine LARC methods, due to the need to return every three months for repeat injection, and may impact on bone density with long term use.^{111 112} Teenagers who have given birth and choose an implant or intrauterine LARC have a lower rate of rapid repeat pregnancy and higher contraception continuation rates at one year and two years compared to those who choose combined oral contraceptives.^{113 114}

7.3 Ensuring access to emergency contraception

Whilst prevention of unplanned pregnancy through consistent contraceptive use is preferred, young women need access to emergency contraception if required. Levonorgestrel emergency contraception is easy to use in the absence of medical advice, has only rare, mild side effects and is available without prescription at pharmacies in both Australia and New Zealand.¹¹⁵

In Australia, Pharmaceutical Society of Australia guidelines note the need to consider state-based legislation, and suggest referring those under the age of 16 to a medical practitioner. This can complicate and delay access to levonorgestrel, which is most effective when taken as soon as possible after unprotected intercourse. Where timely referral is not possible, pharmacists are advised to follow similar guidelines to medical practitioners when assessing capacity to consent, including encouraging the young person to inform their parents.¹¹⁶ To strengthen the role of pharmacy access to emergency contraception, revised training for pharmacists with a focus on empathy, privacy and discretionary concerns has been suggested.¹¹⁷

Insertion of a copper IUD within five days of unprotected intercourse is a highly effective emergency and long-term contraception method. However, significant cost and difficulties with timely access to trained clinicians currently limit uptake.¹¹⁸

7.4 Termination of pregnancy

Legislation regarding termination of pregnancy, in respect to both surgical and medical options, differs across jurisdictions.¹¹⁹ Uniformity and clarity of legislation would benefit both health practitioners and the women for whom they care.^{120 121} There is no current national data on terminations of pregnancy, or on how many women seek to terminate a pregnancy, and there is no data to indicate how many are unable to do so for reasons of cost or access. Estimates of induced abortion over a decade ago, in 2003, suggest that young women aged 20–24 years had more terminations than other age groups.¹²² Young women experiencing intimate partner violence have been found to be more likely to terminate their pregnancies than non-abused peers.¹²³ Access to public services for both medical and

surgical termination is often minimal and young Australian women with an unplanned pregnancy may struggle both financially and geographically to access the care they need.^{124 125} In New Zealand, abortion is legal with the agreement of two certifying doctors, and there are no age limits.^{126 127}

Non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality, whereas termination of pregnancy is a safe procedure for which major complications and mortality are rare.¹²⁸ Uniform access to safe, legal, accessible and affordable abortion services with both medical and surgical options is needed for young women who do not choose to continue their pregnancy.¹²⁹

National data is urgently needed as a baseline so that efforts to reduce unplanned pregnancy and termination can be measured over time.

For young women who opt for termination, confidentiality, pre- and post-termination counselling and advice on ongoing contraception, when required, are essential components of care. This advice should include the option of inserting a LARC during surgical termination as this may reduce the risk of future terminations.^{130 131}

Conscientious objection to termination of pregnancy by some medical practitioners is acknowledged. The Medical Board of Australia and the Australian Medical Association provide guidance, which states that personal beliefs should not impede patient access to treatments that are legal and referrals to alternative health professionals should be provided where required.^{132 133} Similarly, the New Zealand Medical Council provides guidance for practitioners whose personal beliefs may affect their advice or treatment, including the need to explain this to patients and tell them about their right to see another doctor.¹³⁴

7.5 Teenage pregnancy care

Teenage birth rates in both Australia and New Zealand continue to decline. In 2013, there were 11,400 babies born to teenage mothers in Australia; a birth rate of 15 babies per thousand women under 20 years, the lowest in over a decade.¹³⁵ New Zealand has a higher rate of teenage births, at 6.5 per cent of all births in 2011,^{136 137} of which just over two-thirds were in young women aged 18 and 19 years. Aboriginal and Torres Strait Islander and Māori teenagers have significantly higher rates of parenthood.^{138 139 140}

Pregnancy in younger adolescents raises complex and sensitive issues requiring careful consideration of their safety, their supports, and jurisdictional child protection reporting responsibilities.¹⁴¹

Adolescent mothers who are not adequately supported are at risk of negative outcomes, including lower educational attainment, lower self-esteem, intimate partner violence, depression and substance abuse.^{142 143} Children born to adolescent mothers are in turn at higher risk of adverse outcomes, including becoming adolescent parents themselves.^{144 145}

Young women may struggle to negotiate the antenatal care system and may access care late.¹⁴⁶ However, comprehensive multidisciplinary support for teenage mothers before, during and after pregnancy can help meet the social, economic, health and educational needs of young parents and improve long-term outcomes for both mother and child.^{147 148 149}

8 SEXUAL ABUSE, SEXUAL ASSAULT AND INTIMATE PARTNER VIOLENCE

Almost one-in-five Australian women aged 15 and over have experienced sexual violence and one in three have experienced intimate partner violence.¹⁵⁰ *The National Plan to Reduce Violence against Women and Their Children 2010–2022* emphasises the need for prevention, with a long-term approach that includes building respectful relationships and reducing gender inequality as well as interventions for those who are violent.¹⁵¹

In New Zealand, the Ministry of Women's Affairs recognises that a quarter to a third of New Zealand women will experience intimate partner or sexual violence in their lifetime.

Providing health care for young people reporting sexual abuse, sexual assault and intimate partner violence should conform to jurisdictional mandatory reporting requirements. Information on and options for medical care, reporting and support in relation to the criminal justice system, access to forensic assessment, and counselling should be provided. Medical care may include injury assessment and care, assessment of the need for emergency contraception, STI and baseline BBV screening, hepatitis B immunisation, HIV post-exposure prophylaxis (PEP) and consideration of HPV immunisation.^{152 153 154} A young person also needs safe accommodation following any form of sexual violence as well as access to ongoing counselling support.

Issues that become apparent during initial assessment, such as drug and alcohol use, form part of follow-up care planning. With consent, liaison between specialist sexual assault services and a young person's general practitioner or other health care providers facilitates ongoing care and support. Follow-up consultation intervals vary according to the need to allow for review of injury and emotional wellbeing, follow-up pregnancy testing, and STI and BBV screening. Usual follow-up intervals take place at two weeks, three months and six months post-assault. Young people who present on a number of occasions for sexual assault care may benefit from case-conferencing between clinicians and services involved in their care to optimise management.¹⁵⁵

9 SEXUAL AND REPRODUCTIVE HEALTH CARE FOR INDIGENOUS YOUNG PEOPLE

9.1 Māori young people

New Zealand health services have a responsibility under the Treaty of Waitangi to address issues of inequality and work from a cultural perspective.¹⁵⁶ The Medical Council of New Zealand position statements remind clinicians of the importance of correct pronunciation of names, respecting where people are from, and asking permission to explore people's cultural heritage.¹⁵⁷ In the area of sexual and reproductive health, there are significant health disparities between Māori and non-Māori young people.

Young Māori have disproportionately high rates of bacterial STI.¹⁵⁸ Māori women have twice the rates of cervical cancer, a disease largely preventable by vaccination of young women against HPV.¹⁵⁹ These negative health outcomes in part reflect differences in health risk behaviour and preventive health practices.^{160 161 162} They may also indicate that services are not currently providing equal access to health care. Such disparities in Māori health persist even after allowing for factors such as poverty and education, suggesting that ethnicity is an independent determinant for differential health outcomes in New Zealand.¹⁶³

In the provision of health care, there are a number of critical differences and perspectives that need to be taken into account when working with Māori young people and their whānau (extended family). For example, clinicians require an ability to involve whānau respectfully when a young person brings them to a consultation while also recognising the rights of the young person to privacy. Clinicians need to be mindful of the diversity between individual Māori.

Rates of pregnancy for young Māori women are high, as are terminations of pregnancy and infant mortality rates.¹⁶⁴ While research highlights barriers to early antenatal care, what is less clear is how many pregnancies were valued and contributed positively to the lives of young Māori women.

9.2 Aboriginal and Torres Strait Islander young people

“Sexual health is sensitive, complex and personal. We want to really dramatically change the stats and change the rates of transmission in Aboriginal youth. We want to engage young Aboriginal and Torres Strait Islander people to lead honest conversations in their communities about HIV, and about sexual health more generally.”

Todd Fernando – ANTHYM: Aboriginal Nations Torres Strait Islander HIV Youth Mob (with permission).

Rates of diagnosis for STI are far higher for Aboriginal and Torres Strait Islanders than for other Australians, with chlamydia reported at three times the rate amongst Aboriginal and Torres Strait Islander populations.¹⁶⁵ This has occurred despite extensive programs aimed at reducing infection rates in areas with large Indigenous populations.

The *GOANNA* study is a national cross sectional survey of nearly 3000 Aboriginal and Torres Strait Islander people aged 16-29 years conducted in 2013, and provides important insights into knowledge, risk factors and health service access in relation to STI and BBV.¹⁶⁶ Younger participants in the study were less likely to be aware of basic sexual health precautions and factors affecting STI transmission, with young men being particularly susceptible. In contrast, however, condom use was more prevalent amongst 16–19 year olds than amongst 25–29 year olds.

The *GOANNA* study highlights that similar trends in the broader population are present amongst young Aboriginal and Torres Strait Islander peoples, but that those trends are exacerbated in the young Indigenous population. This includes lower testing rates for STI amongst the youngest sexually active groups and the need for better strategies to encourage men to access sexual health services. There are also more Indigenous health-specific issues, such as delivering services using local Aboriginal dialects where appropriate.

It is important that health promotion activities engage more effectively with young Aboriginal and Torres Strait Islander people. Appropriate models of care are needed to address the health needs of Aboriginal and Torres Strait Islander young people, and these generally need to include Aboriginal and Torres Strait Islander Health Workers. More recently, young Indigenous men and women are emerging as local and national leaders in STI and HIV prevention. The Aboriginal Nations Torres Strait Island HIV Youth Mob (ANTHYM) is a network of Aboriginal and Torres Strait Islander young people promoting messages of safe sex and safe injecting practices in the hope of reducing the rates of HIV infection within Indigenous communities.¹⁶⁷

Other initiatives include the *Young Person Check*, a program designed to provide similar outcomes to existing adult initiatives. One of its key focuses has been high-coverage screening for 15–24 year olds in remote communities. Evidence suggests that when properly implemented and monitored the program can improve sexual health outcomes.¹⁶⁸

10 YOUNG PEOPLE WHO ARE SAME-SEX ATTRACTED OR GENDER DIVERSE, AND YOUNG PEOPLE WITH INTERSEX VARIATIONS

Same-sex attracted (SSA) young people of all backgrounds often face additional challenges. In *Growing up Queer*, a recent Australian study, 16 per cent of young people identifying as lesbian, gay, bisexual, trans, intersex or queer (LGBTIQ) had attempted suicide and 33 per cent had harmed themselves as a response to homophobic and transphobic harassment and violence.¹⁶⁹ Bullying, feelings of isolation and difficulties in rural and regional areas can be more pronounced.¹⁷⁰ These challenges are reflected in higher rates of depression, anxiety and risky sexual behaviours in parallel with reports of high levels of discrimination.^{171 172 173 174}

Young people are often aware of their same-sex attraction at a young age. *Writing Themselves in 3* (WTi3), the third national Australian study on the sexual health and wellbeing of SSA and gender diverse or questioning young people, was conducted in 2010 and surveyed 3,134 young people aged between 14 and 21 years.¹⁷⁵ Most young men were exclusively SSA, whereas over half of young women were attracted to both sexes. More than a third of young people, both girls and boys, were aware of their sexual difference before puberty.

SSA young people are more likely to become sexually active at an earlier age than their heterosexual peers, less likely to use condoms and more likely to contract a sexually transmitted infection. Young SSA women who also had sex with men were twice as likely to become pregnant than their heterosexual peers. Young men were more likely to disclose their sexual preferences and to be supported by their parents, young women somewhat less so, and those from culturally, religiously and linguistically diverse backgrounds were less likely to disclose or to receive family support. Young people in rural and remote areas spoke of isolation, discrimination and lack of appropriate services and support. Again, experiences of homophobia were common. There were strong links between homophobic abuse and feeling unsafe, excessive drug use, self-harm and suicide attempts. Almost all participants in *WTi3* had disclosed SSA to at least one person and it was clear that the support of friends and family and safe school environments acted as a buffer against negative health outcomes. These findings are supported by those from the Adolescent Health Research group in New Zealand.¹⁷⁶

Gender diverse or questioning young people were included in the *WTi3* survey. Gender diverse young people described knowing from a young age, or always knowing, that their gender identity was other than their biological sex. These young people were less likely to be supported and had greater risk of reduced academic performance, school change or drop-out, homelessness, physical abuse, self-harm and suicide.

Difficulties experienced by SSA and gender questioning young people in adolescence and young adulthood may translate to poorer long-term health outcomes. *Private Lives 2*, the second national survey of gay, lesbian, bisexual and transgender Australians, demonstrated that the general health of male participants was lower than the national average, that of female participants lower still, and trans men and women reported the lowest levels of general health.¹⁷⁷ Over 50 per cent of respondents reported having had depression or anxiety.

Frameworks to improve health service delivery for LGBTIQ people have been developed in Australia, and while these do not focus on young people alone, they provide good guidance for inclusive practice.^{178 179} In New Zealand, there is no specific guidance but an important framework for mental health care has been proposed, which includes the need to reduce stigma and enhance young people's safety.¹⁸⁰

10.1 Same-sex attracted young men

Young men who have sex with men are at greater risk of acquiring HIV than their heterosexual peers. New HIV diagnoses in Australia have increased steadily over the past 13 years, including an increase in newly acquired HIV in young men aged less than 25 years.¹⁸¹

Young gay men need the opportunity to disclose their sexuality to health care providers and to receive affirming clinical care. They need access to a range of prevention strategies, including condoms and HIV PEP. In Australia, clinical guidance on HIV pre-exposure prophylaxis (PrEP) is available, whilst daily antiviral medication is effective in preventing HIV infection PrEP is not government funded and current costs and complexities of obtaining PrEP are likely to be a significant barrier to access for many young same-sex attracted men.¹⁸²

Young gay men also need access to testing in a range of clinic and community settings and encouragement to test regularly for STI and HIV,¹⁸³ in some cases up to four times a year, in accordance with Australian guidelines.¹⁸⁴ Peer-based education and support including point-of-care HIV testing (also known as rapid testing) can provide connections to the community.

Young men who have sex with men commonly report unprotected anal sex. *Gay Community Periodic Survey* data in 2012 indicates that almost 40 per cent of all men with casual partners have some unprotected sex. As well as encouraging condom use, sexual health care for young SSA men ideally includes support to develop skills to discuss safer sex and understand trends in HIV diagnoses, as well as opportunities to discuss other ways of reducing their HIV risk including serosorting (decisions based on known or assumed HIV status), seropositioning (unprotected anal intercourse between HIV serodiscordant MSM, in which the HIV uninfected partner is preferentially insertive during anal intercourse) and negotiated agreements with partners (understandings about sex within the relationship and with outside partners).^{185 186}

The 2007 introduction of school-based HPV immunisations has reduced genital wart diagnoses in women aged 21 or under,¹⁸⁷ reducing the risk of HPV transmission to their unvaccinated male (and female) partners. School-based HPV immunisation for adolescent boys was not introduced in Australia until 2013, so most same-sex attracted young men born before 2000 are unable to benefit. Thus, most of the current generation of young MSM in Australia remain at higher risk of genital warts and HPV-related cancers later in life than their heterosexual peers. Where they can afford it, these men should be encouraged to seek vaccination.

10.2 Same-sex attracted young women

Same-sex attracted (SSA) young women in Australia are more likely to report poorer mental and physical health, greater levels of stress, poorer general health and less life satisfaction than their heterosexual peers. They report greater rates of harassment, violence and abuse, and double the rate of anxiety or depression diagnosis of their heterosexual peers. Bisexual and mainly heterosexual

women had the highest levels of distress, perhaps due to isolation and stigma from both straight and gay communities.¹⁸⁸

Positive factors contributing to mental health for SSA young women include a supportive family of origin and a positive coming out experience, community connectedness, being in a relationship and workplace/school support. Given this, it is concerning that SSA young women in New Zealand report greater family discord, school dissatisfaction and physical abuse.¹⁸⁹

Bisexual young women appear to have the poorest sexual health with higher rates of STI, abnormal pap tests and hepatitis B or C virus infections. Some of this disease burden may be due to increased sexual risk taking, such as having a greater number of sexual partners or more unprotected sex. Some overseas studies have shown an association between sexual risk taking and poor mental health, high levels of victimisation, and high levels of drug and alcohol use.¹⁹⁰

Exclusively SSA young women were most likely never to have had a pap test or to be under-screened.¹⁹¹ This may reflect misunderstanding about the need for pap tests or fewer triggers for clinicians to offer pap tests due to, for example, fewer contraception-related consultations. Apart from genital herpes, STI are relatively rare in young women who only have sex with other women.

Bisexual young women need encouragement to use condoms with male partners and to consider additional contraception. For sex between female partners, avoiding oral sex during oral Herpes Simplex Virus outbreaks or menstruation can reduce STI risk. While latex barrier protection can be used, uptake appears to be low.

In addition to having poorer physical health and higher rates of mental illness, SSA young women report lower continuity of primary care and lower satisfaction with that care than heterosexual youth.¹⁹² This may be because they are fearful of disclosing their sexual orientation and have trouble finding a doctor they trust.

Increasing the awareness and training of health-care providers to the particular needs of young SSA women can help overcome this health inequity. SSA young women may need treatment for anxiety, depression or substance use issues, encouragement to participate in cervical screening, and appropriate safer sex and contraceptive advice.

10.3 Gender diverse young people

The terms gender dysphoria (DSM-5) and gender identity disorder (ICD-10) are used to capture the experience of children, adolescents and adults whose biological sex is different to the gender they identify with, a mismatch that causes clinically significant distress.¹⁹³ In order for a diagnosis of gender dysphoria or gender identity disorder to be made, the difference between expressed or experienced gender and biological sex must continue for at least six months. Transgender youth are aware of the incongruence between their emotional gender identity and their biological sex at early ages.^{194 195} Transgender children have strong desires to be treated as the other gender or to be rid of their sex characteristics, or have a strong conviction of feelings and reactions typical of the other gender. Treatment options throughout life other than psychological counselling include puberty suppression, cross-sex hormones, social and legal transition to the desired gender and eventually gender reassignment surgery.

Whilst children as young as three years of age may question their gender, it appears that less than one in five of these children have dysphoria that persists into adolescence and adulthood,¹⁹⁶ although others may eventually identify as bisexual or same-sex attracted.¹⁹⁷ International consensus guidelines for hormone treatment of adolescents with gender identity disorder are endorsed by the Australasian Paediatric Endocrine Group¹⁹⁸ and focus on adolescent care, with treatment to suppress pubertal development after onset of puberty (Tanner stages two to three), administration of cross-sex hormones from 16 years, and deferral of surgery until adulthood. There are risks of irreversible effects during cross-sex hormone treatment, including infertility, and informed consent is required prior to each stage of treatment. Professionals involved in provision of care should be aware of the legal requirements within their jurisdiction surrounding administration of cross-sex hormonal treatment leading to gender reassignment. Currently in Australia, authorisation is required from the Family Court before commencement of cross-sex hormone treatment in patients aged less than 18 years, a requirement which entails significant financial costs and may delay treatment.

Until recently, there was minimal Australian or New Zealand epidemiological data on the prevalence of adolescents and young adults who are gender questioning or experience gender dysphoria. The *Youth'12* survey of secondary students in New Zealand found that 1.2 per cent of students reported identifying as transgender and 2.5 per cent were unsure. The students who identified as transgender had higher rates of depressive symptoms, were more likely to report suicidal thoughts and being bullied, and less likely to feel a parent cared for them.^{199 200} In recent years, centres across Australia and New Zealand have developed services providing care to children and adolescents with gender dysphoria.²⁰¹ As the health risks of being young and transgender become better understood, together with improved outcomes following treatment, it is important for clinicians to become familiar with referral options in order to provide optimal and welcoming care.²⁰² With appropriate care, gender dysphoria resolves, psychological wellbeing improves and young people who have struggled with gender identity can develop into well-functioning young adults.²⁰³

10.4 Young people with intersex variations

Intersex variations are congenital conditions where the chromosomal, gonadal or genital sex is atypical.²⁰⁴ They are also known as differences of sex development (DSD), disorders of sex development, and divergent sex development. Intersex variations are a group of rare conditions with a spectrum of newborn presentations from mild hypospadias to ambiguous genitalia. The incidence of ambiguous genitalia, where the sex cannot be obviously determined at birth, is 1 in 4,500 births.²⁰⁵ Differences in sex development may also present as delayed puberty in an adolescent.²⁰⁶

Young people with intersex variations can be at risk of serious health complications including fertility issues, gonadal cancer, mental health concerns and direct issues from their genital or gonadal surgery. Partnerships and sexual relationships may be difficult areas of life for young people with DSD.²⁰⁷ Empathic, sensitive and multidisciplinary care from knowledgeable health professionals, as well as peer support, can help young people with DSD understand their bodies. This can also support those who face challenges sharing information about their bodily differences or altered fertility and developing intimate partnerships.²⁰⁸ Young people with DSD require support to transition from paediatric to adult care.²⁰⁹

International human rights institutions state that medical interventions for cosmetic or psychosocial reasons should not take place until the person concerned can provide free and fully informed

consent.^{210 211 212 213} This includes surgical and hormonal interventions, and respect for the right of persons with intersex variations not to undergo sex assignment treatment. The Organisation Intersex International Australia has also advocated on these issues.²¹⁴

Individuals with intersex variations require subspecialist care by expert multidisciplinary management teams, with careful consideration of the issues that can be raised in these conditions, including minimising physical and psychosocial risk, preserving potential for fertility, preserving or promoting capacity to have satisfying sexual relations, and leaving options open for the future.²¹⁵

The care of adolescents and young adults with intersex variations can be facilitated by:

- Review of the recommendations of the Senate Inquiry into the Involuntary or Coerced Sterilisation of Intersex People 2013, including the establishment of a Special Advisory Group for national review of treatment of affected individuals.²¹⁶
- Establishment of funded specialised clinical services with established clinical protocols.
- Provision of effective and resourced peer support.
- Funding for fertility preservation services for minors.
- Research addressing sexual and reproductive health, best practice care and longer-term physical and mental health outcomes.

11 YOUNG PEOPLE WITH DISABILITIES AND LONG-TERM HEALTH CONDITIONS

11.1 *Young people with intellectual disability*

Young people with intellectual disability often face similar issues to their peers without disability but also have some additional challenges. These may relate to cognitive and linguistic capacity, social context and prevailing attitudes of family members, educators and service providers.

In 2008, Australia and New Zealand ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and its Optional Protocol. The Convention upholds the rights of people with disability to be provided the same access to health care as other people and specifically addresses rights around reproductive and sexual health, including protection from abuse, retention of fertility, and elimination of discrimination in all matters relating to marriage, family, parenthood and relationships.²¹⁷ There is no consistent policy or legislative framework within Australia or New Zealand regarding the sexual and reproductive health of people with disability, with only Victoria and Tasmania having government policy documents in this area.

Young people with intellectual disability often face higher levels of abuse and greater difficulties reporting abuse than their peers without disability.²¹⁸ Young people with intellectual disability may have poor knowledge of when, where and how to access appropriate services. In addition to finding it difficult to access care and services, these young people may also have difficulties recognising sexual and health-related symptoms, which can also impact negatively on their health outcomes.

Gaps in the skills of health care professionals to engage a young person with intellectual disability may further impede access to care including contraception and cervical and STI screening, although simple guidelines to foster communication between a young patient and a clinician can help greatly.²¹⁹ Targeted flexible outreach services may assist in the delivery of high-quality evidence-based care to young people with intellectual disability.²²⁰

Young people with intellectual disability are more likely to require direct instruction to learn positive and protective skills,²²¹ and research shows that sexuality and relationships education can contribute to knowledge and skill acquisition as well as influence positive behaviour development.²²² Focus areas for sexual and reproductive health education programs for young people with intellectual disability should include information to help them understand the body, relationships and consent. Extensive education on STI, contraception and utilisation of sexual health services should also be included. It is also critical that these programs instil an understanding of abuse and how to report it.^{223 224 225 226 227 228}

Parents and carers play a critical role in supporting young people with disability through puberty and in providing them with information related to relationships and safe sexual behaviour, although for some, supporting safe, constructive sexual relationships can be a challenging and complex task.²²⁹ Parents and carers need opportunities to acquire knowledge and skills to assist them in supporting the sexual development of the young person in their care. Family Planning organisations across Australia and New Zealand deliver a number of programs focusing on the needs of parents and carers, including education forums and disability-specific resources.^{230 231}

11.2 *Young people with long-term health conditions*

Many young people struggle with chronic medical, surgical or psychiatric conditions that complicate their lives as they become sexually active. The percentage of young people with chronic physical illness is increasing, as a result of both increased survival into adulthood and the increase in prevalence of chronic physical disorders, with an estimated one in five children living with a long-term health condition.²³² Notable disorders include cystic fibrosis, diabetes, inflammatory bowel diseases, obesity and eating disorders, psychiatric disorders with heightened mood, and malignancy. Survivors of childhood malignancies require ongoing intermittent review.^{233 234 235 236 237 238 239 240}

Young people with chronic physical illness may miss out on sexuality and relationships education because of missed schooling. In addition, health professionals providing long-term care may not discuss issues relating to sex and sexual health, including sexual risk taking, despite risk taking having been shown to be higher on average in young people with chronic physical illness and challenges accessing appropriate care.²⁴¹ Ideally, both primary care physicians and specialist paediatricians should be equipped to initiate referral or provide sexual and reproductive health care, including contraception. In later adolescence, transition planning provides an additional opportunity to explore sexual and reproductive health needs.²⁴²

Other complications in this group of young patients may need to be foreseen and managed. Regular medications may interfere with the efficacy of some contraceptive options, or may be teratogenic and need to be changed prior to contemplating pregnancy. Some chronic physical conditions may preclude the use of certain contraceptive options altogether. Obesity can increase the risk of polycystic ovarian syndrome and gestational diabetes, along with other pregnancy complications.²⁴³ Cancer and treatments for cancer can impact the fertility of young people or survivors of childhood cancer.²⁴⁴

A willingness to discuss pregnancy planning is essential, and may involve both the young person and their parent or carer.²⁴⁵ While once pregnancy may have been perceived as unsafe for young people with certain chronic physical conditions, pregnancy may now be a relatively safe possibility when coupled with genetic counselling and/or high-risk pregnancy care.²⁴⁶

11.3 *Young people with physical disabilities*

Adolescents with physical disabilities may report good self-esteem but participate in fewer social activities and have fewer intimate relationships than their peers.²⁴⁷ Others, like some of their peers with chronic physical illness, may have more risk-taking behaviours including sexual risk-taking.^{248 249} Young people with disability may experience stigma in relation to their sexuality.²⁵⁰

Young people with physical disabilities may miss out on sexuality and relationships education because of missed schooling, and the education that they do receive may not address relevant challenges. Health professionals may make assumptions about disability reducing sexual interest or activity and may not offer sexual and reproductive health care or feel poorly equipped to do so. Ideally, all clinicians involved in their long-term care of people with disabilities should be willing to discuss sexuality and intimate relationships, and use their expertise to support young people with disabilities who are, or who would like to be, sexually active.^{251 252}

For young women with more severe physical disability, menstruation and contraception can be challenging, both in terms of discussing options and managing periods and contraception. In those cases, a referral to specialist adolescent gynaecology care may be helpful.^{253 254} LARCs, in particular hormonal intrauterine systems, may be particularly helpful for this group, with insertion under general anaesthetic if required.

12 CONCLUSION

Adolescence and young adulthood are periods in which young people require support to develop the skills and knowledge needed to engage in intimate and healthy relationships.

Sexually transmitted infections, unplanned pregnancy, abuse and bullying in relation to sexuality and gender identity, and domestic and sexual violence remain significant concerns for the health and wellbeing of many young people in Australia and New Zealand – and should be the focus of ongoing government efforts to improve delivery of sexuality and relationships education and sexual and reproductive health services.

This position statement will inform policy development, service planning and service delivery, to ensure that all young people can access timely, informed and welcoming sexual and reproductive health care.

13 GLOSSARY

BBV	Blood-borne viruses; HIV, hepatitis B and hepatitis C.
DSD	Disorders of sex development, also known as differences of sex development.
Gender dysphoria	A condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and gender identity.
Gender identity	A person's deeply felt sense of being male, female, both, in between, or something other. Everyone has a gender identity.
GQ	Gender questioning; when a young person questions their current biological sex and/or assigned gender. This includes young people who feel that their gender does not align with the sex assigned to them at birth, and those who feel that the separation of male and female/masculine and feminine is unduly restrictive.
HEEADSSS	Home and environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression and safety from injury and violence. HEEADSSS is a psychosocial assessment approach for adolescents, which is complementary to a medical history.
Homophobia	The fear and hatred of lesbians and gay men and of their sexual desires and practices that often leads to discriminatory (homophobic) behaviour or abuse.
Intersex	Intersex people are born with atypical sex characteristics. Intersex relates to a range of congenital physical traits or variations that lie between stereotypical definitions of male and female. Many different forms of intersex exist.
LARC	Long-acting reversal contraception; including hormonal or copper intrauterine systems, or hormonal contraceptive implants or injections. LARC is more effective at preventing unintended pregnancy and has better continuation rates than shorter acting methods.
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, queer.
MSM	Men who have sex with men; an epidemiological term that encompasses all men who have sex with other men.
PEP	Post-exposure prophylaxis; a four-week course of HIV antiviral medication commenced as soon as possible and no later than 72 hours after potential HIV exposure, to reduce the risk of HIV acquisition.
PrEP	Pre-exposure prophylaxis; HIV antiretroviral treatment taken by HIV uninfected individuals who are at high risk of becoming HIV infected. Not currently government subsidised in Australia or New Zealand.
Queer	An umbrella term to include a range of alternative sexual and gender identities including gay, lesbian, bisexual and transgender, or gender questioning.
SSA	Same-sex attracted; young people who experience feelings of sexual attraction to others of their own sex. This includes young people who are exclusively homosexual in their orientation, bisexual, undecided young people, and heterosexual young people who have these feelings at some time.
Transgender	An umbrella term and, for some people, an identity term used to describe all kinds of people who sit outside the gender binary or whose gender identity is different from the sex assigned to them at birth. Transgender people may or may not feel the need to access hormone therapy and/or surgery.
Transphobia	A fear and hatred of people who are transgender that often leads to discriminatory (transphobic) behaviour or abuse.
Young people	Adolescents and young adults between 12 and 24 years of age (inclusive).

14 REFERENCES

- ¹ Committee on the Rights of the Child 2013. United Nations Convention on the Rights of the Child. General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24).
- ² CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment 2014. Record of the proceedings May 21–22, 2014. Centres for Disease Control and Prevention. Available from: [REDACTED]
- ³ Global Policy Committee of the WHO 1994. Position paper on health, population and development for the International Conference on Population and Development. Cairo, 5–13 September 1994, p. 24, para. 89.
- ⁴ Williams H, Kang M, Skinner SR 2013. Sexual and reproductive health. In Kang M, Skinner SR, Sanci LA, Sawyer SM. Youth health and adolescent medicine. Chapter 12. East Hawthorn, Vic, Australia: IP Communications.
- ⁵ Kang M 2013. The health of young Australian people. In Kang M, Skinner SR, Sanci LA, Sawyer SM. Youth health and adolescent medicine. Chapter 2. East Hawthorn, Vic, Australia: IP Communications.
- ⁶ Bennett D, Robards F 2013. What is adolescence and who are adolescents. In Kang M, Skinner SR, Sanci LA, Sawyer SM. Youth health and adolescent medicine. Chapter 1. East Hawthorn, Vic, Australia: IP Communications.
- ⁷ Toumbourou JW, Olsson CA, Williams I, Hallam B 2013. Resilience, risk and protective factors in adolescence. In Kang M, Skinner SR, Sanci LA, Sawyer SM. Youth health and adolescent medicine. Chapter 3. East Hawthorn, Vic, Australia: IP Communications.
- ⁸ Mitchell A, Patrick K, Heywood W, Blackman P, Pitts M 2014. 5th National survey of Australian secondary students and sexual health 2013. ARCSHS Monograph Series No. 97. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Available from: [REDACTED]
- ⁹ Clark TC, Fleming T, Bullen P, Denny S, Crengle S, Dyson B, Fortune S, Lucassen M, Peiris-John R, Robinson E, Rossen F, Sheridan J, Teevale T, Utter J 2013. Youth'12 overview: the health and wellbeing of New Zealand secondary school students in 2012. Auckland: The University of Auckland.
- ¹⁰ Hendry N, Brown G, Johnston K, Dowsett G 2013. Beyond high school: what do we know about young adults' social and sexual contexts? ARCSHS Monograph Series No. 90, Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Available at: [REDACTED]
- ¹¹ Adam P, de Wit J, Treloar C, Shepherd B, Duck T, Byron, Bourne C, Murray C, Welsby D, Holden J 2014. Towards an online periodic survey of sexual health among young people in Australia. Monograph 8/2014. Sydney: Centre for Social Research in Health, UNSW.

¹² Mitchell A et al. 2014. op. cit.

¹³ *ibid.*

¹⁴ *ibid.*

¹⁵ Clark TC et al. 2013. op. cit.

¹⁶ United Nations Educational, Cultural and Scientific Organization (UNESCO) 2009. op. cit.

¹⁷ Australian Curriculum, Assessment and Reporting Authority 2012. The shape of the Australian curriculum: health and physical education. Available at:

[REDACTED]

¹⁸ Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence 2001. Sexuality education for children and adolescents. *Pediatrics*;108(2):498–502.

¹⁹ Oringanje C, Meremikwu MM, Eko H, Esu E, Meremikwu A, Ehiri JE 2009. Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database Syst Rev.*;7(4):CD005215.

²⁰ Gavin LE, Catalano RF, David-Ferdon C, Gloppen KM, Markham CM 2010. A review of positive youth development programs that promote adolescent sexual and reproductive health. *Journal of Adolescent Health*;46(3 Suppl):S75–91.

²¹ Frost JJ, Forrest JD 1995. Understanding the impact of effective teenage pregnancy prevention programs. *Fam Plann Perspect.*;27(5):188–195.

²² Gavin LE et al. 2010. op. cit.

²³ Taliaferro LA, Sieving R, Brady SS, Bearinger LH 2011. We have the evidence to enhance adolescent sexual and reproductive health –do we have the will? *Adoles MedState Art Rev.*;22(3):521–543, xii.

²⁴ Gavin LE et al. 2010. op. cit.

²⁵ United Nations Educational, Cultural and Scientific Organization (UNESCO) 2009. op. cit.

²⁶ Australian Government Department of Education 2014. Review of the Australian Curriculum. Available at:

[REDACTED]

²⁷ Mitchell A et al. 2014. op. cit.

²⁸ New Zealand Ministry of Education 2007. The New Zealand Curriculum 2007. Available at:

[REDACTED]

²⁹ New Zealand House of Representatives 2013. Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception to 3 years. Report of the Health Committee, November. Available at: [REDACTED]

³⁰ Shtarkshall RA, Santelli JS, Hirsch JS 2007. Sex education and sexual socialization: roles for educators and parents. *Perspect Sex Reprod Health*;39(2):116–119.

³¹ Hepatitis Victoria. Hepatitis C and body art – educator’s kit for secondary school. Available at: [REDACTED]

³² Dahl R 2004. Adolescent brain development: a period of vulnerabilities and opportunities. *Ann N Y Acad Sci.*;1021:1–22.

³³ Weinberger D, Elvegag B, Gledd J 2005. The adolescent brain: a work in progress. Washington DC: The National Campaign to Prevent Teen Unplanned Pregnancy.

³⁴ Broderick G 2004. Risk-taking behaviour of young women in Australia: screening for health-risk behaviours. *Med J Aust.*;180(10):544.

³⁵ Walsh J 2008. Talk soon, talk often. Department of Health, Western Australia. Available at: [REDACTED]

³⁶ Skinner SR, Robinson M, Smith MA, Robbins SC, Mattes E, Cannon J, Rosenthal SL, Marino J, Hickey M, Marion JL, Doherty D 2015. Problem behaviour and age at first sexual intercourse: a prospective birth cohort study. *Pediatrics*;135(2):255–263. doi 10.1542/peds.2014-1579.

³⁷ American Academy of Pediatrics: Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence. Sexuality education for children and adolescents. *Pediatrics*. Aug 2001;108(2):498-502.

³⁸ Cohen E, Mackenzie RG, Yates GL 1991. HEADSS, a psychosocial risk assessment instrument: implications for designing effective intervention programs for runaway youth. *J Adolesc Health*;12(7):539–544.

³⁹ Eade DM, Henning D 2013. Chlamydia screening in young people as an outcome of a HEADSS – Home, Education, Activities, Drug and alcohol use, Sexuality and Suicide – youth psychosocial assessment tool. *J Clin Nurs.*;22(23–24):3280–3288. Epub 2013 Sep 19.

⁴⁰ Rayner G, Crossen K 2014. Can a paediatric department provide health care for vulnerable adolescents? *N Z Med J*. 2014 July 18, Issue – 127, pg 67-76.

⁴¹ Matich P, Harvey C, Page P, Johnston K, Jukka C, Hollins J, Larkins S 2015. Young people. *Sex Health*:Mar 10 [Epub ahead of print].

⁴² Cohen E et al. 1991. op. cit.

-
- ⁴³ Klein D, Goldenring J, Adelman W 2014. HEEAADSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media. *Contemp Pediatr.*;31(1):16–28.
- ⁴⁴ Sancu LA, Sawyer SM, Kang MS-L, Haller DM, Patton GC 2005. Confidential health care for adolescents: reconciling clinical evidence with family values. *Med J Aust*;183(8):410–414.
- ⁴⁵ Royal Australasian College of Physicians 2010. Confidential health care for adolescents and young people (12–24 years). Sydney: RACP.
- ⁴⁶ Denny S, Farrant B, Robinson E, Cosgriff J, Harte M, Cameron T, Johnson R, McNair V, Utter J, Crengle S, Fleming T, Ameratunga S, Sheridan E 2013. Forgone health care among secondary school students in New Zealand. *J Prim Health Care*:5(1):11–18.
- ⁴⁷ Copland R, Denny S, Robinson E, Crengle S, Ameratunga S, Dixon R 2011. Self-reported pregnancy and access to primary health care among sexually experienced New Zealand high school students. *J Adoles Health*;49(5):518–524.
- ⁴⁸ Reddy D, Fleming R, Swain C 2002. Effect of mandatory parental notification on adolescent girls' use of sexual health services. *JAMA*;288(6):710–714.
- ⁴⁸ Ford CA, Millstein SG, Halpern-Felsher BL, Irwin C 1997. Influence of physician confidentiality assurances on adolescent's willingness to disclose information and seek future health care: a randomized controlled trial. *JAMA*;278(12):1029–1034.
- ⁴⁹ Australian Institute of Family Studies. Age of consent laws. Australian Government. Available at: [REDACTED]
- ⁵⁰ Royal Australasian College of Physicians 2015. Protecting children is everybody's business: paediatricians responding to the challenge of child protection. Sydney: RACP.
- ⁵¹ Department of Health 2004. Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health. Available at: [REDACTED]
- ⁵² Clark TC et al. 2013. op. cit.
- ⁵³ Denny S et al. 2013. op. cit.
- ⁵⁴ Bird S 2011. Consent to medical treatment: the mature minor. *Aus Family Physician*;40(3):159–160. Available at [REDACTED]
- ⁵⁵ Chown P, Kang M, Sancu L, Newnham V, Bennett DL 2008. Adolescent health: enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds. GP resource kit. 2nd edition. Chapter 6: Medico-legal issues. Sydney: NSW Centre for the Advancement of Adolescent Health and Transcultural Mental Health Centre.

⁵⁶ Fyfe J, Connolly A, Bond B 2013. Informed consent. In St George IM (ed.). *Cole's medical practice in New Zealand*, 12th edition. Chapter 10. Wellington: Medical Council of New Zealand.

⁵⁷ Grimwood T 2009. Gillick and the consent of minors: contraceptive advice and treatment in New Zealand. Available at: [REDACTED]

⁵⁸ Schofield M, Minichiello V, Mishra G, Plummer D, Savage J 2000. Sexually transmitted infections and use of sexual health services among young Australian women: women's health Australia study. *International Journal of STD & AIDS* [serial online];11(5):313–323.

⁵⁹ Sexual Health and Family Planning Australia 2012. *Sexual and reproductive health in rural and remote areas of Australia – Issues paper*. Available at: [REDACTED]

⁶⁰ Australian Institute of Health and Welfare 2011. *Young Australians: their health and wellbeing 2011*. Cat. no. PHE 140. Canberra: AIHW.

⁶¹ Pursche C 2007. *Teenagers need midwives*. Sydney: Southern Cross University.

⁶² Warr D, Hillier L 1997. That's the problem with living in a small town: privacy and sexual health issues for young rural people. *The Aust J Rural Health*;5(3):132–139.

⁶³ Clark TC et al. 2013. *op. cit.*

⁶⁴ Gamage DG, Fuller CA, Cummings R, Tomnay JE, Chung M, Chen M, Garrett CC, Hocking JS, Bradshaw CS, Fairley CK 2011. Advertising sexual health services that provide sexually transmissible infection screening for rural young people – what works and what doesn't. *Sexual Health* [serial online];8(3):407–411.

⁶⁵ Denny S, Robinson E, Lawler C et al. 2012. Association between availability and quality of health services in schools and reproductive health outcomes among students: a multilevel observational study. *Am J Public Health*;102(10):e14–20.

⁶⁶ Copeland R et al. 2011, *op. cit.*

⁶⁷ Sexual Health and Family Planning Australia 2012. *op. cit.*

⁶⁸ Commonwealth Government of Australia 2014. *Third national sexually transmissible infections strategy 2014-2017*. Available at: [REDACTED]

⁶⁹ DiClemente R, Crittenden C, Rose E, Sales J, Wingood G, Crosby R, Salazar LF 2008. Psychosocial predictors of HIV-associated sexual behaviors and the efficacy of prevention interventions in adolescents at-risk for HIV infection: what works and what doesn't work? *Psychosom Med*;70(5):598–605.

⁷⁰ Rissel C, Heywood W, de Visser RO, Simpson JM, Grulich AE, Badcock PB, Smith AM, Richters J 2014. First vaginal intercourse and oral sex among a representative sample of Australian adults: the Second Australian Study of Health and Relationships. *Sex Health*;11(5):406–415.

⁷¹ Mitchell A et al. 2014. op. cit.

⁷² The Kirby Institute 2015. HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2015. Sydney: The Kirby Institute, UNSW.

⁷³ *ibid*

⁷⁴ *ibid*

⁷⁵ The Kirby Institute 2014. HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2014. Sydney: The Kirby Institute, UNSW.

⁷⁶ Brotherton JM, Saville AM, May CL, Chappell G, Gertig DM 2015. Human papillomavirus vaccination is changing the epidemiology of high-grade cervical lesions in Australia. *Cancer Causes Control*; 26(6):953–954.

⁷⁷ New Zealand Ministry of Health 2014. HPV immunisation program. Available at:

[REDACTED]

⁷⁸ Poole T, Goodyear-Smith F, Petousis-Harris H, Desmond N, Exeter D, Pointon L, Jayasinha R 2012. Human papillomavirus vaccination in Auckland: reducing ethnic and socioeconomic inequities. *Vaccine*;31(1):84–88.

⁷⁹ Chelimo C, Wouldes TA, Cameron LD 2010. Human papillomavirus (HPV) vaccine acceptance and perceived effectiveness, and HPV infection concern among young New Zealand university students. *Sex Health*;7(3):394–396.

⁸⁰ The Kirby Institute 2015. op. cit.

⁸¹ The Kirby Institute 2014. op. cit.

⁸² The Kirby Institute 2015. op. cit.

⁸³ Eora call to action to step up the pace in responding to HIV in Aboriginal and Torres Strait Island communities. Available at: <https://eoracalltoaction.wordpress.com>

⁸⁴ The Kirby Institute 2015. op. cit.

⁸⁵ *ibid*.

⁸⁶ *ibid*.

⁸⁷ Brown G, Croy S, Johnston K, Pitts M, Lewis V 2013. Rapid review: reducing sexually transmissible infections in young people. Melbourne: Australian Institute for Primary Care & Ageing (AIPCA) and Australian Research Centre in Sex, Health & Society (ARCSHS), La Trobe University. Available at: [REDACTED]

⁸⁸ Australian STI management guidelines for use in primary care 2014. Available at: [REDACTED]

⁸⁹ Royal Australasian College of General Practitioners. Guidelines for preventative activities in general practice. 8th Edition. Available at: [REDACTED]

⁹⁰ Lachowsky NJ, Saxton PJ, Dickson NP, Hughes AJ, Summerlee AJ, Dewey CE 2014. Factors associated with recent HIV testing among younger gay and bisexual men in New Zealand, 2006–2011. *BMC Public Health*;14:294.

⁹¹ Brown G, Croy S, Johnston K, Pitts M, Lewis V 2013. Rapid review: reducing sexually transmissible infections in young people. Melbourne: Australian Institute for Primary Care & Ageing (AIPCA) and Australian Research Centre in Sex, Health & Society (ARCSHS), La Trobe University. Available at: [REDACTED]

⁹² Lim MS, Gold J, Bowring AL, Pedrana AE, Hellard ME 2014. Young people's comparative recognition and recall of an Australian Government sexual health campaign. *Int J STD AIDS*;26(6):398–401. Epub 2014 Jul 8.

⁹³ Temple-Smith M, Pirotta M, Kneebone J, McNamee K, Fairley C, Bilardi J, Hocking J 2012. A missed opportunity – lessons learnt from a chlamydia testing observation study in general practice. *Aust Fam Physician*;41(6):413–416.

⁹⁴ Brown G et al. 2013. *op. cit.*

⁹⁵ *ibid.*

⁹⁶ Mak DB, Johnson GH, Plant AJ 2004. A syphilis outbreak in remote Australia: epidemiology and strategies for control. *Epidemiol Infect.*;132(5):805–812.

⁹⁷ Lewis LN, Skinner R 2014. Adolescent pregnancy in Australia. In Cherry AL, Dillon ME, eds. *International handbook of Adolescent Pregnancy*. New York: Springer Science+Business Media.

⁹⁸ *ibid.*

⁹⁹ *ibid.*

¹⁰⁰ Mitchell A et al. 2014. *op. cit.*

¹⁰¹ Clark TC et al. 2013. *op. cit.*

¹⁰² Clark T, Fleming T, Bullen P, Crengle S, Denny S, Dyson B, Peiris-John R, Robinson E, Rossen F, Sheridan J, Teevale T, Utter J, Lewycka S 2013. Health and well-being of secondary school students in New Zealand: trends between 2001, 2007 and 2012. *J Paediatr and Child Health*;49(11):925–934.

¹⁰³ Kang M, Sanders J 2013. Medicolegal issues in adolescent health. In Kang M, Skinner SR, Sanci LA, Sawyer SM. *Youth health and adolescent medicine*. Chapter 5. East Hawthorn, Vic, Australia: IP Communications.

¹⁰⁴ Bird S 2011. *op. cit.*

¹⁰⁵ Sanci LA et al. 2005. *op. cit.*

¹⁰⁶ RACP. 2015. *Protecting Children is Everybody's Business: Paediatricians responding to the challenge of child protection*.

¹⁰⁷ Berenson A, Tan A, Hirth JM, Wilkinson GS 2013. Complications and continuation of intrauterine device use among commercially insured teenagers. *Obstetrics & Gynecology*;121(5):951–958. Available at: [REDACTED]

¹⁰⁸ Gray E, McDonald P 2010. Using a reproductive life course approach to understand contraceptive method use in Australia. *J Biosoc Sci.*;42(1):43–57. Available at: [REDACTED]

¹⁰⁹ Sexual Health and Family Planning Australia 2013. *Time for a change: increasing the use of long acting reversible contraceptive methods in Australia*. Endorsed by the Public Health Association of Australia.

¹¹⁰ *ibid.*

¹¹¹ Family Planning Alliance Australia 2014. *Long-acting reversible contraception (LARC) position statement*. October. Available at: [REDACTED]

¹¹² Family Planning Alliance Australia. 2014. *Achieving change: increasing the use of effective long acting reversible contraception (LARC)*. October.

¹¹³ Lewis LN, Doherty DA, Hickey M, Skinner SR 2010. Predictors of sexual intercourse and rapid-repeat pregnancy among teenage mothers: an Australian prospective longitudinal study. *Med J Aust.*;20:193(6):338–342.

¹¹⁴ Stevens-Simon C, Kelly L, Singer D 1999. Preventing repeat adolescent pregnancies with early adoption of the contraceptive implant. *Fam Plann Perspect.*;31(2):88–93.

¹¹⁵ Department of Reproductive Health and Research 2010. *Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (LNG ECPs)*. World Health Organization. Available at: [REDACTED]

¹¹⁶ Pharmaceutical Society of Australia 2011. Guidance for provision of a Pharmacist Only medicine Levonorgestrel – Approved indication: emergency contraception. Available at:

[REDACTED]

¹¹⁷ Hussainy SY, Stewart K, Chapman CB, Taft AJ, Amir LH, Hobbs MK, Shelley JM, Smith AM 2011. Provision of the emergency contraceptive pill without prescription: attitudes and practices of pharmacists in Australia. *Contraception*;83(2):159–166. Epub 2010 Aug 11.

¹¹⁸ Sexual Health and Family Planning Australia 2013. Statement on emergency contraception. November. Available at: [REDACTED]

¹¹⁹ Costa CM, Russell D, Carrette M 2010. Abortion in Australia still to emerge from the 19th century. *Lancet*;375(9717):804–805.

¹²⁰ Royal Australian College of Obstetricians and Gynaecologists 2012. C-Gyn 17 termination of pregnancy. Available at: [REDACTED]

¹²¹ Public Health Association Australia 2008. Abortion Policy. Available at:

[REDACTED]

¹²² AIHW, NPSU: Grayson N, Hargreaves J, Sullivan EA 2005. Use of routinely collected national data sets for reporting on induced abortion in Australia. AIHW Cat. No. PER 30. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 17).

¹²³ Taft AJ, Watson LF 2007. Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. *Aust N Z J Public Health*;31(2):135–142.

¹²⁴ Belton S, De Costa CM, Whittaker A 2015. Termination of pregnancy: a long way to go in the Northern Territory. *Med J Aust*;202(3):130–131.

¹²⁵ Doran F, Hornibrook J 2014. Rural New South Wales women's access to abortion services: highlights from an exploratory qualitative study. *Aust J Rural Health*;22(3):121–126.

¹²⁶ New Zealand Family Planning. The law around abortion. Available at:

[REDACTED]

¹²⁷ Abortion Supervisory Committee 2014. Report of the Abortion Supervisory Committee. New Zealand House of Representatives. Available [REDACTED]

[REDACTED]

¹²⁸ Royal Australian College of Obstetricians and Gynaecologists 2012. op. cit.

¹²⁹ Public Health Association Australia 2008. op. cit.

¹³⁰ Rose SB, Stanley J, Lawton BA 2015. Time to second abortion or continued pregnancy following a first abortion: a retrospective cohort study. *Hum Reprod.*;30(1):214–221.

¹³¹ Royal Australian College of Obstetricians and Gynaecologists 2012. op. cit.

¹³² Medical Board of Australia 2014. Good medical practice: a code of conduct for doctors in Australia. Available at: [REDACTED]

¹³³ Australian Medical Association 2013. Conscientious objection – position statement. Available at: [REDACTED]

¹³⁴ Medical Council of New Zealand 2013. Good medical practice. April. Available at: www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf

¹³⁵ Australian Bureau of Statistics 2013. Births, Australia, 2013. Cat. no. 3301.0. Available at: [REDACTED]

¹³⁶ *ibid.*

¹³⁷ New Zealand Families Commission 2012. Teen pregnancy: regional and national trends evidence brief 2012. Available at: [REDACTED]

¹³⁸ Australian Institute of Health and Welfare 2011. op. cit.

¹³⁹ New Zealand Families Commission. Teenage pregnancy and parenting: an overview. Available at: [REDACTED]

¹⁴⁰ Ward J, Bryant J, Worth H, Kaldor J, Delaney-Thiele D, Pitts M, Kelaart D, Moore E, Cairnduff S, Williams S, Waples-Crowe P, Byron K, Bamblett A, Betts S and Coburn T 2013. Findings from the GOANNA study. *HIV Australia*;11(3).

¹⁴¹ Williams H, Kang M, Skinner R 2013. op. cit.

¹⁴² Ruedinger E, Cox JE 2012. Adolescent childbearing: consequences and interventions. *Curr Opin Pediatr.*;24(4):446–452.

¹⁴³ Boden JM, Fergusson DM, Horwood LJ 2008. Early motherhood and subsequent life outcomes. *J Child Psychol Psychiatry*;49(2):151–160.

¹⁴⁴ Rafferty Y, Griffin KW, Lodise M 2011. Adolescent motherhood and developmental outcomes of children in early head start: the influence of maternal parenting behaviors, well-being, and risk factors within the family setting. *Am J Orthopsychiatry*;81(2):228–245.

¹⁴⁵ Flaherty SC, Sadler LS 2011. A review of attachment theory in the context of adolescent parenting. *J Pediatr Health Care*;25(2):114–121.

¹⁴⁶ Makowaremahihi C, Lawton BA, Cram F, Ngata T, Brown S, Robson B 2015. Initiation of maternity care for young Māori women under 20 years, *NZMJ*;127(1393). Available at:

[REDACTED]

[REDACTED]

¹⁴⁷ Raatikainen K, Heiskanen N, Verkasalo PK, Heinonen S 2006. Good outcome of teenage pregnancies in high-quality maternity care. *Eur J Public Health*;16(2):157–161.

¹⁴⁸ Sullivan K, Clark J, Castrucci B, Samsel R, Fonseca V, Garcia I 2011. Continuing education mitigates the negative consequences of adolescent childbearing. *Matern Child Health J.*;15(3):360–366.

¹⁴⁹ Savio Beers LA, Hollo RE 2009. Approaching the adolescent-headed family: a review of teen parenting. *Curr Probl Pediatr Adolesc Health Care*;39(9):216–233.

¹⁵⁰ Council of Australian Governments 2010. National plan to reduce violence against women and their children 2010–2022. Available at: [REDACTED]

[REDACTED]

[REDACTED]

¹⁵¹ *ibid.*

¹⁵² World Health Organization 2003. Guidelines for medico-legal care for victims of sexual violence. Available at: [REDACTED]

¹⁵³ Clinical Effectiveness Group: British Association for Sexual Health and HIV 2011. UK National guidelines on the management of adult and adolescent complainants of sexual assault 2011. Available at: [REDACTED]

¹⁵⁴ Fontenot HB 2013. Intersection of HPV and sexual assault: an opportunity for practice change. *J Forensic Nurs*;9(3):146–154.

¹⁵⁵ Classen CCI, Palesh OG, Aggarwal R 2005. Sexual revictimization: a review of the empirical literature. *Trauma Violence Abuse*;6(2):103–129.

¹⁵⁶ Medical Council of New Zealand 2006. Best health outcomes for Maori: practice implications. A resource booklet prepared for the Medical Council of New Zealand by Māori Ora Associates.

¹⁵⁷ Medical Council of New Zealand 2008. Best health outcomes for Māori: practice implications. A resource booklet prepared for the Medical Council of New Zealand by Māori Ora Associates.

¹⁵⁸ The Institute of Environmental Science and Research Ltd 2013. Sexually transmitted infections in New Zealand: Annual surveillance report 2013 Porirua, New Zealand. Available at: [REDACTED]

¹⁵⁹ Ministry of Health 2013. Cancer: new registrations and deaths 2010. Wellington: Ministry of Health.

¹⁶⁰ Clark T, Robinson E, Crengle S, Watson P 2006. Contraceptive use by Māori youth in New Zealand: associated risk and protective factors. *N Z Med J*;119(1228):U1816.

¹⁶¹ Clark TC, Crengle S, Sheridan J, Rowe D, Robinson E 2014. Factors associated with consistent contraception and condom use among Māori secondary school students in New Zealand. *J Paediatr Child Health*;50(4): 258–265.

¹⁶² Saewyc E, Clark TC, Barney L, Brunanski D, Homma Y 2014. Enacted stigma and HIV risk behaviours among sexual minority Indigenous youth in Canada, New Zealand, and the United States. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*;11(3):411–420.

¹⁶³ Medical Council of New Zealand 2014. Appendix 2: Statement on best practices when providing care to Maori patients and their whanau. In draft. Available at: [REDACTED]

¹⁶⁴ The Institute of Environmental Science and Research Ltd 2013. op. cit.

¹⁶⁵ The Kirby Institute 2015. op. cit.

¹⁶⁶ Ward J et al. 2013. op. cit.

¹⁶⁷ ANTHYM. Aboriginal Nations Torres Strait Island HIV Youth Mob. Available at: [REDACTED]

¹⁶⁸ Fagan P, Cannon F, Crouch A 2013. The young person check: screening for sexually transmitted infections and chronic disease risk in remote Aboriginal and Torres Strait Islander youth. Public Health Association of Australia.

¹⁶⁹ Robinson KH, Bansel P, Denson N, Ovenden G, Davies C 2014, Growing up queer: issues facing young Australians who are gender variant and sexuality diverse. Melbourne: Young and Well Cooperative Research Centre. Available at: [REDACTED]

¹⁷⁰ Hillier L, Jones T, Monagle M, Overton N, Gahan L, Blackman J, Mitchell A 2010. Writing Themselves in 3 (WTi3): the third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. Monograph Series No. 78, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University.

¹⁷¹ Williams H et al. 2013. op. cit.

¹⁷² Robinson KH et al. 2014. op. cit.

¹⁷³ Lucassen MF, Merry SN, Robinson EM, Denny S, Clark T, Ameratunga S, Crengle S, Rossen FV 2011. Sexual attraction, depression, self-harm, suicidality and help-seeking behaviour in New Zealand secondary school students. *Aust N Z J Psychiatry*;45(5):376–383.

¹⁷⁴ Australian Human Rights Commission 2015. Resilient individuals: sexual orientation, gender identity & intersex rights. National Consultation Report. Available at: [REDACTED]

¹⁷⁵ Hillier L et al. 2010. op. cit.

-
- ¹⁷⁶ Denny S, Lucassen MF, Stuart J, Fleming T, Bullen P, Peiris-John R, Rossen FV, Utter J 2014. The association between supportive high school environments and depressive symptoms and suicidality among sexual minority students. *J Clin Child Adolesc Psychol.*;53:1–14.
- ¹⁷⁷ William Leonard, Marian Pitts, Anne Mitchell, Anthony Lyons, Anthony Smith, Sunil Patel, Murray Couch and Anna Barrett (2012) *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*. Monograph Series Number 86. Melbourne: The Australian Research Centre in Sex, Health & Society, La Trobe University.
- ¹⁷⁸ Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing 2009 (revised 2011). *Well proud: A guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. Melbourne: Victorian Government, Department of Health. Available at: [REDACTED]
- ¹⁷⁹ Barrett C, Stephens K 2012. *Beyond: 'We treat everyone the same'. A report on the 2010–2011 program: How² create a gay, lesbian, bisexual, transgender and intersex inclusive service*. Melbourne: Gay and Lesbian Health Victoria. Available at: [REDACTED]
- ¹⁸⁰ Adams J, Dickinson P, Asiasiga L 2013. Mental health promotion for gay, bisexual, transgender and intersex New Zealanders. *J Prim Health Care*;5(2):105–113.
- ¹⁸¹ The Kirby Institute 2013. *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2013*. Sydney: The Kirby Institute, UNSW.
- ¹⁸² Australasian Society for HIV Medicine (ASHM) 2015. *ASHM Communique. Update on HIV PrEP for HIV clinicians*. February. Available at: [REDACTED]
- ¹⁸³ Lachowsky NJ, Saxton PJ, Dickson NP, Hughes AJ, Summerlee AJ, Dewey CE 2014. Factors associated with recent HIV testing among younger gay and bisexual men in New Zealand, 2006–2011. *BMC Public Health*; 14:294.
- ¹⁸⁴ Templeton DJ, Read P, Varma R, Bourne C 2014. Australian sexually transmissible infection and HIV testing guidelines for asymptomatic men who have sex with men 2014: a review of the evidence. *Sex Health*;11(3):217–229
- ¹⁸⁵ Philip SS, Yu X, Donnell D, Vittinghoff E, Buchbinder S 2010. Serosorting is associated with a decreased risk of HIV seroconversion in the EXPLORE study cohort. *PLoS ONE*;5(9):e12662.
- ¹⁸⁶ Cameron S 2014. *Are young gay men really so different? Considering the HIV health promotion needs of young gay men*. Australian Federation of Aids Organisations. April.
- ¹⁸⁷ The Kirby Institute 2013. *op. cit.*
- ¹⁸⁸ McNair R, Szalacha L, Hughes T 2011. Health status, health service use, and satisfaction according to sexual identity of young Australian women. *Women's Health Issues*;21(1):40–47.

¹⁸⁹ Lucassen MFG, Clark TC, Denny SJ, Fleming TM, Rossen FV, Sheridan J, Bullen P, Robinson EM 2014. What has changed from 2001 to 2012 for sexual minority youth in New Zealand? *J Paediatr Child Health*. Sep 10 [Epub ahead of print].

¹⁹⁰ Koh AS, Gomez CA, Shade S, Rowley E 2005. Sexual risk factors among self-identified lesbian, bisexual women, and heterosexual women accessing primary care settings. *Sex Transm Dis*. 2005 Sep;32(9):563-9.

¹⁹¹ McNair R et al. 2011. op. cit.

¹⁹² *ibid.*

¹⁹³ American Psychiatric Association Diagnostic and Statistical Manual-5 (DSM-5) 2013. Available at:

¹⁹⁴ Olson J, Schrage SM, Belzer M, Simons LK, Clark LF 2015. Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *J Adolesc Health*. 2015 Oct;57(4):374

¹⁹⁵ *ibid.*

¹⁹⁶ Steensma TD, Biemond R, Boer FD, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry*;16:499–516.

¹⁹⁷ Wallien MSC, Cohen-Kettenis PT 2008. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry*;47(12):1413–1423.

¹⁹⁸ Australasian Paediatric Endocrine Group Disorders of Sex Development Working Group 2010. Gender identity disorder guidelines. Available at:

¹⁹⁹ Clark TC, Lucassen MFG, Bullen P, Denny SJ, Fleming TM, Robinson EM, Rossen FV 2014. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey (Youth'12). *J Adolesc Health*;55(1):93–99.

²⁰⁰ *ibid.*

²⁰¹ Hewitt JK, Paul C, Kasiannan P, Grover SR, Newman LK, Warne GL 2012. Hormone treatment of gender identity disorder in a cohort of children and adolescents. *Med J Aust*.;21:196(9):578–581.

²⁰² Guss C, Shumer D, Katz-Wise SL 2015. Transgender and gender nonconforming adolescent care: psychosocial and medical considerations. *Curr Opin Pediatr*.;26(4):421–426. .

²⁰³ de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT 2014. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*;134(4):696–704.

²⁰⁴ Hughes IA, Houk C, Ahmed SF, Lee PA 2006. Consensus statement on management of intersex disorders. Available at:

²⁰⁵ Warne GL 2012. Long-term outcomes of disorders of sexual development (DSD): a world view. In Hutson JM, Warne GL, Grover SR (eds). Disorders of sex development: an integrated approach to management. Berlin: Springer-Verlag, pp. 281– 285.

²⁰⁶ Kyriakou A, Lucas-Herald AK, McGowan R, Tobias ES, Ahmed SF 2015. Disorders of sex development: advances in genetic diagnosis and challenges in management. *Advances in Genomics and Genetics*;5:165–177.

²⁰⁷ Jürgensen M, Kleinemeier E, Lux A, Steensma TD, Cohen-Kettenis PT, Hiort O, Thyen U, Köhler B; DSD Network Working Group 2013. Psychosexual development in adolescents and adults with disorders of sex development – results from the German Clinical Evaluation Study. *J Sex Med.*;10(11):2703–2714.

²⁰⁸ Sanders C, Carter B, Lwin R 2015. Young women with a disorder of sex development: learning to share information with health professionals, friends and intimate partners about bodily differences and infertility. *J Adv Nurs*;71(8):1904–1913.

²⁰⁹ McCracken KA, Fallat ME 2015. Transition from pediatric to adult surgery care for patients with disorders of sexual development. *Semin Pediatr Surg.*;24(2):88–92.

²¹⁰ Council of Europe, Commissioner for Human Rights 2015. Human rights and intersex people: Issue paper. April. Available at:

[REDACTED]

²¹¹ World Health Organization, OHCHR, UN Women, UNAIDS, UNDP, UNFPA and UNICEF 2014. Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement. Available at: [REDACTED]

²¹² United Nations, Committee against Torture 2011. Consideration of reports submitted by States parties under article 19 of the Convention. Concluding observations of the Committee against Torture. Geneva: United Nations. 12 December. Available at:

[REDACTED]

²¹³ United Nations, Committee on the Rights of Child 2015. op. cit.

²¹⁴ Carpenter M 2013. Statement on the Senate Report 'Involuntary or Coerced Sterilisation of Intersex People in Australia'. Sydney: Organisation Intersex International Australia Limited. 29 October. Available at [REDACTED]

[REDACTED]

²¹⁵ Australian Human Rights Commission 2009. Surgery on intersex infants and human rights.

²¹⁶ Australian Senate 2013. Involuntary or coerced sterilisation of intersex people in Australia. Canberra: Community Affairs References Committee.

²¹⁷ United Nations 2006. Convention on the rights of persons with disabilities and Optional Protocol. Available at: [REDACTED]

²¹⁸ Eastgate G, Van Driel ML, Lennox N, Scheermeyer E 2011. Women with intellectual disabilities: a study of sexuality, sexual abuse and protection skills. *Aust Fam Phys*;40(4):226–230.

²¹⁹ Eastgate G 2011. Sex and intellectual disability: dealing with sexual health issues. *Aust Fam Phys*;40(4):188–191.

²²⁰ United Nations Population Fund 2007. Emerging issues: sexual and reproductive health for persons with disabilities. New York: United Nations Population Fund.

²²¹ May D, Kundert D 1996. Are special educators prepared to meet the sex education needs of their students? A progress report. *The Journal of Special Education*;29(4):433–441.

²²² Sexual Health and Family Planning Disability Special Interest Group 2013. Improving sexual and reproductive health in people with intellectual disability. May.

²²³ *ibid.*

²²⁴ NSW Council for Intellectual Disability 2011. Sexuality. Factsheet. May. Available at:
[REDACTED]

²²⁵ United Nations Population Fund 2007. *op. cit.*

²²⁶ Eastgate G 2011. *op. cit.*

²²⁷ NSW Council for Intellectual Disability 2011. *op. cit.*

²²⁸ Family Planning NSW 2013. All about sex. Ashfield, NSW: FPNSW.

²²⁹ Eastgate G, Scheermeyer E, van Driel ML, Lennox N 2012. Intellectual disability, sexuality and sexual abuse prevention: a study of family members and support workers. *Australian Family Physician*;41(3):135–139.

²³⁰ NSW Council for Intellectual Disability 2011. *op. cit.*

²³¹ Family Planning NSW 2013. Love and kisses: taking action on the reproductive and sexual health and rights of people with disability. Available at: [REDACTED]

²³² De Sanctis V1, Soliman A, Mohamed Y 2013. Reproductive health in young male adults with chronic diseases in childhood. *Pediatr Endocrinol Rev.*;10(3):284–296.

²³³ Frayman KB, Sawyer SM 2015. Sexual and reproductive health in cystic fibrosis: a life-course perspective. *Lancet Respir Med.*;3(1):70–86.

²³⁴ Jaser SS, Yates H, Dumser S, Whitemore R 2011. Risky business: risk behaviors in adolescents with type 1 diabetes. *Diabetes Educ.*;37(6):756–764..

²³⁵ Mackner LM, Crandall WV 2006. Brief report: psychosocial adjustment in adolescents with inflammatory bowel disease. *J Pediatr Psychol.*;31(3):281–285.

-
- ²³⁶ Wood PL, Bauman D 2014. Gynaecological issues affecting the obese adolescent. *Best Pract Res Clin Obstet Gynaecol.* 2015 May;29(4)
- ²³⁷ Linna MS, Raevuori A, Haukka J, Suvisaari JM, Suokas JT, Gissler M 2014. Pregnancy, obstetric, and perinatal health outcomes in eating disorders. *Am J Obstet Gynecol.*;211(4):392..
- ²³⁸ Brown LK, Hadley W, Stewart A, Lescano C, Whiteley L, Donenberg G, Di Clemente R: Project STYLE Study Group 2010. Psychiatric disorders and sexual risk among adolescents in mental health treatment. *J Consult Clin Psychol.*;78(4):590–597.
- ²³⁹ Jacobs LA, Pucci DA 2013. Adult survivors of childhood cancer: the medical and psychosocial late effects of cancer treatment and the impact on sexual and reproductive health. *J Sex Med.*;10 Suppl 1:120–126.
- ²⁴⁰ Murphy D, Klosky JL, Reed DR, Termuhlen AM, Shannon SV, Quinn GP 2015. The importance of assessing priorities of reproductive health concerns among adolescent and young adult patients with cancer. *Cancer.*;121(15):2529–2536.
- ²⁴¹ Denny S et al. 2013. op. cit.
- ²⁴² Gleit R, Freed G, Fredericks E M. Transition Planning: Teaching Sexual Self-Management. *Contemp Pediatr.* 2014 April ; 31(4): 16–2.
- ²⁴³ Ecklund LC, Usadi RS 2015. Endocrine and reproductive effects of polycystic ovarian syndrome. *Obstet Gynecol Clin North Am.*42(1):55–65.
- ²⁴⁴ Brotherton JM et al. 2015. op. cit.
- ²⁴⁵ Charron-Prochownik D, Fischl AR, Choi J, Schmitt PL, White NH, Becker D, Downs J, Hannan M, Thurheimer J, Sereika SM 2014. Mother–daughter dyadic approach for starting preconception counseling at puberty in girls with diabetes. *Res J Womens Health*;29:1.
- ²⁴⁶ Bacopoulou F, Greydanus DE, Chrousos GP 2010. Reproductive and contraceptive issues in chronically ill adolescents. *Eur J Contracept Reprod Health Care*;15(6):389–404.
- ²⁴⁷ Stevens SE, Steele CA, Jutai JW, Kalnins IV, Bortolussi JA, Biggar WD 1996. Adolescents with physical disabilities: some psychosocial aspects of health. *J Adolesc Health*;19(2):157–164.
- ²⁴⁸ Nosek MA, Hughes RB, Swedlund N, Taylor HB, Swank P 2003. Self-esteem and women with disabilities. *Soc Sci Med.*;56(8):1737–1747.
- ²⁴⁹ Cardenas DD, Topolski TD, White CJ, McLaughlin JF, Walker WO 2008. Sexual functioning in adolescents and young adults with spina bifida. *Arch Phys Med Rehabil.*;89(1):31–35.
- ²⁵⁰ Esmail S, Darry K, Walter A, Knupp H 2010. Attitudes and perceptions towards disability and sexuality. *Disabil Rehabil.*;32(14):1148–1155.

²⁵¹ Verhoef M, Barf HA, Vroege JA, Post MW, Van Asbeck FW, Gooskens RH, Prevo AJ 2005. Sex education, relationships, and sexuality in young adults with spina bifida. *Arch Phys Med Rehabil.*;86(5):979–987.

²⁵² Neufeld JA, Klingbeil F, Bryen DN, Silverman B, Thomas A 2002. Adolescent sexuality and disability. *Phys Med Rehabil Clin N Am.*;13(4):857–873.

²⁵³ Grover SR 2011. Gynaecological issues in adolescents with disability. *J Paediatr Child Health.*;47(9):610–613.

²⁵⁴ Quint EH 2014. Menstrual and reproductive issues in adolescents with physical and developmental disabilities. *Obstet Gynecol.*;124(2 Pt 1):367–375.