Carlton, Australia: La Trobe University, Centre for the Study of Sexually Transmissible Diseases

ISBN 1 86446 106 3

THE RURAL MURAL: SEXUALITY AND DIVERSITY IN RURAL YOUTH

RESEARCH REPORT
1996

Lynne Hillier, Deborah Warr and Ben Haste

National Centre in HIV Social Research: Program in Youth/General Population
Centre for the Study of Sexually Transmissible Diseases
Faculty of Health Sciences
La Trobe University
Locked Bag 12
Carlton South VIC 3053

ACKNOWLEDGMENTS

No project such as this can be implemented without the input of many people. Our thanks must first go to the hundreds of young people living in rural areas who gave willingly and enthusiastically of their time and effort in order to take part in the research. This report is dedicated to them. We also owe gratitude to the many school communities (parents and staff) who took an interest in the research, saw its potential for change and supported its implementation in their schools. Thank you also to a number of rural youth workers who supported this project from the beginning and helped pave its way.

The Community Liaison Officer with the National Centre in HIV Social Research: Program in Youth/General Population is Jenny Walsh. This Centre has a commitment to community liaison, and without Jenny's hard work and grounding in the community, this research could not have taken place. Many thanks to Dr. Lyn Harrison for proof reading several versions of this report.

We would also like to acknowledge the work of Professor Doreen Rosenthal, the Director of the Centre for the Study of Sexually Transmissible Diseases in this research project and her support and valuable insight throughout 1995.

This work was supported by a Commonwealth AIDS Research Grant.

TABLE OF CONTENTS

EXECUTIVE SUMMARY *1*

INTRODUCTION *4*

Aims of the study *6*

METHOD *7*

Sampling *7*
Focus group format *7*
Questionnaire description and development *7*
Procedure *8*

RESULTS *9*

Student participation rate *9*
Student profile *9*
Quality of life and well-being *10*
Positive things about living in the country
When living in the country is difficult
Sex education in schools *13*
HIV knowledge *15*
STD knowledge *16*
Knowledge of safe and unsafe sexual practices *17*
Sources of information about sex *18*
Accessing sexual health services *21*
Perceived invulnerability *22*
Attitudes towards people living with AIDS *26*
Attitudes to sex roles and relationships *26*
Sexual behaviours *29*
Condom use *33*
Alcohol and sex *37*
Communicating about sex *38*
Sexual orientation *39*

DISCUSSION *41*

Conclusion *44*

REFERENCES *46*

Appendix A *48*

EXECUTIVE SUMMARY

This research, undertaken by the National Centre in HIV Social Research - Program in Youth/General Population, was set up to document and understand the factors pertaining to the sexual health behaviours, knowledge and issues of rural young people and to determine the barriers that these young people face in practising safe sex. We found that just over a quarter of the young people surveyed had commenced having sexual intercourse and that many more were exploring sexual touching with their partners. This suggests that it is crucial that rural youth have access to the appropriate services and resources that will enable them to take responsibility for their sexual health.

Issues around privacy and confidentiality were important to these young people and girls in particular found it difficult to practise and attend to their sexual health needs in private. The inevitably high profile of the everyday activities of people in small communities created real problems for young people and especially those young people whose sexual identities varied from the heterosexual norm. Girls, in particular, often felt that they had little privacy in small communities and were expected to conduct their sexual relationships within the bounds of steady relationships and sexual double standards. This made it more difficult for them to access condoms and other sexual health resources. Eighty-nine percent of students in the study identified as heterosexual. The remaining 11% identified either as homosexual, bisexual or were unsure of their sexual orientation. Given the excessively aggressive attitudes to gay and lesbian people that were generally expressed by students, it would be reasonable to assume that those young people who did not identify as heterosexual would be highly motivated to maintain anonymity. This could in turn impact on their ability to negotiate safer sex.

As a consequence of limited options in terms of work, study and life experiences, many young people envisaged leaving their town once they had completed their schooling. Only a quarter of the sample intended to remain and these students were more likely to be boys for whom more options, especially in terms of work, were available in rural economies. A small number of students had trouble accessing services that assisted them with their sexual health and this figure was even higher when issues such as privacy were considered. Many girls preferred to see a female doctor yet they are not readily accessible in many small rural communities. HIV knowledge was high although the students' knowledge of more prevalent STDs was not as high as for HIV. Girls demonstrated better knowledge of STDs than boys. Many students expressed confusion in regard to safe and unsafe sex practices often linking unsafe practices to particular activities and failing to specify that condoms would ensure that many activities such as intercourse and oral sex were safe. Condom use was similar to levels reported in other studies of urban young people although quite a few young people (more

often girls) in this study experienced some degree of difficulty or discomfort in obtaining them.

Few students believed that they were likely to contract an STD. For the majority of students who believed themselves to be invulnerable, this was largely attributed to avoidance of high risk behaviours although many students saw themselves as being protected because they were not sexually active and this situation would be likely to change over the next few years. Most students did protect themselves by always using a condom. Other students, however, attributed their invulnerability to the protection afforded through only having sex within a steady relationship and to a lesser, but nonetheless not insignificant extent, by being able to avoid infected partners. This latter set of beliefs was more frequently held by boys although both boys and girls believed they could avoid STDs by not having sex with people whom they considered to be promiscuous.

Mothers were the most commonly used sources of information about sex and they were also a highly trusted source. School health education programs were the next most frequently utilised sources of information. The information available in school based programs was more often derived from biomedical issues associated with sex education such as reproduction, contraceptive methods and pathology. Young people reported wanting more information on the socio/cultural aspects of sexuality including skills to resist having sex (nominated more frequently by girls) and values about sex (nominated more frequently by boys). The media was also an important source of information about sex but it was not highly trusted by students.

Steady relationships provide a license to engage in sexual intercourse but many girls expressed ambivalence towards being involved with boys in this way. The positive aspects of a relationship for girls were associated with having someone care for them and show affection towards them but negative aspects were perceived in the expectation to have sex and the ways in which they lost some control over other parts of their lives. Boys enjoyed the status of having a girlfriend and the availability of sex afforded through being in a relationship. This evident incompatibility between the expectations of girls and boys towards relationships was apparent in many facets of young people's sexual experience and the issues that were consequently raised from this. In particular, girls tended to express a great deal of ambivalence towards sexual intercourse and experienced difficulty in negotiating consent when boys were very persistent in regards to initiating and maintaining intercourse as a part of their relationship.

There were also serious concerns for the association between alcohol and unsafe sex and the way in which alcohol use impacted on sexual behaviours. High numbers of young people combined alcohol accasionally, often or always when engaging in sex. Alcohol diminishes

competency and motivation to practise safer sex and it was evident that some young people engaged in unwanted sex or failed to practise safe sex as a consequence of being intoxicated.

The needs of rural young people are in some instances common to young people everywhere in that they require a range of appropriate information and skills to deal with their sexual health issues. Sexual health promotion material needs to directly address the way in which gendered power relations impact upon safe sex practices and spend some effort to dismantle the sexual double standards and harassment that can be directed towards those individuals who challenge these norms. The more specific needs of young people are associated with ensuring privacy and confidentiality and services need to be aware of how these qualities of service provision can be guaranteed for rural young people.

INTRODUCTION

A 1993 report, commissioned by the Commonwealth Department of Human Services and Health, which reviewed the research (and research gaps) relating to young people's sexual behaviours, beliefs and attitudes concluded with the observation that 'very little is known about rural youth and whether their sexual worlds differ from their urban peers' (Rosenthal & Reichler, 1994, p. 20). The Rural Mural research project reported here was initiated in response to the finding by this report that the sexual issues of young people in rural Australia have, to date, been inadequately investigated and theorised. This study began with the recognition that the circumstances of rural life contribute particular qualities to young people's sexual experience and this holds some implications for the issues associated with their sexual health.

The sexual knowledge, attitudes and beliefs of young people in general have come under an intense research spotlight as they are beginning to explore their sexuality at younger ages than ever before and doing so increasingly beyond the expectations attached to marriage or impending marriage (Rosenthal & Moore, 1991; Waters, 1989; Farber, 1992). The AIDS pandemic has lent a special urgency to the task of ensuring that in the changing contexts of adolescent sexuality young people are more aware of the risks that are posed by HIV/AIDS and other STDs. Preparing young people to manage their sexuality in the age of AIDS means that they are well informed and confident, not only in regard to understanding the risks associated with STDs, but also with a knowledge of the resources that are available to promote their sexual health. In addition to this, young people also need to develop the skills that will enable them to assert their own needs and interests. This is more complex than 'learning how to have sex', a commonly heard objection to sex education programs in schools, and ideally can assist in resisting unwanted sex, negotiating mutually acceptable boundaries and feeling comfortable with the diversity of sexual experiences that young people have.

It is no longer accepted that, given the right information on how to make their sexual encounters safe, young people will automatically align their behaviours to follow safe sex guidelines. Although knowledge is a necessary component for safer sexual encounters, other factors are also part of the safe sex equation. For example motivation (influenced by perceptions of personal vulnerability), cultural context (which includes the ways young people situate themselves as masculine and feminine) and access to services and condoms are all likely to impinge on the ability of young people to negotiate their sexual safety. Moreover, there are other unique factors which are likely to impact on rural youth. Access to information, services and condoms and rights to privacy and confidentiality can be

compromised in areas where populations are sparse and the provision of services of all kinds are at a reduced level in comparison with urban areas.

The National Centre in HIV Social Research - Program in Youth/General Population (NCHSR PY/GP) is a four year research program, set up in 1995 to address some of the research gaps highlighted by Rosenthal and Reichler's (1994) report. The brief for the first phase of the project was to document the factors surrounding the sexual practices of young people in rural areas in order to determine the special barriers they face in making their relationships safer. From the literature available on urban youth, it is clear that many adolescents become sexually active while at secondary school. While this is not true of all adolescents, most research suggests that 50% of them will experience sexual intercourse before they leave school (Dunne, Donald, Lucke, Nilsson & Raphael, 1993; Rosenthal & Reichler, 1994). There is also evidence to show that many of these young people are not practising safer sex, and this raises concerns, not only about HIV, but other STDs, such as chlamydia, which are common in young people (Kovacs, 1987). Moreover, most young people tend to engage in a series of steady relationships which may last from several months to several years.

This serial monogamy could in fact be no less dangerous where contracting STDs is concerned, than the practice of multiple partnering, and yet there is reason to believe that girls in particular, are more likely to assume that sexual intercourse with a steady partner *per se*, is a safe option (Abbott, 1988; Wyn, 1991). Unfortunately there is a dearth of research information about the ways that rural young people conceptualise safety in their relationships and the knowledge and attitudes which inform them. There is evidence from Dunne et al's (1993) study that rural secondary students, particularly boys, may be engaging in sexual intercourse less frequently and more safely than their urban peers. In contrast, Grunseit, Lupton, Crawford, Kippax and Noble's (1995) study found rural tertiary students to be more sexually experienced compared with a group of Macquarie University students. Clearly, until reliable information is available about these young people's sexual health needs, it will be impossible to evaluate the adequacy of existing educational and health services .

Developing an understanding of the term "rural" was the first task for this project and the research literature and discussions with workers in rural areas yielded many different definitions. Dunne et al (1993) defined rural as a town with a population of under 25,000, a size which many rural workers regarded as provincial. Alternatively, the Australian Bureau of Statistics (Castles, 1992) described any town with a population over 1,000 as urban. The Victorian Country Youth Affairs Network Journal stressed that rural towns were not only characterised by demographic factors such as population but could be seen to exhibit other differences such as the greater role of churches, a tendency towards conservatism and resistance to change and greater discrimination, (which can be expressed and experienced in

relation to race and sexual preference). Clearly some of these characteristics of rural living would seem likely to impinge on the sexual practices of young people. Remoteness as a characteristic of rural living may, for example, result in a lack of health services for young people, and restrict access to condoms, information and other support services. The *gemeinshaft* qualities of the rural town are also likely to be important. Where populations are small and generations of families have lived in the same area, young people (among others) can expect that a good deal of their behaviour will not go unnoticed. In relation to sexual health this may mean that even where health services, information and condoms are available, it may be impossible to access them anonymously. Having the town's folk know that one is visiting a sexual health service or wanting to buy condoms, may be very difficult for many young people living in a small community where everyone soon knows your business. With all of these considerations in mind, we chose to restrict the research to towns which were at least 50 kilometres from the nearest city and which had stable populations of under 10,000 with minimal seasonal population changes.

AIMS OF THE STUDY

Our primary aim was to gather baseline information on the sexual knowledge attitudes and behaviours of rural young people, with particular regard to the barriers to safer sexual practices which they may face. Further, given that individual factors alone may account for only part of the safer sex equation, we aimed to gather information about the context of sexual encounters and barriers to safer sex, including access to services and condoms, and the constructions of masculinity, femininity and heterosexuality which are dominant in the cultures of these young people and how these constructions may impinge on young people's ability to negotiate safety into their sexual practices.

METHOD

SAMPLING

Eight towns were chosen on the basis of town size (under 10,000), stability of population (no tourist towns) and distance from the nearest city (at least 50 kilometres). Five of these towns had populations of around 2,000 (2 in Tasmania, 1 in Victoria and 2 in Queensland), and three had populations of close to 10,000 (1 in Victoria and 2 in Queensland). Within these towns, all secondary schools, both private and government, were targeted. Within the schools, two year levels were approached, one junior year level (year 8 in Tas. and Vic. and year 9 in Qld.) and one senior year level (year 10 in Tas. and Vic. and year 11 in Qld.). All students in these year levels were invited to participate in the research which took two forms: single sex focus discussion groups and 45 minute surveys.

FOCUS GROUP FORMAT

The aim of these semi-structured discussions was to heighten our understanding of the issues that were addressed in the surveys and to obtain information about the lives of young people in rural towns which was too complex to capture in questionnaire form. The theme-list (see Appendix A) was identical for each group, though the discussions varied according to the unique dynamics of each group. Focus group discussions were conducted in most of the schools with girl only and boy only groups. Same sex leaders facilitated focus group discussions because it was felt that the participants would feel more comfortable and speak more freely that way.

QUESTIONNAIRE DESCRIPTION AND DEVELOPMENT

The questionnaire consisted of the following sections: demographics, relationships, attitudes to sex roles, sexuality and privacy, peer norms, STD & HIV knowledge, knowledge sources, access to services, sexual experiences and sex education at school. Two versions, (junior and senior), of the questionnaire were used. The items dealing with sexual experience and ideas about sexuality were omitted from the junior version.

The questionnaire was informed by a number of sources. Extensive consultation with Victorian rural youth workers which enabled us to utilise their expertise and practice wisdom in formulating the rural-specific questionnaire items. In order to afford a degree of comparability, it was also deemed appropriate to use some questionnaire items that had been included in research on secondary school students in general. To this end, a number of items (HIV and STD knowledge, some of the perceived invulnerability, discrimination and

confidence items) came from the Dunne et al (1993) survey of secondary school students. The questions relating to reasons for wanting a boy/girlfriend and those concerning confidentiality/privacy were developed in the course of research undertaken by Fiona Stewart whose PhD research is being undertaken at the Centre. There was also considerable input, in the form of feedback and comment, from the adolescent sexuality researchers at the Centre for the Study Of Sexually Transmissible Diseases at La Trobe University.

PROCEDURE

Once ethics approval was granted for the study, applications were sent to the educational authorities in the three states. When state approval was obtained, introductory letters were sent to the Principals of the secondary schools in the targeted towns, and meetings with the school communities were arranged. The towns of 2,000 each had one secondary school (all government run) and in all cases, after meetings with members of the school communities, approval for the research was granted. The larger towns had between one and three secondary schools in each of them and of these, only one declined our invitation to be involved in the research. Once we received approval at the state and school levels, students in years 8 and 10 (9 and 11 in Queensland) at these schools were given a ten minute briefing about the research, following which they were invited to ask questions and, if agreeable, to participate in the project.

An active consent procedure was used in which a consent form had to be signed by the students' parents/guardians in order for them to participate in the survey. To participate in focus group discussions active consent was required from both a parent/guardian and the student. Students who were interested in taking part in focus discussion groups were chosen by teachers who had been requested by the researchers to select students who were inclined to be open and talkative, and who would be expected to display a variety of opinions and to avoid friendship groups. Eight students took part in each of the same sex focus discussion groups which went for approximately one hour. Sessions were tape recorded and transcribed. Surveys were administered after the focus discussion groups had been completed. Surveys were completed by year level groups and efforts were made to ensure privacy when students were completing the questionnaires by spacing chairs and discouraging conversation until they were completed.

RESULTS

STUDENT PARTICIPATION RATE

A total of 1,958 students who were enrolled at the selected high schools were given a consent form to take home. Twenty-one percent of these students did not return their consent forms, 6% returned their forms and were not allowed to participate and 13% who had positive consent failed to participate on the day the surveys were administered. Failure to participate on the day was attributed to being absent from school or conflicting school activities such as camps and sports events. Because of the particularly sensitive nature of this research, many parents and students were cautious about being involved. Response rates differed according to schools, gender and year levels, with younger students and girls being more likely to participate than older students and boys. Sixty percent (n = 1168) of the students enrolled at the selected schools participated in the survey, an acceptable response rate given the sensitive nature of the topics that were addressed.

STUDENT PROFILE

Eleven hundred and sixty eight students in 8 rural towns in Victoria, Queensland and Tasmania completed questionnaires with a higher response rate for girls (56%) than boys (44%). Four Victorian schools (3 schools in one town of 10,000 and one in a town of 2,000), 4 Queensland schools (2 in towns of 8,000 and 2 in towns of 2,000) and 2 schools in Tasmania (each in a town of 2,000) participated in the research. Fifty six percent (n = 654) of the students were in year 8 (Victoria and Tasmania) and year 9 (Queensland) and 44% (n = 534) were in year 10 (Victoria and Tasmania) and Year 11 (Queensland).

The age range of the year 8/9 students was 12-16 while the year 10/11 students ranged between 15 and 17 years. The overlap in age between the two groups (see Figure 1) has occurred mainly because the Queensland students were on average six months older when they began their new class year, and because the research was conducted several months later in Queensland than in the other two states. Where age differences on any factor were considered, these were based on year level rather then age in year. This was done because decisions made by the schools about questionnaire content and sex education classes were based on class level rather than age although these are well correlated.

Ninety-seven percent of the students who participated in the survey were Anglo-Australian which reflects the ethnicity of rural Australia overall and 5% of the participants were Aboriginal and Torres Strait Islander students. Half of the students' parents who had been born overseas had migrated from the United Kingdom or New Zealand. Three quarters of the

students lived with both of their parents, while 12% lived with one parent only and 10% lived with one parent and a step-parent. Although 62% of the students described themselves as Christian, they indicated that religion had little importance in their lives and 40% said they had no religion at all. Almost half of the students had mothers who worked in full time paid employment (42%) and a quarter had mothers who had no paid employment outside of the home.

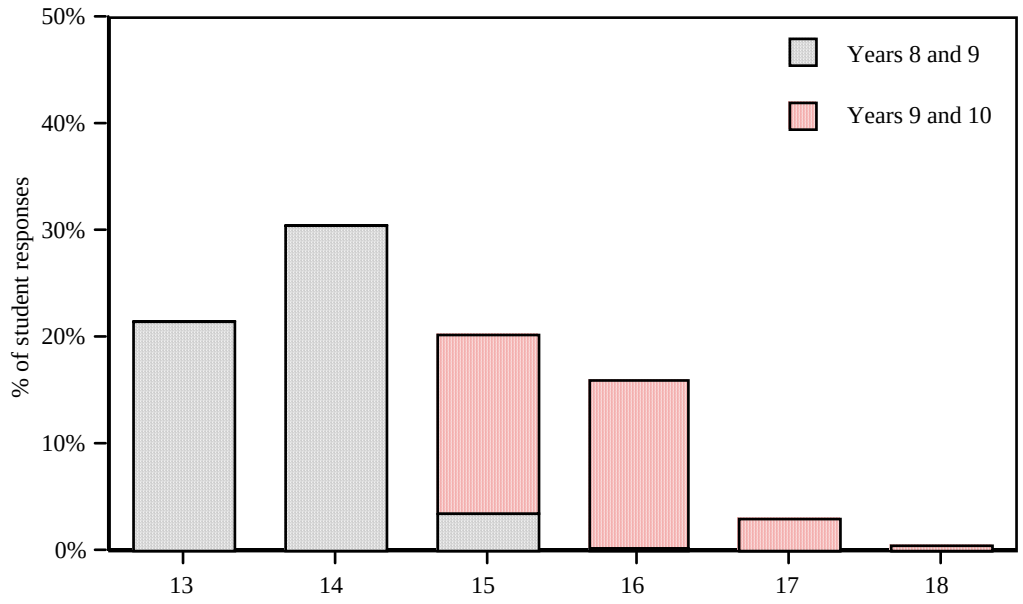

Figure 1. Age and year levels of students

QUALITY OF LIFE AND WELLBEING

Visits to the nearest regional centre were fairly infrequent with the average being once a month. Students were mainly driven there by their parents (84%) or were accompanied by friends. Older students were more likely to travel to regional centres on their own (at least without parents) although they did not necessarily visit these larger towns more frequently. Monthly visits to larger centres may not provide the opportunities needed to cater for the sexual health needs of these young people (as most adolescents must rely on parents for transportation it can be especially difficult if their parents are not aware or unsupportive of their needs) and so it is important that their needs are adequately catered for in their home town. A later section headed *Access to Services* will deal with the adequacy of home town services.

Positive things about living in the country

Many students felt that rural living offered unique opportunities and they drew idyllic images of country life to explain what they liked about living in the country. Clean air, the security of knowing most (if not all) of the people in your town and the sense of being far removed

from the problems of the city, such as violence and drugs were some of the positive things about country life that were raised by students in focus discussion groups. However, when students were asked whether they would leave or remain in the town when they finished their secondary schooling, only 25% indicated that they would stay. There were more boys who intended to stay and reasons for staying (for both boys and girls) included family, work and liking the town where they lived.

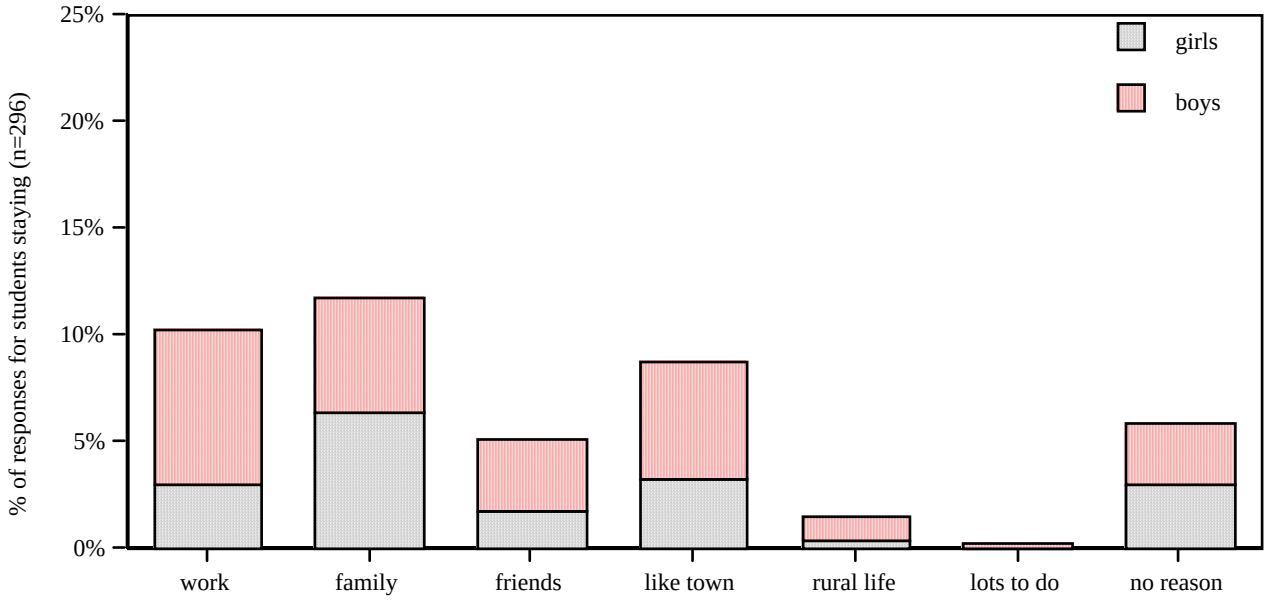

Figure 2 . Reasons for staying in the town as reported by students who intended to stay

Despite many young people having ambitions to leave when they finished school they still valued many aspects of country life as one year 8 girl explained:

"... and when you're in town you're sort of you know you can say hello to heaps of people and I don't think you get as many experiences, whether they're good or bad as you do in the city, like I go to the city a little bit because an aunty stays there but I sort of, you know you see people those weird people on the trains and everything and you just don't see them around here and I think it's a more warm, loving, caring sort of community thing, everybody cares about everybody else"

When living in the country is difficult

The disadvantages of rural towns were associated with a tendency towards conservatism, the lack of options for those young people uninterested in sports and other country activities, and a general lack of privacy. For many students, a frequently mentioned disadvantage of country life was that everybody knew everybody's business and this could become an issue if this lack of privacy impinged on their feelings of comfort in regards to their sexual practices and in ensuring their sexual health. In this survey, confidentiality and privacy were measured through issues related to accessing medical services and enjoying some degree of privacy from community surveillance and judgement on sexuality issues and in such things as

purchasing condoms. While both boys and girls indicated that they did not have a lot of privacy, girls experienced this more acutely and on all items perceived more problems with confidentiality and privacy than boys. Issues of privacy and confidentiality were also raised in focus discussion groups where girls not only experienced themselves as under intense scrutiny, but felt that they were far more likely to be judged negatively for what they were doing. As one senior girl commented:

"Well, gossip spreads really quickly and you get a reputation really quickly"

Sixty-four percent of girls felt that it was not easy to do anything without everyone else knowing and 60% felt that this surveillance restricted them in some things that they wanted to do. Over half of the girls felt it was difficult to visit a doctor without everyone knowing about it. There was also a good deal of uncertainty around the extent to which local doctors could be trusted to maintain confidentiality with almost half of the sample (same for both boys and girls) unsure about whether their local doctor would inform their parents about a doctor's visit and another 20% being quite certain that their local doctor could not be trusted to maintain confidentiality.

More girls (80% compared to 65% of boys) planned to leave their town upon finishing school and some of their comments suggested that, in addition to seeking education and work opportunities in bigger cities, one response to rigid sex role expectations was to leave:

g1 "You don't have much choice [about leaving] unless you want to be a check out girl"
g2 "There's so many old-fashioned people here. They don't like to change"

Although it is recognised that rural youth are forced, for many reasons beyond their own control, to leave their home towns, their subjective feeling of well-being can in part be measured by their intention to leave or stay at the completion of their secondary schooling. Almost three quarters envisaged leaving their town after they finished school, overwhelmingly for reasons associated with education and employment opportunities. There were a number however, who were clearly dissatisfied with their lives and wanted to leave because they were bored, hated the town or wanted new experiences. Almost half of the students expressed the ambition to attend a university or college when they finished school, while other options (in order of nominated responses) included finding a job and beginning an apprenticeship. More girls (52%) wanted to go to university or college while more boys (21% compared to 4% of girls) intended to start an apprenticeship. Neither boys nor girls were eager to get married or start a family upon completing school.

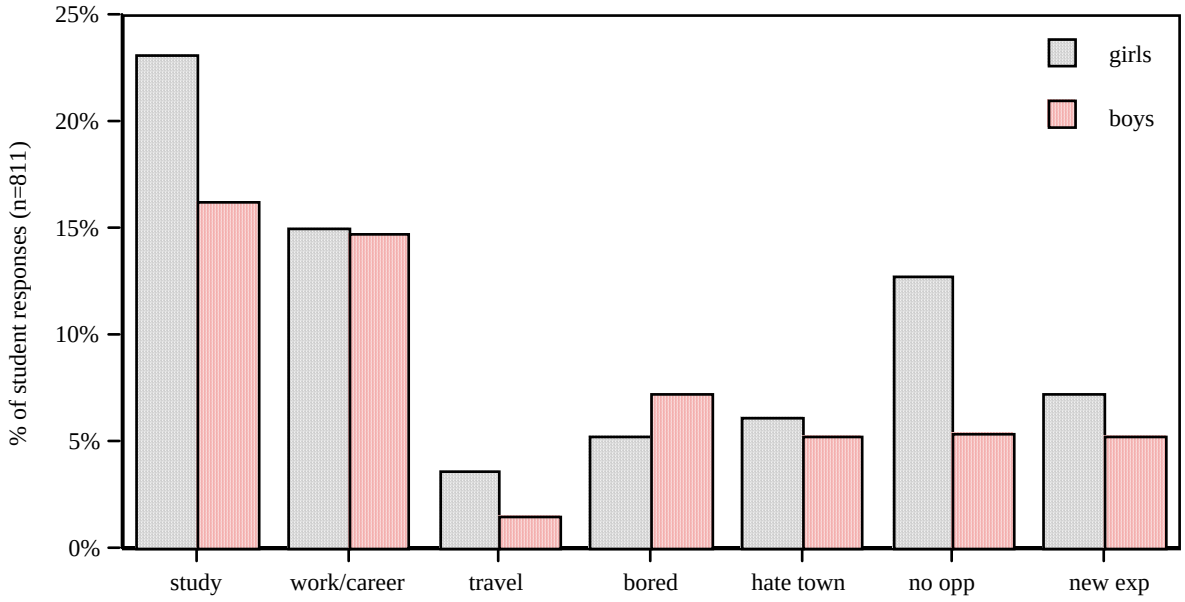

Figure 3 . Reasons for leaving the town as reported by those who intended to leave

Although boys also expressed similar concerns to the girls when talking about the limited opportunities available to them if they stayed, the farm based economies of small towns do tend to favour boys if they are to manage the family farm or enter an industry that services the rural sector when they complete their schooling. Girls also felt that it was very difficult to move beyond the tightly circumscribed boundaries of gender expectations in terms of both their social and sexual behaviour and their career aspirations.

SEX EDUCATION IN SCHOOLS

The findings from the section of the questionnaire dealing with what topics were taught in sex education programs at school and what topics students wanted to be taught more of are represented in Figures 4 and 5. The biological processes of reproduction and disease comprised a significant component of the information that was passed on to students in school based sex education programs which also, but to a lesser extent, attempted to address some of the socio/cultural issues around sexual behaviour. These two aspects of sex education have been termed **Biomedical** and **Sociocultural** to more clearly differentiate between the types of information and skills that were being taught in sex education programs. There is also the recognition of overlap between these categories, where abortion, for example, has a large sociocultural component. The nominated topics that were covered in school based sex education, in order of frequency, were HIV/AIDS, menstruation, STDs, sex and peer group pressure, relationships, contraception and values about sex. Less frequently mentioned topics included abortion, demonstrating condom use, resisting sex, homosexuality, religion and sex and abstinence.

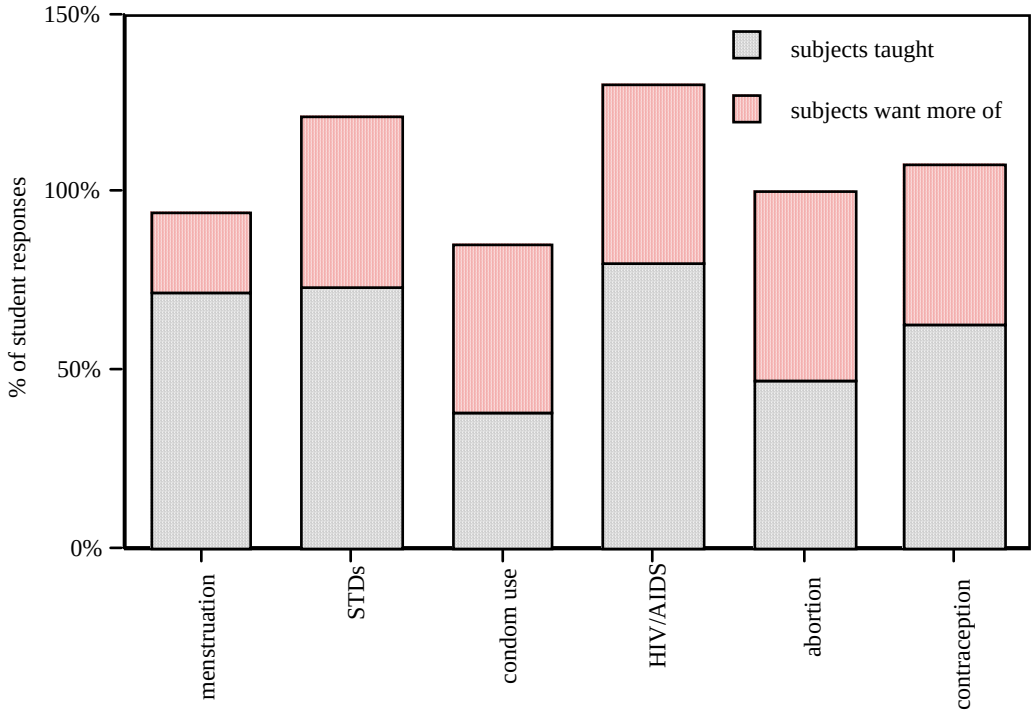

Figure 4 . Biomedical topics that students were taught and on which students wanted more information

Overall the course contents reflected a dominant approach to school based sex education which tends to focus on the more impersonal facts relating to the mechanics of reproduction and the dangers of sex. Given the urgency imparted by the spectre of the AIDS pandemic in promoting the need for school based sex education, topics dealing with HIV/AIDS and STDs were, understandably, given a great deal of prominence in course content. The most commonly taught sex education topics reflected the importance attributed to these health and medical issues associated with sexuality, but students wanted more information on the inter-personal issues that arise when learning to manage their sexual lives. Students nominated wanting to have more information on the sociocultural aspects of sex including more discussion around values about sex, relationships, HIV/AIDS, abortion and resisting sex. Significant sex differences were found between the topics that students wanted to be taught more of. Girls were keen to obtain more information on developing the skills to resist pressure to have sex, contraception and abortion, while boys wanted more taught on the values about sex. Values about sex refers to moral notions of 'right and wrong' that inform sexual possibilities and where boys were more likely to want more information on this, we might cautiously consider that they were experiencing a sense of confusion in issues of sex, perhaps as an effect of girls' expressed dissatisfaction with the status quo. There will be more discussion of this in a later section titled *Attitudes to Sex Roles and Relationships.*

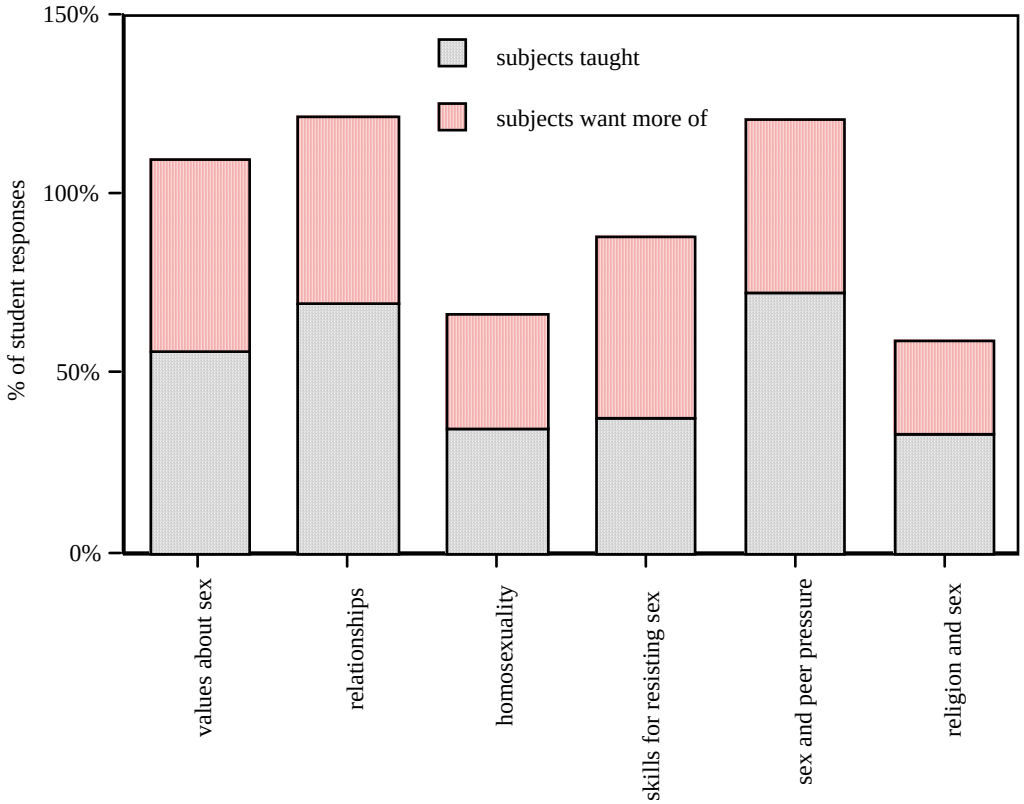

Figure 5 . Socio/cultural topics that students were taught and on which students wanted more information

HIV KNOWLEDGE

This section of the questionnaire assessed the general knowledge of HIV transmission and results are presented in Figure 6. Students were generally very knowledgeable about HIV transmission with over 80% of the students answering four of the questions correctly (this was even higher for older students on some answers). The question that linked safety from HIV with having sex with one steady partner scored the highest incorrect and unsure responses and reflects a common belief held by many people that they are protected from HIV and STD risks if their sexual activities remain within the bounds of a steady relationship. While this can be a realistic expectation for many people, it is a belief that poses some problems when translated into the context of adolescent relationships that are typically characterised as 'serial monogamy'. Adolescent relationships (a steady relationship was thought, on average, to be of 12 weeks duration by the younger group and even less by the older group) can not always allow for sufficient window periods in which sexual partners can be sure that they are free of infection. It is also difficult to be confident of a partner's fidelity at a time when many things, including desire, emotions, peer pressure and personal uncertainty can not always be carefully managed. This blurring of safety and monogamy is discussed later in this report under the heading *Perceived Invulnerability to STDs.*

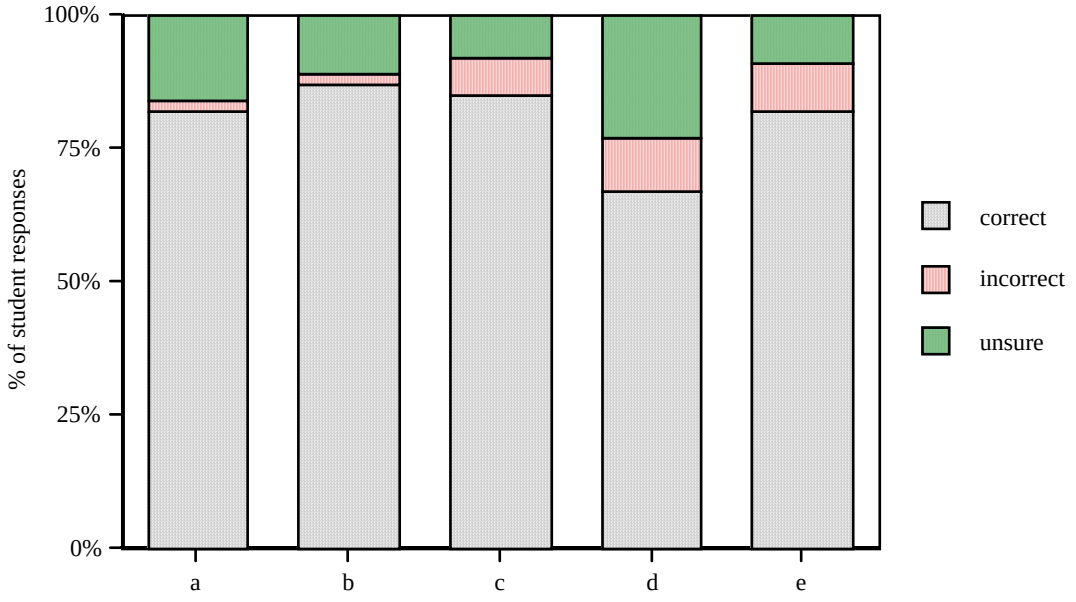

Figure 6 . Students' responses to HIV knowledge items

The questions were as follows:

a Does the pill (birth control) protect a woman from HIV infection?
b Could a man get HIV through having sex with a woman?
c Could someone who looks very healthy pass on HIV infection?
d Is a person completely safe from the sexual transmission of HIV if they have sex only with one steady partner?
e If condoms are used during sex does this help to protect people from getting HIV?

STD KNOWLEDGE

This section of the questionnaire assessed the general knowledge of STDs and results are presented in Figure 7. In accordance with their urban peers, these young people's knowledge about STDs (other than HIV) was generally not as high as for HIV (Lucke et al, 1993; Wyn, 1991). In particular, less than half knew that not all STDs (other than HIV) can be cured, and that not all STDs show symptoms. Though many of these students were not yet sexually active, correct information about the signs and symptoms of STDs will eventually be vital for them in the future. The assumption that a person is disease free because of an absence of symptoms could be a risky basis for making decisions about safe sex.

In another STD knowledge item, the participants were asked to name as many STDs as they could. Fifty-four percent of the sample could not name an STD other than HIV. However, when year levels were compared, 72% of the year 10/11 students were able to recall the names of other STDs compared to only 25% of the year 8/9 students. One could assume that the younger group will pick up more information in health education or elsewhere in the next

few years. The most frequently named STDs were herpes, warts, gonorrhoea, syphilis and pubic lice. There are other STDs, such as chlamydia, which are especially common among girls, which were not mentioned often. It is important that the more relevant STDs be included in health education curricula.

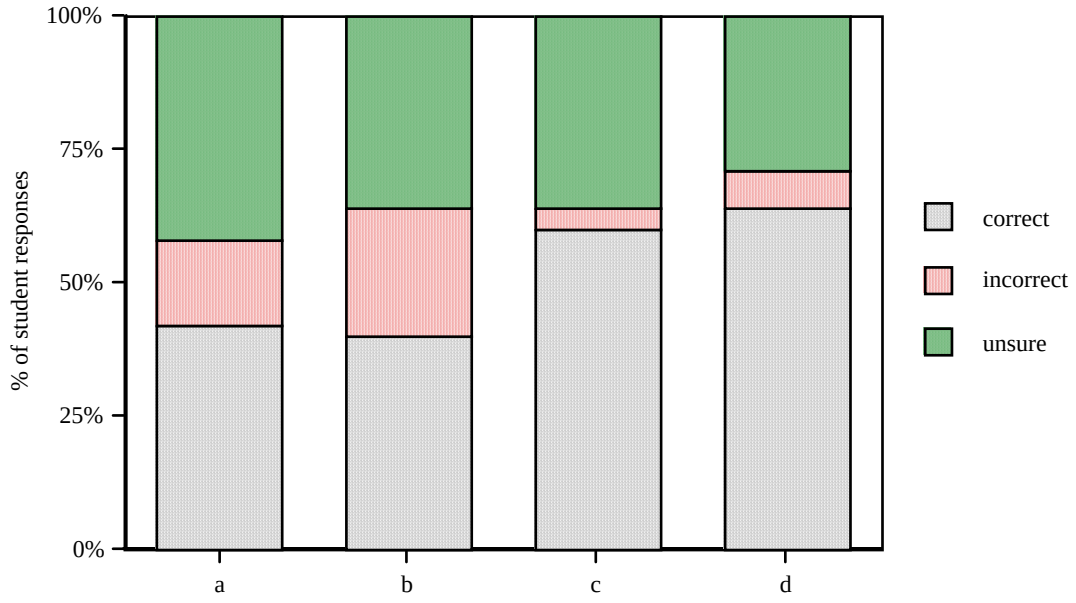

Figure 7 . Students' responses to STD knowledge items

a *All STDs (other than HIV) can be cured if they are treated*
b *You'd know if you had an STD because you'd have symptoms*
c *Some STDs can lead to infertility (you can't have children)*
d *'Pulling out' before you 'cum' (withdrawal) will stop the spread of STDs*

KNOWLEDGE OF SAFE AND UNSAFE SEXUAL PRACTICES

As with the naming of STDs, this section of the questionnaire relied upon the student's recall memory. Year 10 students only were asked to expand on their understanding of unsafe and safer sexual activities and to nominate two unsafe and two safer sex practices. Twenty-seven percent of the students did not answer this question and it was evident in the responses of those who did that there was considerable confusion expressed towards the concepts of safer and unsafe sex practices. Although, quite correctly, the most commonly nominated unsafe activity was unprotected intercourse (53%), oral sex and anal intercourse were also frequently nominated as unsafe activities (52% and 29%). Oral sex was nominated as risky more frequently than anal sex (30%) and this was the source of some confusion for us in interpreting this finding. One explanation could be that both oral and anal sex were beyond the experiences of many students. However, when oral sex was mentioned it was equated with revulsion and danger. As one boy explained in a focus group discussion:

"OK WHAT HAPPENS AT PARTIES AROUND HERE, DRINKING?"
"Yeah drinking. A lot of other sick things going on too"
"YEAH LIKE FOR INSTANCE?"
"Oral sex"

Oral sex may have been mentioned more frequently because it was a known, although unfamiliar, practice and many students remained uncertain about the transmission paths of STD infection through oral sex. Intercourse (without specifying protection) was considered unsafe by 30% of students and suggests that some students were unclear about the functional uses of a condom in ensuring that intercourse is safe. Promiscuous sex was nominated as unsafe by 17% students which indicates (this will be more fully discussed below) that sex within a relationship continued to feature strongly as a protective mechanism. Sex with prostitutes and homosexual anal sex were also suggested by some students as an example of an unsafe sexual practice and revealed that unsafe sex was still associated with risk groups rather than risk practices and fails to acknowledge the important point that condom use in both of these situations would ensure that sex was safe.

The most mentioned safer practices were protected intercourse (57%), kissing (34%), sexual touching and feeling (25%) and oral sex [protection unspecified] (17%). There were many other activities mentioned (albeit infrequently) but some confounding answers included intercourse (with protection unspecified) and anal sex. The fact that many students (24%) nominated intercourse and oral sex without specifying that a condom should be used is alarming when condoms are given such a high profile in safe sex education. Mutual masturbation, kissing, sexual touching and feeling and digital penetration were also mentioned as safer activities and were activities that could serve as alternatives to unprotected intercourse. Another cluster of responses again reflected the pre-eminence of relationships as protective mechanisms where monogamous intercourse and sexual history taking would supposedly ensure sexual safety and this was extended to include precautionary measures such as a medical check for both partners. Abstinence was also nominated as a safe sex activity by only 6% of students.

SOURCES OF INFORMATION ABOUT SEX

Figures 8, 9 and 10 present the sources of information on sexuality and sexual health issues that have been accessed by the students. Mothers, female friends (used by girls), health education, television, pamphlets and posters and books and magazines were the most frequently utilised. In comparison, some of the more trustworthy sources, such as fathers, health education, doctors and sexual health clinics, did not appear to be as accessed by young people, despite being more positively perceived by them. Overall, girls used all the information sources (except for fathers and male friends) more often than the boys. Even health education at school, which all students were required to attend, was nominated more

frequently by girls, suggesting that boys may not have felt that the information was as useful to them. Dominant constructions of sex as a 'natural', self-evident and urge-driven activity (particularly for men) tends to establish men as 'experts' and seeking help or asking too many questions may serve to cast doubts over one's masculinity.

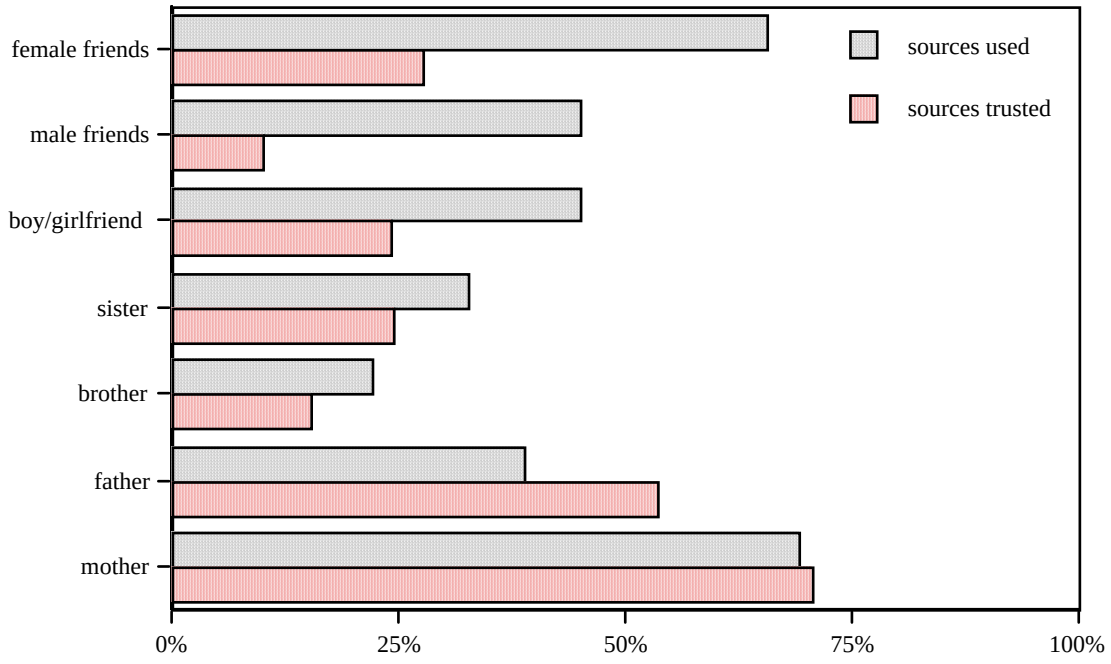

Figure 8 . Use and trust of family and friends as sources of information

As sexuality issues are customarily presented in highly medicalised terms the fact that information sources, such as doctors and sexual health clinics, rated highly in terms of trust was not surprising. These sources of information would seem to be assessed as trustworthy because of the scientific, 'objective' and impersonal nature of the knowledge that they can contribute. School health education programs are also developed from an objective and reproductive paradigm and rate as a highly trusted information source.

Parents and friends, on the other hand, involve a more intimate passage of knowledge that is presumably both experiential and practical and (in the case of friends) consisting largely of gossip and conjecture and consequently scored low on trust. Both girls and boys preferred to talk to their mothers when they wanted to talk about sexual issues, though boys more frequently than girls rated their fathers as a trusted source of information. The under-utilisation of fathers, while they are perceived to possess the qualities of experience and knowledge in sexual issues, may be because they are unavailable to their sons, difficult to approach or reluctant to discuss these sensitive topics with them. The following comments from boys in a year 8 focus group illustrate this:

b1 "I could tell my mum just about anything. She's pretty good about it. She's

pretty open and that. But I wouldn't be bothered telling my dad...."

b2 "My dad would go ape"

b3 "Oh my dad would go sick"

b4 "I think I couldn't tell my dad because he's sort of in denial...he's too old-fashioned sort of thing"

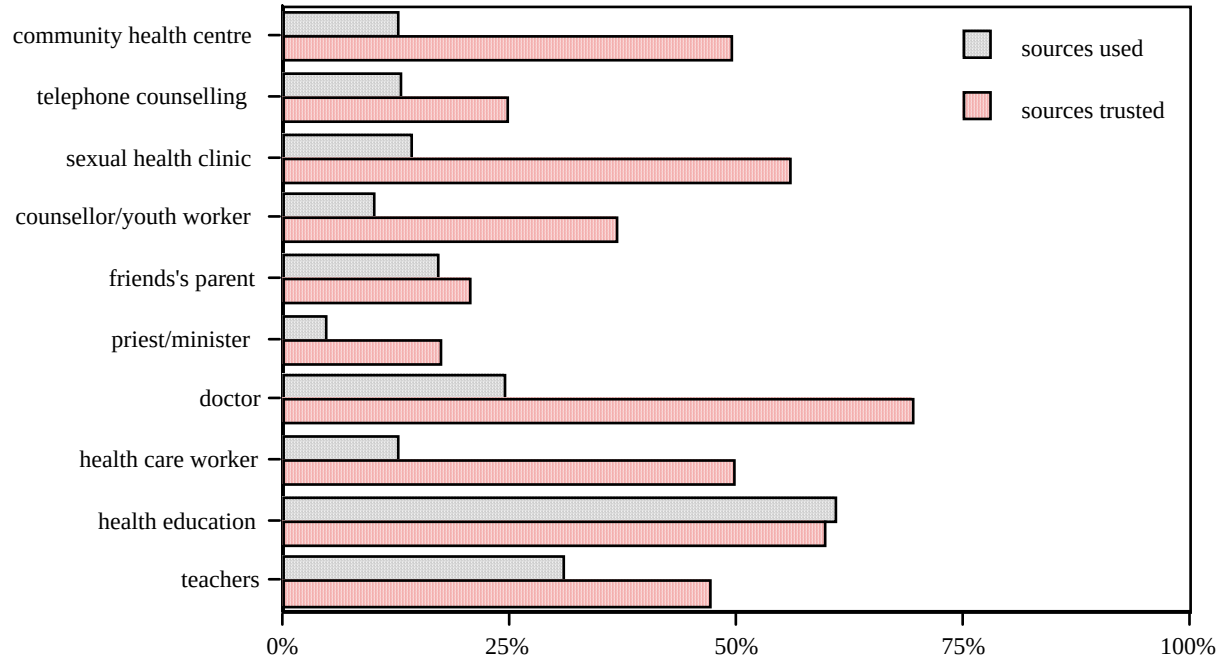

Figure 9 . Use and trust of health workers and other professionals as sources of information

The media was a source of a great deal of information on sexual issues for the young people in this survey. Television, pamphlets and magazines scored highly on use but generally low on trust. Knowledge gathered through sources such as television were not judged as highly credible by the students, but the large extent to which young people used television for information about sex ensures that it is nonetheless very influential. Posters and pamphlets on the other hand are usually produced with a mixture of medical insight and practical wisdom and are both highly utilised and reasonably trusted. Girls used both pamphlets, posters, books and magazines more often than boys probably because they are generally highly motivated to seek medical help to manage contraception and other issues associated with their reproductive health. They may also have been more interested in gathering advice and information on things such as relationships. Teenage magazines, such as *Dolly* and *Girlfriend*, were frequently mentioned in the focus groups by girls as a source of information on sex. These magazines have a strong emphasis on relationships and girls are clearly more interested than boys in accumulating information on this aspect of their sexuality. As for the lower score on trust that was attributed to books and magazines (there were no sex differences) there was no scope in this survey to understand the ways in which the personal

feelings and experiences of girls and boys connects (and fails to connect) with what they see and read in the media.

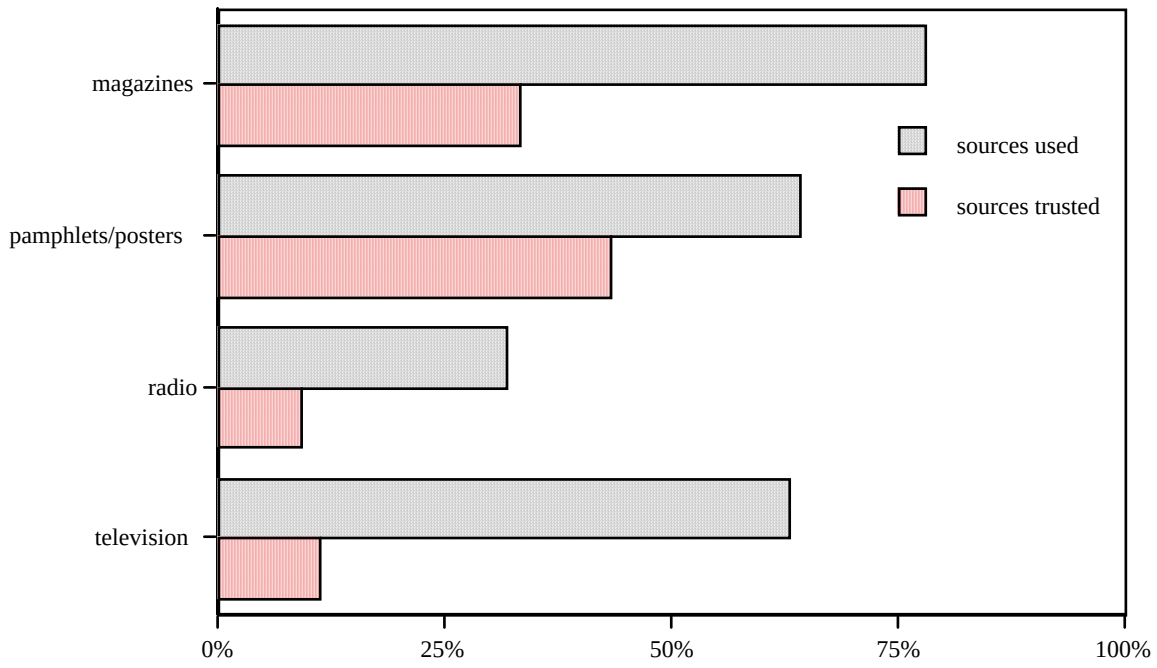

Figure 10 . Use and trust of the media as sources of information

ACCESSING SEXUAL HEALTH SERVICES

The students were asked who they would rather talk to about personal sexual issues. We asked this as a precursor to a question about difficulty of accessing services so we could ascertain whether the students were being reasonably catered for. The most preferred people for girls to go to were female friends (74%), mother/female guardian (63%), a different female doctor (60%), girl/boyfriend (58%), sisters (51%) and family doctor (44%). Boys' preferences were boy/girlfriend (55%), mother/female guardian (53%), fathers (44%), the family doctor (44%), a different male doctor (32%) and male friends (28%). It appears likely that many students would rather first approach either their mother, partner or friends, who we can assume are accessible and then seek medical help. There were significant differences between girls and boys here with 60% of girls preferring to see a different female doctor while only 32% of boys preferred to see a different male doctor. Given that one could assume the romantic partner of most of the boys was female, these results show that the two most preferred sources for both girls and boys were female. Ten percent of respondents (no significant sex differences) said that they would talk to no one else and we can only speculate as to the reasons why they would opt to do this.

We asked the participants about their perceived difficulty in accessing a range of health services. There were few differences between girls and boys in their perceptions of difficulty

of accessing any professional service. Youth centres (69%), sexual health clinics (68%), family planning clinics (64%) and community health centres (53%) were thought to be difficult to access by the largest number of students. Male doctors (19%) nurses (23%) and chemists (15%) were thought to be difficult to access by a smaller number of participants. The largest discrepancy between preferred service and difficulty of access was for a different female doctor whom 60% of the girls said they would prefer to see but 36% found difficult to access. The shortage of doctors in rural areas has been well documented, though 81% of this group found that male doctors were not difficult to access. There was greater difficulty however in accessing female doctors who were a preferred source for girls to access for matters that were of a personal sexual health nature.

PERCEIVED INVULNERABILITY

In reference to young people's feelings of invulnerability to STDs, Rosenthal and Reichler (1984) have stated that: "The extent to which young people misperceive their risk of HIV and other STDs and the relationship between risk perception and risky practices is important in planning intervention strategies" (1994, p. 43). This is because there is evidence that young people's perceived vulnerability to STDs may in some way affect their motivation to negotiate safety in sexual encounters (Rosenthal & Moore, 1991; Wyn, 1991). If the beliefs which young people use to bolster their feelings of invulnerability, and presumably the safety of their sexual practices, are valid beliefs, then we no longer need concern ourselves with their safety. However, if their beliefs are based on information which is false, their ability to protect themselves will be compromised. The large majority of the young people in the research sample believed that they were unlikely to contract an STD (85%), including HIV (86%). Students who believed that they were unlikely to contract an STD were further required to nominate from a series of statements that were provided, why they felt they were protected against STDs. The items used in this section were taken from the Dunne et al report (1993) and further developed from discussions with community youth workers and sexual health literature.

A sense of invulnerability was bolstered by a variety of beliefs which were divided into three groups. We have called the first group *reasonable beliefs* because behaviours which are based on these beliefs could reasonably be expected to afford protection from STDs. For example those who do not engage in penetrative sex or any sex at all, or those who always use a condom when engaging in penetrative sex, and those who do not inject drugs, will be unlikely to contract a sexually transmitted or blood borne disease. Figure 11 shows the percentages of the students who endorsed each of the reasonable beliefs as the basis for their sense of invulnerability. .

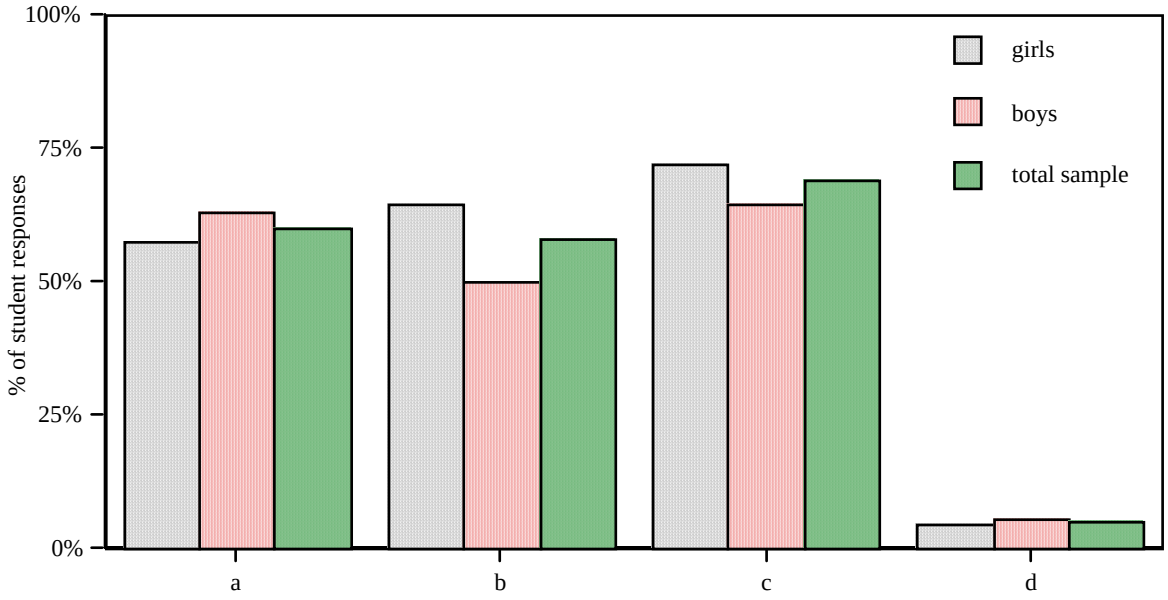

Figure 11 . Students who attributed their invulnerability to STDs as a result of reasonable beliefs

Items that assessed reasonable beliefs about invulnerability (see Figure 11) were as follows:

a *I don't inject drugs*
b *I've never had sex*
c *I will always use a condom when having sex*
d *I don't have penetration during sex*

With one exception, it was pleasing to note the fairly high numbers of students who gave sound reasons for their personal sense of invulnerability to STDs. Around 5% said they were unlikely to catch an STD because they did not engage in penetrative sex. That this safe sex practice was mentioned by a very small percentage of the students is indicative of a culture which defines sex in terms of sexual intercourse. The much larger number of students (over 60%) who gave condom use as a reason for invulnerability is also evidence of a focus on penetrative sex, albeit safer penetrative sex. It should be noted also that many more girls gave *never having had sex* as a reason for safety, even though girls and boys in this sample were fairly equally sexually active. This may be due to dominant constructions of acceptable femininity situating girls as sexually naive and therefore quite free to express their virginity, whereas dominant notions of masculinity situate boys as sexually experienced. Girls were also more likely to use *always using a condom* as a basis for their feelings of invulnerability to catching an STD though there was no evidence from this study that girls, more than boys, were protected by condoms when engaging in sexual intercourse.

The second group of beliefs was based on a commitment to the quality of present or future relationships and centred around trust and monogamy. Boys and girls were almost equally

committed to these beliefs with between 13% and 45% of the group mentioning each one to justify feelings of invulnerability to STDs. The least mentioned reason (14%) was *not having sex until marriage* and the most mentioned (43%) was *only having sex with my boy/girlfriend* The other beliefs, *having one sexual partner* and *trusting one's partner* were mentioned by around one third of the group.

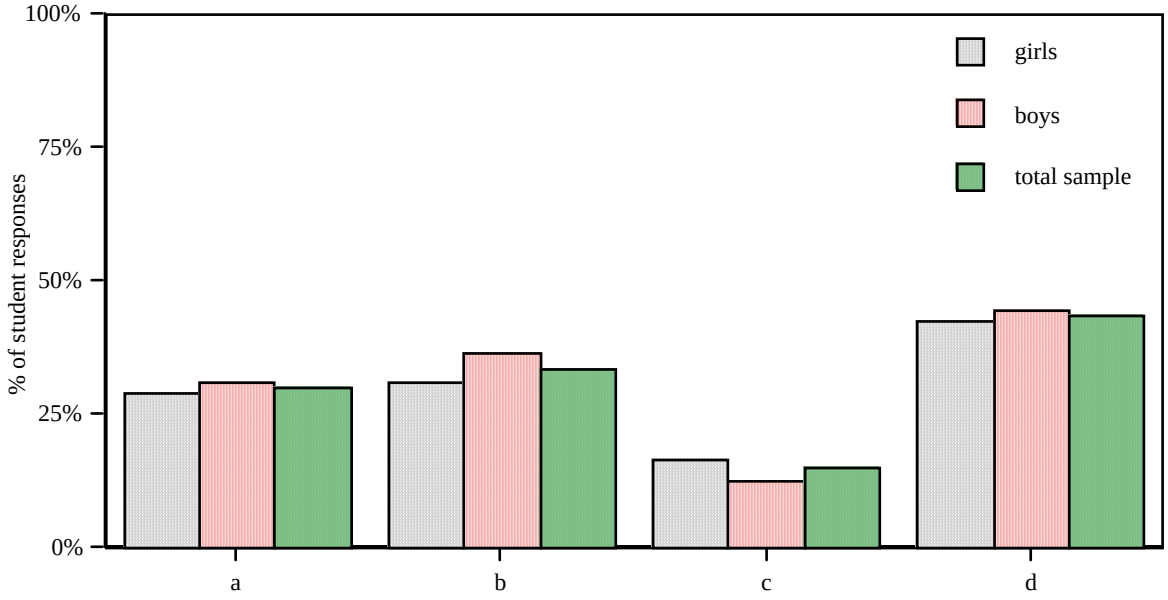

Figure 12 . Students who perceived their invulnerability on the basis of quality of relationships

Questions that assessed the cluster of beliefs about invulnerability being afforded through a relationship (see Figure 12) were as follows:

a *I only intend to have one sexual partner*
b *I trust my partner*
c *I'm not going to have sex until I'm married*
d *I would only have sex with my girl/boyfriend*

Health professionals and teachers have reason to be concerned about this cluster of results where a sense of security is fortified by inappropriate beliefs upon which decisions about sexual practices are likely to be made. Drawing a sense of invulnerability from the restriction of sexual activity to the boy/girlfriend relationship is likely to be problematic for at least two reasons. These young people, on average, regard a relationship as regular after a period of only 12 weeks. Given that it is possible to carry a sexually transmitted infection for months or even years without knowing about it, this type of serial monogamy is likely to afford little protection from STDs. Moreover, as only 2% of the group had been tested for an STD, disease free status was not being established in the space between ending one relationship and beginning another. A second basis for the claim that these beliefs are inappropriate as a foundation for a sense of invulnerability, is that trust in the fidelity of one's partner is often misplaced and one partner's restriction of sexual activity to the relationship is only safe where

it is reciprocated. Certainly, when we asked the students about their peers, 54% of them felt that a few (both girls and boys, though girls believed more boys than girls) had sex with others as well as their steady partner, and a further 7% believed that half to all of their peers had extra relationship sex. Just how close the students' beliefs about their friends' behaviours were to the truth is open to conjecture, however, one could safely assume that basing one's decisions about safer sex behaviours on fidelity is at best inappropriate, and at worst a dangerous practice.

Statements that assessed beliefs about invulnerability as a result of subscribing to common misconceptions about STDs were as follows:

a *The STD problem is not as bad as some people think*
b *I keep away from people who I think might have an STD*
c *I'm too young to get an STD*
d *I only have sex with clean people*
e *I don't have sex with people who sleep around*
f *Young people in the country don't have STDs*
g *In the country you know who is clean*

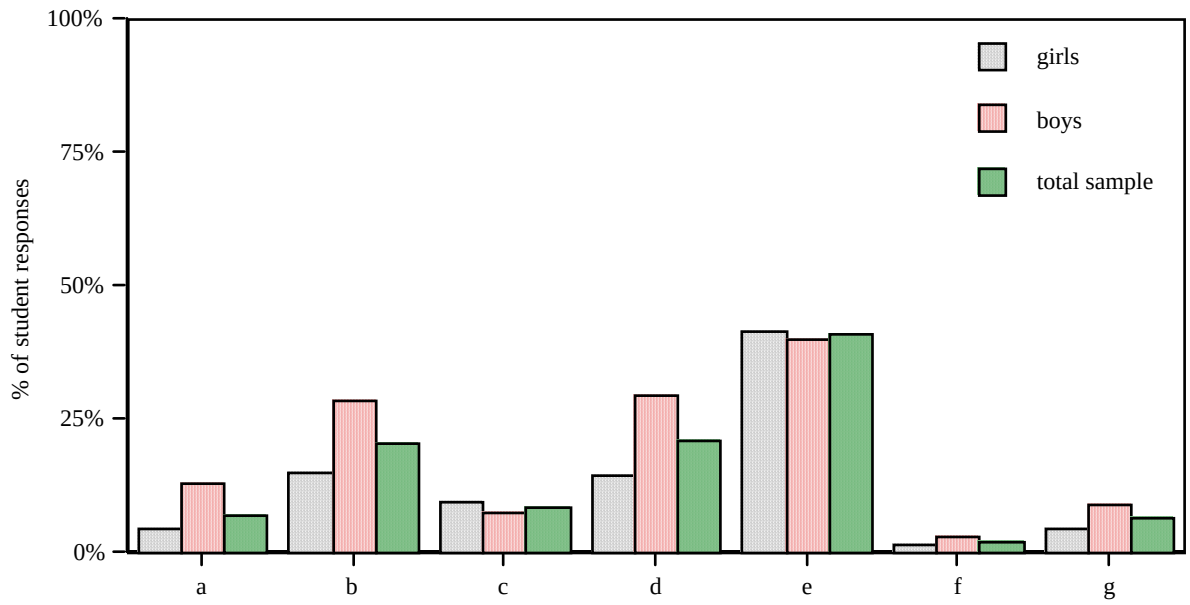

Figure 13. Students who perceived their invulnerability on the basis of myths associated with STDs

The final cluster represented in Figure 13 has been labelled STD myths because the beliefs are based on false information. Most of them depend on an assumption of the disease free status of one's sexual partner based on local knowledge and appearance, such as: *I only have sex with clean people* (21%), *I keep away from people who I think might have STDs* (21%), *In the country you know who is clean* (7%), *I don't have sex with people who sleep around* (41%), and *Young people in the country don't have STDs* (2%). That between 2% and 21% of the students gave these beliefs as reasons for their perceptions of invulnerability is, like the previous cluster, reason for concern and should be noted for intervention when planning

future health education curricula. There was a strong sex difference in the endorsement of these myths with boys significantly more likely to use them to bolster their feelings of security and perhaps to inform their sexual practices. This result is consistent with other research which shows that males, in particular, subscribe to the belief that one can know, without being told, who is infected (Chapman & Hodgson, 1988; Wyn, 1991). This is a strong warning in a culture in which attractiveness and cleanliness are often falsely equated with health. That one cannot tell a person's disease status, in many cases, from appearances, and that reputation and disease are not necessarily correlated, should be clear messages given priority in health interventions.

ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS

It has been suggested in past research, that a person's perceived invulnerability to HIV may in some way be related to beliefs about the type of person who may contract the disease and that this in turn will be related to attitudes towards those living with HIV/AIDS. We did not ask the students about the way in which they would characterise the typical HIV sufferer, however, we did provide them with four statements about people living with HIV/AIDS (PLWHA) and asked them to mark whether they agreed or disagreed with them. The statements concerned the rights of PLWHAs in the workplace, education and the social sphere. A final question asked about the moral responsibility of PLWHAs for their condition. Those who strongly agreed, agreed or were unsure about a discriminatory statement were added together because it was felt that those who were unsure would be more likely to go along with discrimination rather than resist it. The results showed that 26% would end or were unsure about ending a friendship with a PLWHA, 39% disagreed or were unsure about PLWHAs being able to stay at school and 57% disagreed or were unsure about PLWHAs being allowed to work with young people. Perhaps the most concerning result was that 43% of the group agreed or were unsure about the statement that people with HIV have only themselves to blame.

ATTITUDES TO SEX ROLES AND RELATIONSHIPS

Research on young people and the barriers they face in attempting to make their sexual lives safe has moved beyond the rational decision making model to encompass the contextual background of a sexual encounter which includes the motivations and pressures on young people to behave in certain ways. Where most sexual activity between young people takes place within the construct of a relationship, it was important to gather information from the participants about the ways in which they conceptualised the girl/boyfriend relationship. A segment was included in the survey in which participants were asked whether they agreed or disagreed (on a five point scale) with a series of statements about wanting (10 statements) or not wanting (9 statements) a girl/boyfriend. Factor analysis revealed five clusters of

statements. *Factor one*, which covered the romantic positives of having a relationship and was significantly more likely to be endorsed by girls, described *feeling special, getting hugs, and feeling secure and loved,* as positive reasons for having a relationship. *Factor Two*, which encompassed ideas about the high cost of a relationship, again more likely to be endorsed by girls, encompassed *loss of friends, boys' expectation to have sex, male control and the pain of breaking up* as the negatives in a relationship. A *third factor*, endorsed by more boys, saw *having someone to hang out with, being seen to have a boy/girlfriend, everyone else having one and stopping others hassling them* as good reasons to have a partner. A fourth factor gathered together concerns such as *not being ready, parental disapproval and career/schoolwork* as reasons why a boy/girlfriend was not desirable and these reasons were also more frequently endorsed by girls. Finally, factor five which was endorsed by more boys than girls, consisted of one item, *"so I can have sex"* as a reason for having a girl/boyfriend.

It is important to note at the outset that these results are trends which describe the *average* boy's and girl's ideas about relationships. It is not possible from this to predict any individual student's constructions of relationships. While we acknowledge that individual students may experience their gender identities in diverse ways these results could be said to describe the dominant constructions of heterosexuality, masculinity and femininity for these young people.

The picture which emerges from these results is disturbing but not surprising where dominant ways of conceptualising the positive attributes of having a relationship, as understood by girls and boys, proved to consist of often incompatible ideals. Girls were far more likely than boys to believe that there was a rather large price to pay for having a boyfriend whereas boys, in comparison, were far less likely to endorse the negative features associated with being in a relationship. Girls generally valued friendship and emotional intimacy in relationships, whereas boys tended to value the improved status and accessible sex which came with having a girlfriend. Tension in adolescent relationships is evident where more girls saw the expectation to have intercourse as one of the potentially less desirable aspects of a relationship, yet more boys felt that access to intercourse was a positive feature of being in a relationship. This issue was also discussed in focus group and was experienced as a problem by many of the girls. Their frustration with what seemed to be boys' obsession with sex was encapsulated by one group of year 11 girls:

WHAT DO YOU WANT OUT OF A BOYFRIEND?
g1 "I want someone I can talk to"
g2 "Don't want someone who's just going to want to sleep with you...have sex all the time...do what they want to do"
WHAT DO YOU THINK BOYS WANT OUT OF A GIRLFRIEND?
g1 "Sex sex"
g2 "Well the fellows that sit with me at lunchtime, they're always, sex is always the joke, like on their mind"
g3 "Just sex, everything is based around sex"

A senior girl in another group spoke more personally about sex:

"When you love someone you're going to sleep with them. But there's other things you can do if you love someone you know. Like with them if you love someone it's just all sex"

Girls generally felt more ambivalent about sexual intercourse as a part of the sexual repertoire within a relationship. This seemed to be related to what they perceived as the risks of having sex rather than arising from a dislike of sexual behaviours *per se*. Concerns about pregnancy were highlighted by one senior group:

g1 "We've got more to worry about like pregnancy and stuff like that. You've got things to worry about""
g2 "So the boys have nothing to worry about. They don't care what happens to you"
g3 "You get the odd one that does but they are rare"

The issue of privacy took on another dimension when connected to pervasive ideals of gendered sexual behaviour that rigorously circumscribed the acceptable standards of sexual behaviour for girls and boys. Within these ideals, a sexual double standard was a theme that was reiterated in both open ended questions and focus group discussions where girls were only too aware of being penalised and labelled a slut for straying from normative expectations in sexual relations. For example, one junior girl talked of the experience of a sexually active student at school:

"Well sometimes like if you have lots of boyfriends and stuff its like um like I know someone that got a song made up about her because of it...Well the boys made it up about the girl and they just don't care about like what the girl was feeling. She was just so upset and it was really bad"

The problem of sexual double standards and the risks posed through a 'bad' reputation was echoed by these senior girls:

g1 "They [boys] have a one night stand and nothing happens. We're more in fear of getting labelled like a tart or a slut or something whereas the boys if they have it they don't get labelled...and we're more ashamed of it if we do"
g2 "They always care about the reputation of the girl"

These double standards were also recognised by the boys in the group discussions as evidenced in the following interchange with a senior group. These boys recognised the injustice, but were generally unconcerned about it:

WHAT DO THINK ABOUT BOYS WHO HAVE LOTS OF SEX WITH GIRLS?
b1 "Lucky"
DO THEY HAVE A GOOD REPUTATION AROUND THE PLACE?
b2 "Yeah with boys they do but not the females"
WHAT ABOUT GIRLS WHO SLEEP AROUND WITH LOTS OF BOYS?
b3 "Sluts."

b4 "Yeah sluts"
b5 "It's not fair but it happens"

The inequity in gender relations that is a result of dominant constructions of 'good' femininity and 'good' masculinity has been widely reported in research on adolescent sexuality (Holland et al, 1991; Fine, 1992; Thompson, 1995). The difficulties which girls face when under pressure to have sex while at the same time being expected to be sexually naive, present particular barriers in negotiating safe sex. For young women to be able to ensure safety, they need to be sexually assertive and to plan for a sexual encounter. However, the young people in this study made it clear that it was generally unacceptable for girls to plan to have sex (for example by purchasing a condom) and was likely to result in some punitive consequences such as acquiring a 'bad' reputation.

Another barrier to ensuring that sex was safe was the emphasis and priority given by these young people to the risk of pregnancy. Protection from pregnancy does not necessarily equate with protection from STDs, and many of these young people failed to take account of both. In response to the HIV knowledge question about whether the contraceptive pill gave protection from HIV, 18% were either incorrect or unsure. Moreover, when we asked the participants to name two safe sex practices which would protect them from STDs, many students identified the pill as a safe sex practice.

Inflexible expectations of masculinity, experienced by boys as less personally problematic, also did not allow much room for diversity. Certainly the boys who participated in focus group discussions seemed to be of one accord in their discussions around the desirability of getting sex for its own sake and about the qualities they looked for in a girlfriend (*"big tits", "good looking girls" "girls that can get out, like their parents will let them do stuff"* while avoiding *"sluts" "town bikes"* and the *"ugly ones"*). In contrast to this and in the confidentiality of the questionnaire, many boys reported that, for them, sex was deeply linked to being in love and emotional intimacy. It seems likely that some boys may also experience a disjunction between their varied individual experiences and what is expected of them as males in the high visibility of small rural communities.

SEXUAL BEHAVIOURS

The questions concerning sexual behaviours were included under the heading *Your Own Personal Experiences.* Of the items in this section, only the first two (the first about sexual experience, the second about sexual orientation) were included in the junior version of the survey. The rest of the section, for senior students only, included questions about numbers and nature (casual/regular) of sexual partners, frequency of sexual contact, condom use, influence of alcohol, coercion, and communication and negotiation with the sexual partner.

The questions in this section were worded to ensure that there was no assumption that the students were sexually active and responses which catered for students who were not sexually active were provided for each question.

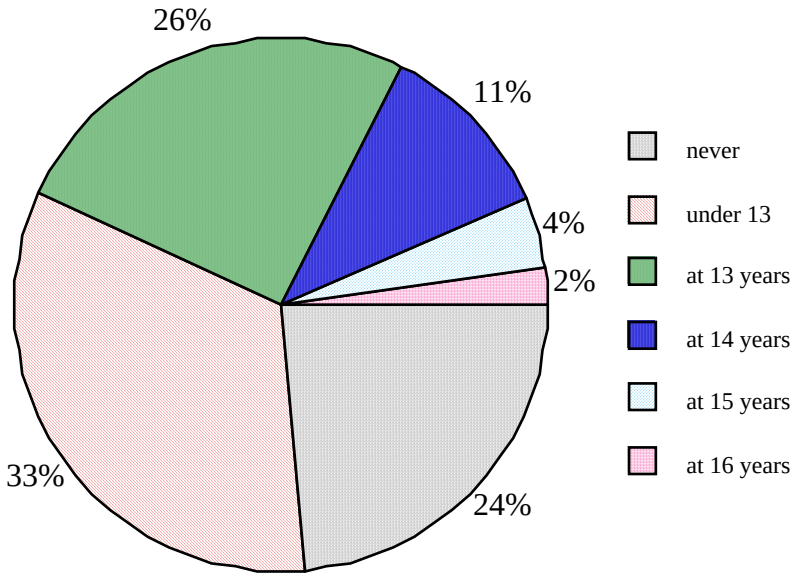

Figure 14. Age at which students first experienced passionate kissing

We learned from the data that the majority of these young people had turned their thoughts and actions to sexual matters with 74% of the whole sample (n = 1168) having experienced passionate kissing in the past. Fifty nine percent of the group were 13 or younger when this happened. There was no gender difference in this result.

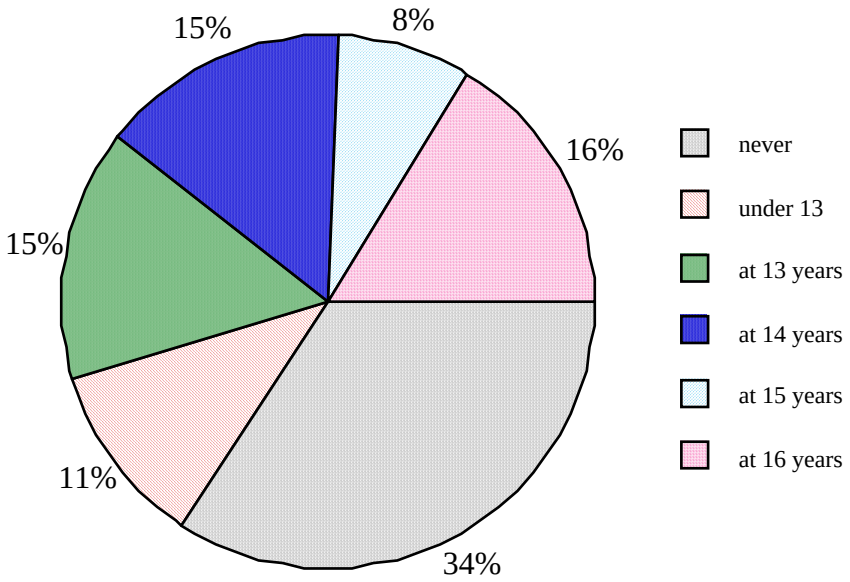

Figure 15. Age at which students first experienced sexual touching

Sixty percent of the group reported experiencing sexual touching. Most of these (49%) were 14 or under when this occurred. There were more boys (74%) and less girls (67%) in this category.

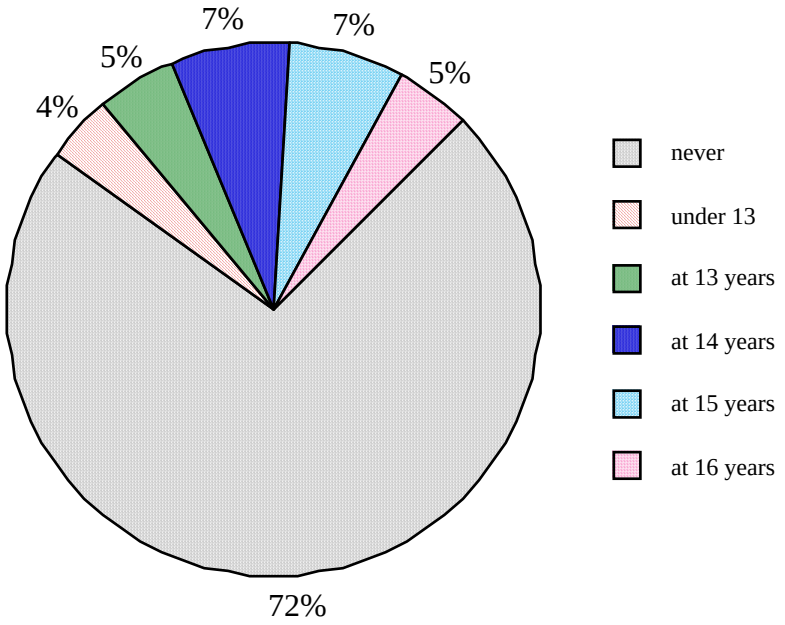

Figure 16. Age at which students first experienced sexual intercourse

Twenty-seven percent of the students, that is, 300 young people, had experienced sexual intercourse. Of these sexually active adolescents, significantly more (65%, n=195) were from the senior group. One hundred and five students from the junior group had experienced sexual intercourse at least once in the past, however we have no further information about the context of these sexual encounters. There were state differences in this result, but these can be accounted for by the different ages of the students as a result of the research timetable. The remainder of the results in this section will refer to senior participants only.

Sixty-one percent of the senior students in the study had not experienced sexual intercourse (39% had had sexual intercourse) and 4% (n=19) had not had intercourse in the past year. We are unable to speculate further about this group though we know there were more boys than girls. Of the remaining students, 21% (n=105) had one partner in the last year, 6% (n=28) had two partners and 8% (n=40) had three or more partners. Girls had as many partners as boys. This information combined with the knowledge that as many of the female students were as sexually active as the males, stands in direct contrast to their expressed ambivalence about sex. This ambivalence was even more apparent with the results to the question *How did you feel after the last time you had sex?* The open-ended answers were coded as positive or negative with positives being responses such as *happy, excellent, loved* and *good* while negative responses were *sad, upset, disgusted, angry, sad coerced or raped.* Thirty-one students, 4 boys and 27 girls, answered in the negative. The overwhelming

number of girls in this group could in some way explain the anxiety they feel about the risks associated with having sexual intercourse. Depending on the safety of the sexual encounter, the girls may have been concerned about pregnancy or STDs, and regardless of whether protection was used there would be the constant worry about their reputations in the town.

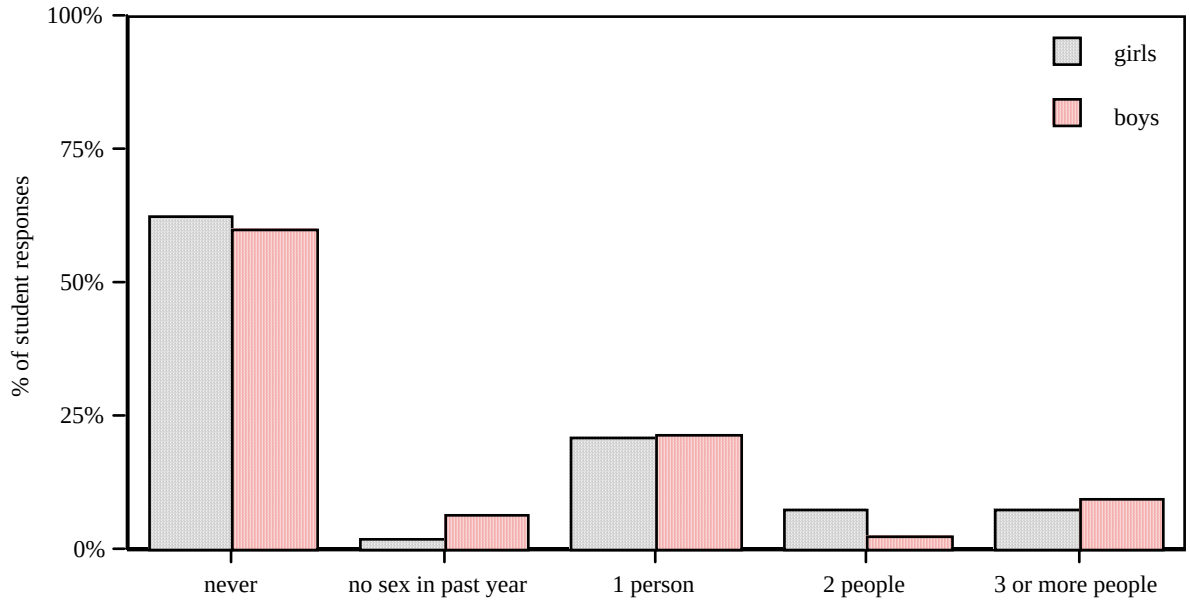

Figure 17 . Sexual partners in past year (senior students only)

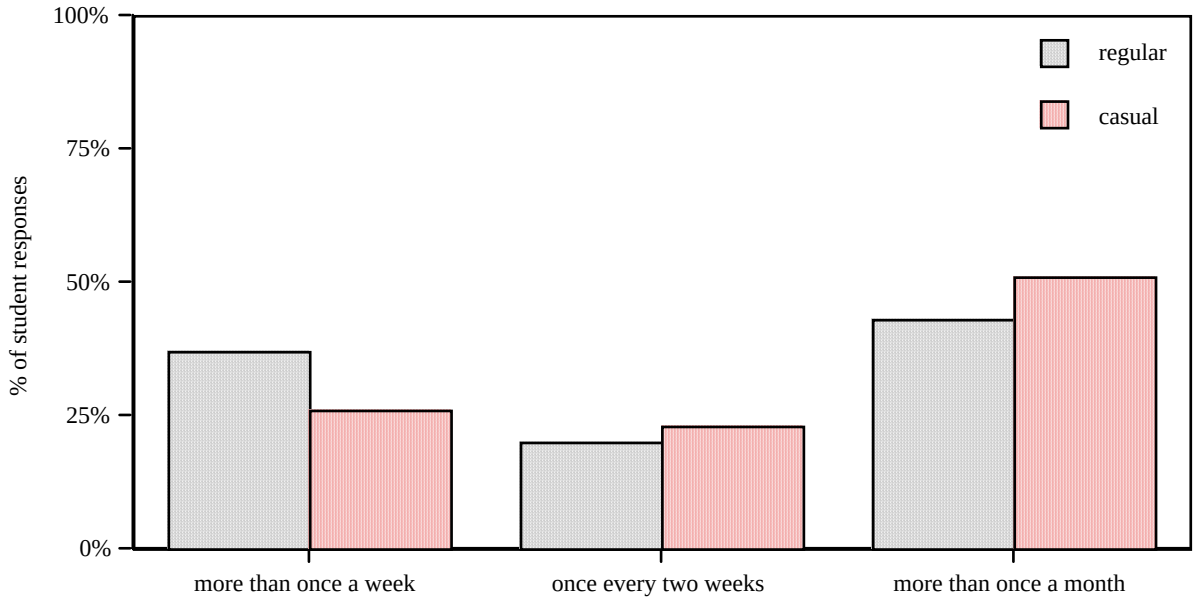

Figure 18 . Frequency of sex in regular and casual relationships (senior students who have had sexual intercourse only)

We asked the students how often they had sex with a regular or casual partners. From Figure 18 it is clear that regular partners had sex more often than casual partners, however the

differences between the frequency of casual and regular are not great leaving us to suppose that many rural young people are quite often also engaging in casual sex. This was supported by 33% of students (see Figure 19) who reported having sex with a first time partner in their last sexual encounter.

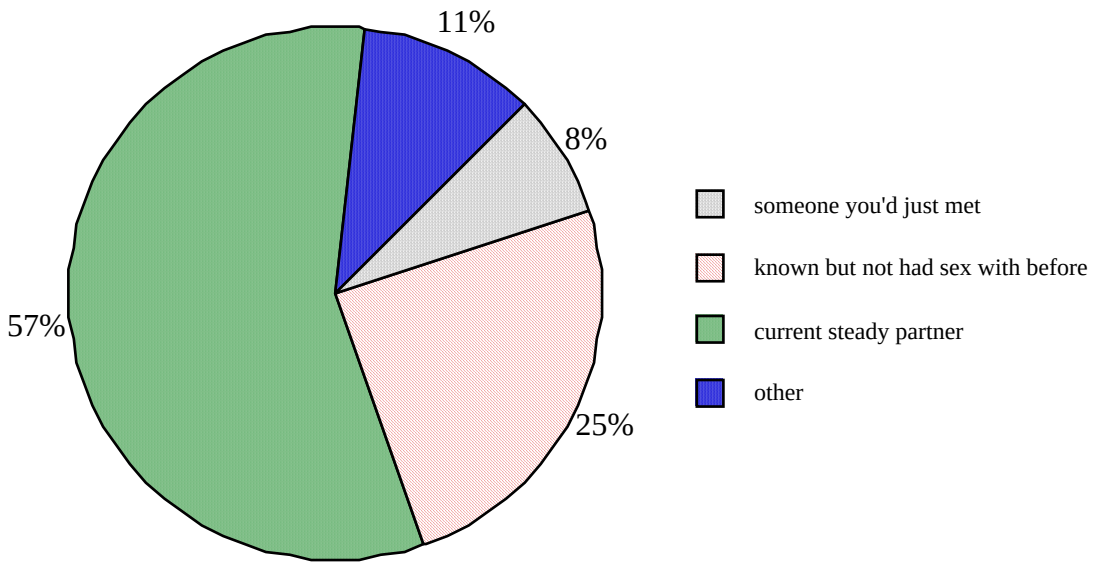

Figure 19. How well students knew their sexual partners on the most recent occasion of sexual intercourse (senior students who have had sexual intercourse only)

CONDOM USE

As dominant constructions of heterosexuality privilege penetration, promoting consistent condom use has been an important strategy in the prevention of STDs and pregnancy. To this end it is necessary that young people not only have reasonable access to condoms but also feel confident and assertive in negotiating their use. The survey explored the experience of rural young people in regard to these issues and the results for condom use have been reported below. This section presents the findings associated with obtaining and using condoms with particular reference to the experiences of girls and boys.

As evident in Figure 20, girls reported more difficulties in getting hold of condoms but with prompting were similar to boys in attributing this difficultly largely to a lack of anonymity (girls: 60%, boys: 43%) and because it was embarrassing (girls: 28%, boys: 33%). The next most frequent explanation for difficulty in obtaining condoms was associated with being refused service or that condoms were simply unavailable. It was alarming to find that some young people's efforts to obtain condoms were curtailed in what could be a very intrusive and threatening manner such as one year 8 boy who was refused condoms by the chemist who reprimanded him with the comment "What would your mother think?"

Girls also reported being more uncomfortable in getting hold of condoms than boys (see Figure 21) again mostly for reasons to do with embarrassment and a lack of anonymity when purchasing them. Girls also mentioned feeling the sting of public disapproval more frequently than boys. This situation ensured that girls experienced more difficulty and felt

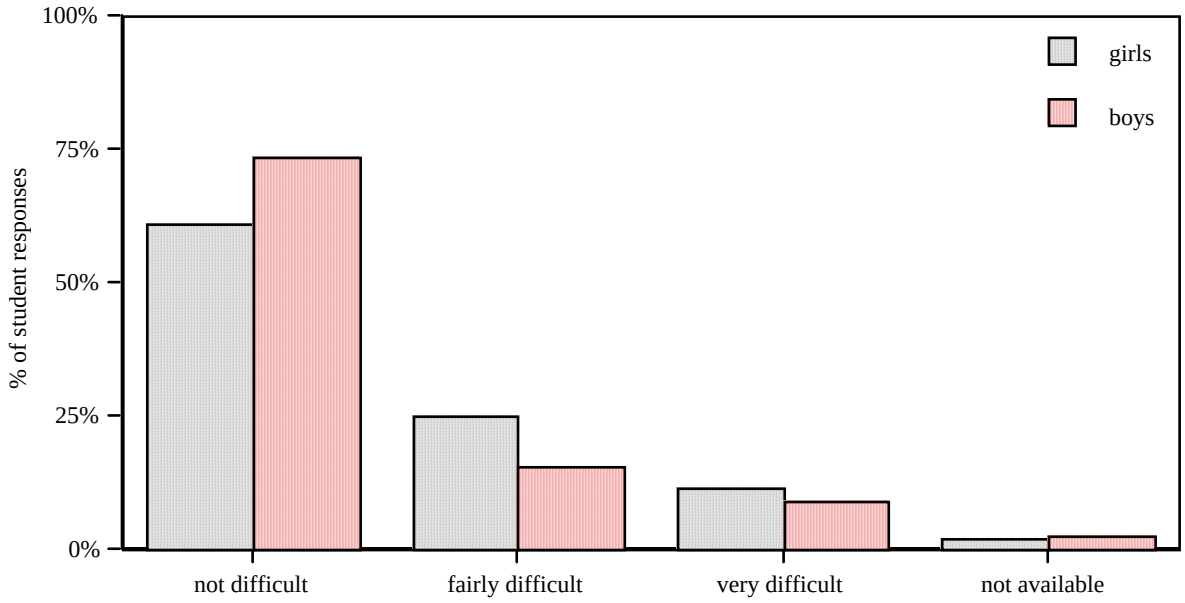

Figure 20. Difficulty of obtaining for girls and boys

more uncomfortable in obtaining condoms. Although almost a quarter of the boys felt that they could not obtain condoms without anyone they knew seeing them, (and 37.9% of girls), the girls further believed that a disproportionate amount of damage was done to a girl's reputation as a result of this perceived high visibility. One year 11 girl in a focus group perceptively noted that boys were given permission to experiment when buying condoms and that their intentions were regarded as more ambiguous than the motives of the girls:

"Well if a guy goes in and buys condoms it's like they're just checking it out or maybe they're just being curious, just being boys. But if a girl goes in then they're having sex"

Despite all of these difficulties the rate of condom use among this sample was similar to that found in other Australian research amongst secondary school students (Donald et al, 1994). Donald et al (1994) also reported higher condom use among males a trend also found in this sample. However, the differences were not significant (boys: 76%, girls: 64%).

Students who had had sexual intercourse were also asked who had supplied the condom for the most recent occasion of intercourse (see Figure 22). There were significant sex differences with more boys saying that they supplied the condom. In contrast to this, girls reported that they both had supplied condoms. This could be explained by assuming that many partners were prepared to have safe sex by having a condom ready but girls were more

likely to wait and see if boys were going to produce one first. There is some cause for concern in the findings that 36% of girls and 24% of boys did not use a condom the last time they had sexual intercourse. The higher rate of non-condom use for girls could be as a consequence of using alternative methods of birth control such as the contraceptive pill. However, the circumstances of adolescent sexual activity (serial relationships of fairly short duration) may mean that these young people are not protected against STDs.

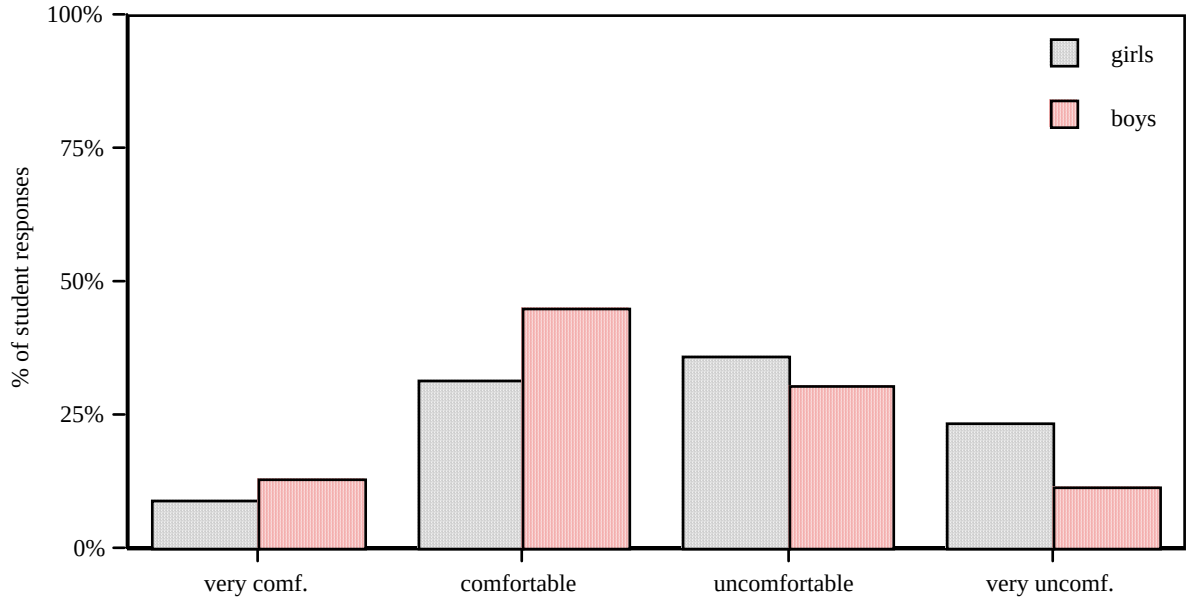

Figure 21 . Comfort with obtaining condoms for girls and boys

The findings reported in Figure 22 (completed only by students who had had sexual intercourse) contradict the findings of an earlier section of the questionnaire in which all the students were asked to nominate, from what they had observed of their peers, who usually suggested using a condom (see Figure 23). Few students believed that boys initiated condom use and almost half of the girls thought that girls supplied the condom while boys were more likely to believe that it was a shared responsibility. While there was a prevalent belief among peers that girls were initiating condom use, this did not seem to be reflected in the safe sex practices of the students who were having sexual intercourse. The discrepancies between these two findings suggest that there may be a gap between the theoretical ideals of girls, (and boys), being pro-active in regard to practising safer sex and the practical difficulties of negotiating safer sex when it is desirable not to look too eager or too prepared to have sex. In response to a question in a focus group discussion on who should be responsible for safer sex, some boys revealed the perils of negotiating and practising safer sex:

"But the male, the guy waits for the girl to pull out the condom... I'll tell you why that happens because he's nervous because he doesn't know whether she wants to have sex with him or not so he's waiting and then when she pulls it out he goes OK"
"But what if the girl's nervous and she's waiting for the guy to pull it out"
SO THIS GUY. WHAT DOES HE THINK WILL HAPPEN IF HE PULLS OUT A CONDOM?

"Oh she'll freak out, it depends on how far she wants to go"

When the appearance of a condom signals the intention (or desire) to have penetrative sex, it is clearly alarming for those girls who have not indicated their willingness to have intercourse. This confusion around intention frequently characterises adolescent sexual experimentation

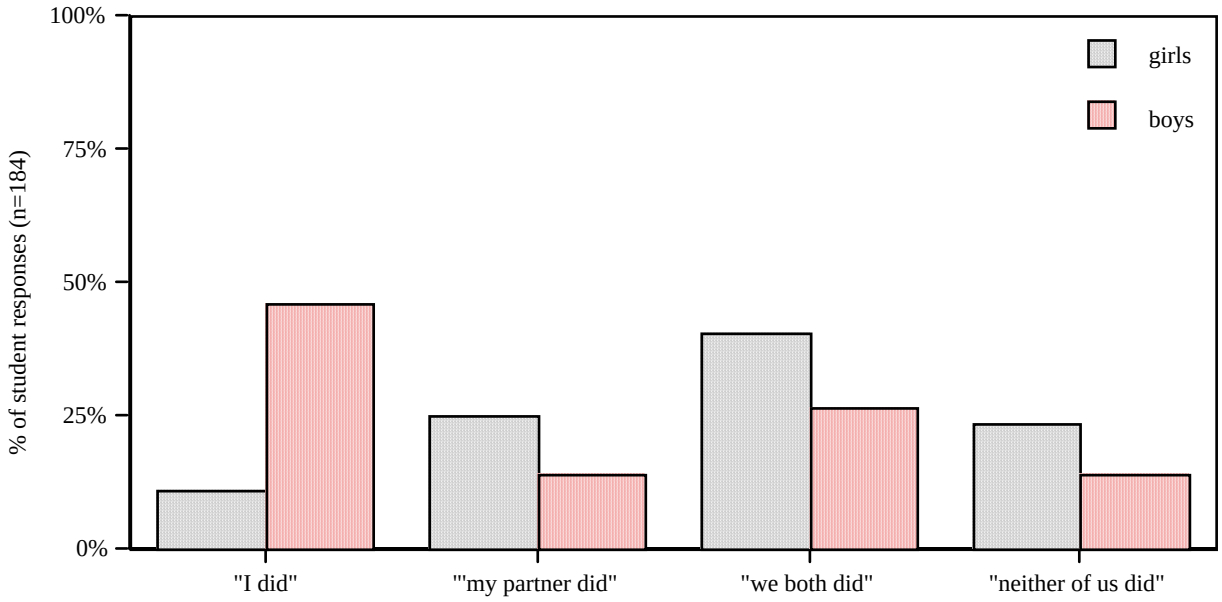

Figure 22 . Who supplied the condom on the most recent occasion of sexual intercourse (senior students who have had sex only)

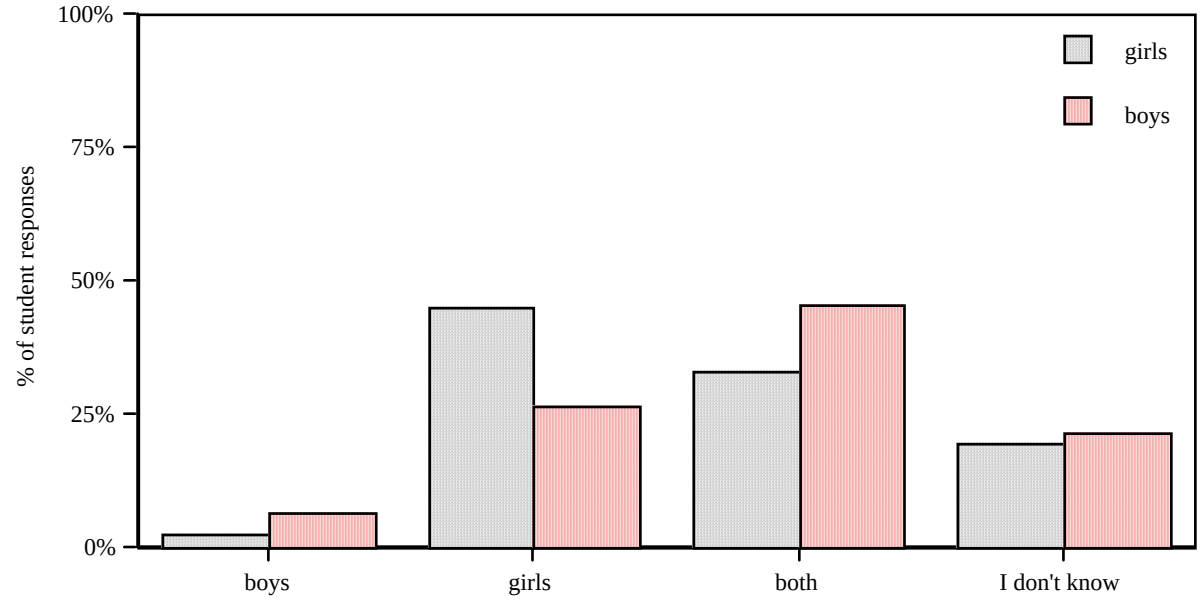

Figure 23 . Peer perceptions of which sexual partner usually suggests using a condom (all students)

when boys are supposed to persist while girls are left to resist. Wight (1992) has noted that

safe sex negotiation becomes easier after first time intercourse has taken place. Once intercourse has been established as the unequivocal intention and goal of sexual play it is easier to discuss issues such as safe sex. This is not without serious consequences for girls as it is frequently presumed that once she has consented to intercourse, often under pressure and uncertain circumstances, she has consented to intercourse being a continuing part of a sexual relationship. It is also pertinent to note here that 33% of this sample were with a new partner on their most recent occasion of sexual intercourse (see Figure 19).

ALCOHOL AND SEX

Questions about the use of alcohol and sexual behaviours were included in the questionnaire because our consultations with rural youth workers indicated that alcohol was an important part of the rural youth culture. It is not clear whether alcohol consumption is higher among rural youth, but it is certainly evident from focus discussion groups that it has a central place in the social life of rural adolescents. Previous research has indicated that the use of drugs and alcohol is correlated with increases in sexual activity and a greater likelihood of engaging in high-risk sexual behaviour (Rotheram-Borus, Mahler & Rosario, 1995). Students in virtually all of the focus groups described the important role of alcohol in social events. For example, a year 10 group of boys said:

b1 "Alcohol plays a very important part"
b2 "It gives you a bit of courage I suppose"
b3 "It's just there's nothing to do and you don't care like"
b4 "It's just like you don't think about going out and going to a party and if you think about that then you think about grog straight away"
b5 "You don't ask if there's going to be grog there you just presume that there is and if there's none there you'll go straight to the pub and get some"

When we asked about the effects of alcohol consumption both the girls and the boys mentioned that alcohol made them more conducive to having sex. One group of year 11 girls portrayed the typical effects of alcohol on boys that they knew:

g1"When they get drunk they fight and they fall down"
g2 "They're more sleazy"
g3 "Yeah, they want everyone in that room"
g4 "Stupidness"

A group of year 11 boys from the same school commented:

b1 "At the moment every boy that goes to a party is drinking. And they (girls) come here where there is all of these guys"
b2 "You can really tell when a girl's drunk, she just makes a fool of herself"
b3 "They get more flirty. Yeah. They might do things they regret, but they're still responsible for themselves"
WHAT DO THEY SAY NEXT DAY AT SCHOOL?
b3 "They're ashamed of themselves"

This anecdotal evidence supports the premise that young people who are drinking may be more likely to engage in sexual practices than those who are not. In order to explore this matter further, the questionnaire included several questions that addressed the relationship between about alcohol and sex (senior students only). We asked the question *In the past year when you has sex, how often were you under the influence of alcohol?* Twenty-four percent of the senior students, (60% of the sexually active students n=114) reported that they occasionally, often or always combined alcohol and sex. Seventeen percent of the sexually active students reported being drunk the last time they had sex as well as reporting that 11% of their partners were drunk. Eight percent (20% of the sexually active students, n= 38) reported that they had had sex when they didn't want to because they were too drunk at the time and 9% (22% of the sexually active students, n=43) said they had not used a condom (even though they had one with them) because they were too drunk at the time. There were no sex differences in these results. This affirms the information given to us in the discussions with these students that alcohol does play a part in sexual encounters, including when these encounters are unsafe.

COMMUNICATING ABOUT SEX

In order to assess the extent to which students were able to negotiate sexual issues with their partners, the students who had experienced sexual intercourse were asked to nominate which topics that they discussed with their partner on the most recent occasion of sexual intercourse. There were no significant sex differences in these responses which are represented in Figure 24. The most frequently discussed topic was using a condom and this was followed by avoiding pregnancy (the major concern in terms of safe sex that is repeatedly self-reported by adolescents).

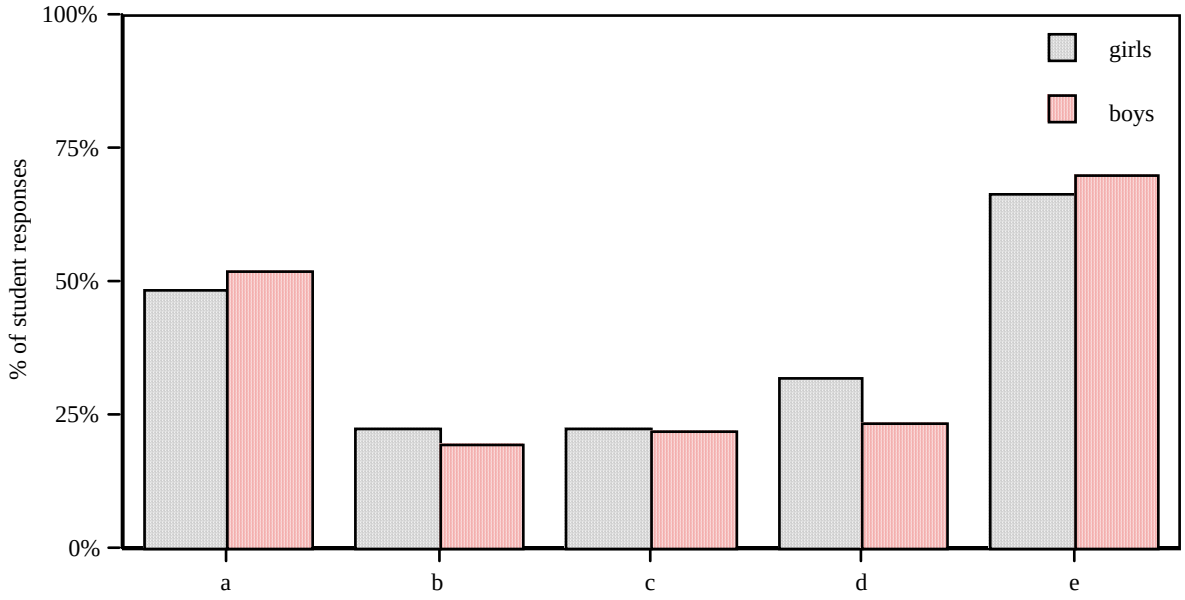

Figure 24 . Topics discussed on the most recent occasion of sexual intercourse (senior students who have had sex only)

Fewer students reported that they had discussed the topic of avoiding STDs and HIV although the topic of condom use would implicitly address these topics and would explain why avoiding HIV and STDs was mentioned less frequently. Avoiding pregnancy, however, remained an important concern that seemed to merit some acknowledgment in its own right by young people. As over a third of the students answering this question were having sexual intercourse for the first time with their partner (see Figure 19), it is important that issues such as avoiding STDs and pregnancy are consistently raised by young people when contemplating having sexual intercourse.

While over a quarter of the sample (on the most recent occasion of sexual intercourse) reported having discussed the topic of pleasure without intercourse, it was a notion that would appear to have been rejected in favour of intercourse. Although there were no significant sex differences for any of the topics discussed, the data from focus groups suggest that it would be unlikely that boys were interested in substituting other sexual pleasures for intercourse yet girls, for a number of reasons, were more often expected to resist intercourse:

SO WHY IS IT BOYS ARE ALWAYS WANTING SEX AND GIRLS ARE ALWAYS WORRIED ABOUT HOW FAR THEY SHOULD GO, WHAT DO YOU THINK THAT'S TO DO WITH?
g1"hormones (laughter)... boys are hornier than us"
g2 "Like we'd probably say something like that but we don't mean [it] whereas guys say it and they really mean it sort of thing like... the guys say they want a root and they mean it and if we say it we're just sort of joking sort of thing"
g3 "and we've got more to worry about like pregnancy and stuff like that, you've got things to worry about"

We might have expected that the tension between the notion of a biological sex drive in boys and the social expectations of femininity for girls would produce some level of negotiation around the topic of sexual pleasure without intercourse. But even when girls were not overly resisting sex, the above excerpt suggests they were still equivocal about wanting intercourse when they admitted to only mimicking the 'sex drive' discourse of boys. There was little evidence of girls resolving this tension in ways other than consenting to intercourse with a degree of discomfit and fear (towards the worrying consequences). Boys reported having discussed pleasure without intercourse as frequently as girls and this may be because their female partners raised the topic (the question does not ask students to specify who initiated the topics). The fact that intercourse took place anyway suggests that girls complied with boys' desires, despite the ambivalence that some girls may have felt towards intercourse.

SEXUAL ORIENTATION

Eighty-nine percent of the respondents were, at the time of the study, attracted only to members of the opposite sex, that is, they felt themselves to be heterosexual. Of the remaining 11%, 6% were unsure, 2% were attracted to both sexes, and 3% were attracted only to people of the same sex.

This was a surprising result, not the least because we learned from informal discussion with staff members and from focus discussion groups with young people in each school we visited, that homosexuals and lesbians in rural towns were a highly stigmatised group. As one young man said *"I reckon they're bloody weird"* and another *"we were told we were homophobic because we had a pretty bad attitude towards them"*. One year 11 girl said *"The thought of a man touching another man or a woman touching another woman; it's just not natural ""*. Boys, in particular, seemed to be particularly disturbed by the idea that any of their peers might be gay and the dominant feeling in the focus groups was one of fear. Part of the concern seemed to be based on the discourse that homosexual men are more predatory than heterosexual men. It may also be that boys are not used to the idea of being pursued in the way that girls are pursued by them. A senior student, a boy, expressed his concern in this way:

"I'd shoot myself if someone tried it. Like if I was drunk and some bloke took advantage of me and I found out, I'd kill them"

Fewer girls revealed themselves to be as staunchly homophobic as the boys and some girls were clearly exasperated with the attitudes of the boys. According to one senior girl:

"[The boys are] pathetic. That's all they talk about. The main insult to each other is to say that that person is gay"

It is difficult to imagine the anxiety which must be felt by the young lesbian and gay students in the research sample. It is vital that school communities, and in particular educators, ensure that the needs of gay and lesbian students are acknowledged in sexuality education and life skills classes. This is a difficult task when the hostile attitudes towards gay and lesbian identities that were evident among many of these young people would work against any productive discussion or dissemination of specific safe sex information and advice. In turn, gay, lesbian and bisexual students would be understandably reluctant to consider schools as a source of support for their sexual issues. Indeed it is probable that they would feel estranged from many of the resources such as family, friends and school health education programs that are generally accessed by students. It is all too easy to fall into complacency and fail to recognise the needs of these students in an atmosphere in which they would be highly motivated to maintain anonymity.

DISCUSSION

Although living in the country has its own special quality, particularly in the sense of safety and familiarity that is engendered in small communities, there are some disadvantages that have implications for the promotion of sexual health among young people. It is especially important that young people feel that they have some privacy and confidentiality in regards to their sexual health where these issues are invariably felt to be of a very sensitive, personal and sometimes potentially embarrassing nature. This is felt all the more keenly by young people tentatively exploring sexual identities and possibilities. Girls experienced an uncomfortable degree of community surveillance towards their sexual practices and although sexual double standards know no geographic or demographic bounds, infringements of this unwritten code had a high profile in these rural communities.

Relationships had a pivotal place in legitimating sexual experience although many students, and in particular girls, expressed ambivalence towards the perceived advantages and disadvantages of being in a relationship. Nevertheless girls were more likely to endorse the romantic positives of having a relationship and enjoyed the feelings of security, receiving affection and being loved. Boys were more likely to value relationships for providing them with a companion, status, the opportunity to have sex and enabling them to avoid being hassled by others. Girls were more likely to endorse the negative aspects of being in a relationship which included the loss of friends, the expectation to have sex, being controlled and the pain of breaking up. Time and again girls expressed an ambivalence towards sexual intercourse except for the way in which sex was able to serve as a demonstration of their commitment and love within a relationship. Girls were frequently concerned with the practical ramifications of intercourse including pregnancy and the myriad of consequences associated with 'a bad reputation'.

While the circumstances of rural life bestow specific experiences it is evident that most of the experiences and needs associated with adolescence are similar to both rural and urban young people. There is little suggestion in these findings that rural young people are any less sexually active than other young people with over a quarter having had sexual intercourse and well over half of the students having explored sexual touching. For those students who had commenced having sexual intercourse this largely took place within a regular relationship. Two thirds of the students who had sexual intercourse used condoms regularly although this leaves one third who did not use them and puts these young people at a potential risk of STD infection. This is particularly worrisome in light of the fact that although intercourse was taking place within a relationship it still remained an unfamiliar situation in which many students were having sex with new, or relatively new, partners.

Students who had not had sexual intercourse may have been sexually active in other ways and a very small number of those who had experienced sexual intercourse did not continue to engage in it. While the decision to keep intercourse as a permanent part of their sexual relationship was a mutual enjoyment shared by some couples, the ambivalence that was expressed by many girls in relation to sexual intercourse suggests that they were unaware of the full implications of consent. It is taken as commonsense by many men (and perhaps unwittingly by women) that consenting to intercourse for the first time means that it is from then on a regular aspect of their relationship. Girls' ambivalence towards intercourse was also evident in their responses to a question on how they felt following the last occasion of sexual intercourse in which it was overwhelmingly girls who described negative feelings such as being upset, sad and (for a few) coerced. It is also evident that there are serious concerns with the way in which alcohol and sex were linked for the young people in this survey. Alcohol not only diminishes one's competency and motivation to practise safer sex but its disinhibiting effects may also invite otherwise unwanted sex.

A small number of students had trouble accessing services that may assist them with their sexual health, including doctors and even chemists, but many rural young people acutely experienced a lack of privacy when visiting these services. Young people in Tasmania had access to a Kids Helpline that specifically addressed sexual health issues and this service was highly utilised. Services such as this afforded young people a degree of privacy that was otherwise hard to come by in rural communities and could be used more extensively as a method of service delivery. Sixty percent of girls preferred to see a female doctor yet they were regarded by many students as difficult to access. Most students' knowledge of HIV transmission was high, however, knowledge of STDs, though far more prevalent, was not as high. These are similar to the findings in other research that has assessed young people's knowledge of STDs. Boys' knowledge of STDs was lower than that for girls. It is evident that more effort could be spent informing young people about the more common STDs which are widespread amongst their age group. Condom use was quite high among both girls and boys in this sample with similar rates of use to their urban peers despite many young people experiencing some degree of difficulty and discomfit with obtaining them (Donald et al (1994).

Few students believed that they were likely to contract an STD while a majority thought it unlikely that they would contract an STD. Among those who believed they were unlikely to contract an STD, most students attributed this to the fact that they abstained from high risk behaviour. A less reassuring basis for believing it unlikely that they could contract an STD was associated with believing that having sex only with one, trusted partner would protect against STDs. A final set of beliefs around invulnerability to STDs was derived from circulating myths in which infection is somehow discernible in prospective partners.

Avoiding promiscuous and 'unclean' people were two examples from this set of beliefs about invulnerability.

Sex education varied across states and schools with some students having received only minimal tuition in this subject. Sex education tended to focus on the more biomedical topics (for example contraception, menstruation and STDs) and less on the sociocultural aspects of sexual experience. Students, however, more frequently indicated they would like more information on these latter subjects with girls in particular wanting more information on resisting pressure to have sex and also contraception and abortion, while boys wanted more information on the values about sex. It would appear from the issues confronting young people in general that access to more participatory and less 'scientific' models of sex education in which it was possible to acknowledge, explore and validate a wider understanding of sexual experience would be of enormous benefit. While mothers are a highly utilised and trusted source of information in regard to sexual issues, it would still appear that young people lack positive, realistic and candid models that they are able to draw from as they begin to develop their own sexual identities.

Alarmingly, many students expressed intolerant views towards people living with AIDS and the fate of PLWHA was seen to be largely of their own doing. This intolerance was extended to gay and lesbian people in general and homophobic attitudes were frequently expressed in focus discussion groups. The vitriol that was directed towards gay and lesbian people raised concern for gay and lesbian students whose right to freedom from harassment and threat is likely to be compromised. The issue of homophobia in schools needs to be addressed beyond the level of policy where the Victorian Directorate of School Education curriculum policy already stipulates that schools must cater for difference including sexual orientation. The difficulties in achieving this in any meaningful way will require all members of the school community to re-examine their own attitudes. This includes students but also extends to teachers, parents and the wider community.

It is apparent that there is a need to incorporate some new ideas into the way in which sex education is taught to young people. Most importantly, education needs to be extended beyond biological and reproductive paradigms. It would seem from what has been confirmed in this research, that young people are struggling with the interpersonal and intrapersonal aspects of sexuality. Health promotion information is inevitably filtered through the gendered power relations that structure heterosexual possibilities (which in practice is largely limited to penetration) and this has many implications for the way in which safer sex is interpreted and practised by young people. Many girls are clearly uncomfortable with penetration as the privileged experience of heterosexuality but find some compensation in the way that intercourse is the tangible experiencing of trust, togetherness and love. As Holland et al (1991) noted, empowering young women means redefining and transforming the nature of

their relationships with young men and others. The sexuality of young women is restrained by dominant discourses in which their sexuality is portrayed not only as merely complimentary to masculine sexual notions, but must also be within the context of 'a relationship'. Equally important to the project of transforming girls' heterosexual relationships is understanding the way in which masculinity must also be redefined in a way that is experienced as positive by young men. Davies (1995) astutely observes that unless boys and young men are able to perceive alternative discourses and patterns of desire in their relationships with young women as being of some benefit to themselves, then reworked notions of masculinity, femininity and heterosexuality will be resisted. Davies' comments are borne out in the experiences of these young people where traditional notions of these constructs are being challenged and have undergone some profound generational changes, including the expectation that most are likely to have sexual intercourse outside of marriage (if indeed they ever decide to get married). Despite these changes, oppositions such as stud/slut are still resistant to change and active, more autonomous accounts of pleasure among these young women are largely absent.

CONCLUSION

Overall there were some differences in the experiences and needs of the rural young people in this sample compared to urban youth and these were largely associated with privacy and access to services. The role of alcohol in the social and sexual lives of rural youth also deserves further investigation and intervention. Where other research has suggested that rural boys in particular begin having sexual intercourse later than their urban peers this has not been evident in this research and both boys and girls in this sample were commencing sexual experimentation and sexual intercourse at similar ages to other young people. Rural young people do, however, have problems with maintaining their privacy in small communities and girls, in particular, were unhappy with the limitations of small communities and many more girls than boys plan to leave their town upon leaving school. The issues that were implicated in unsafe sex practices were more often associated with broader issues, such as girls' and boys' differing expectations of relationships, that have been raised in relation to young people more generally.

It is very clear that health promotion must address the multiple issues that have been briefly outlined here. Safer sex must be seen as a positive concept in young people's sexual experiences rather than being felt to be a series of impositions and hassles that are put upon them. Feeling comfortable when buying condoms and using condoms should be considered acceptable and appropriate for both girls and boys. As well, there needs to be an acknowledgment in the various sources that young people use to access information on sex, that there are a range of sexual possibilities available which can serve as positive alternatives to intercourse. These issues need to be very carefully considered by parents who may become

concerned that sex education (with an emphasis on pleasure) promotes increased sexual activity, although this is unsupported by the research. A number of parents approached us in the course of this research disturbed by the possible effects this research would have on their children. The issue was also raised in a local paper with a contributor asking whether children really needed to know about such matters and commenting that time would be spent more productively just telling them what is right and wrong. The findings presented here reveal that young men and women do need to know about issues affecting their sexual health and that, despite their youth, they are struggling with the complexity of these issues.

REFERENCES

Abbott, S. (1988). AIDS and young women. *The Bulletin of the National Clearing House for Youth Studies, 7,* 38-41.

Castles, I. (1992). *Rural Australia*, Australian Bureau of Statistics, Commonwealth of Australia.

Chapman, S. & Hodgson, J. (1988). Showers in raincoats: Attitudinal barriers to condom use in high risk heterosexuals. *Community Heralth Studies, 12,* 99.

Davies, B. (1995). What about the boys? The parable of the bear and the rabbit. *Interpretations, 28(2),* **1-17.**

Donald, M., Lucke, J., Dunne, M., O'Toole, B., & Raphael, B. (1994). Determinants of condom use by Australian secondary school students. *Journal of Adloscent Health, 15,* 503-510.

Dunne, M., Donald, M., Lucke, J., Milsson, R., & Raphael, B. (1993) *1992 HIV risk and sexual behaviour survey in Australian secondary schools,* Australian Government Publishing Service, Canberra.

Farber, N. (1992). Sexual Standards and Activity: Adolescents' Perceptions. *Child and Adolescent Social Work,* 9 (1), 53-76.

Fine, M. (1992) *Disruptive Voices*: *The Possibilities of Feminist Research*, University of Michigan, Ann Arbor.

Grunseit, A., Lupton, D., Crawford, J., Kippax, S., & Noble, J. (1995). The country versus the city: Differences between rural and urban tertiary students on HIV/AIDS beliefs and attitudes. *Australian Journal of Social Issues, 30,* 389-403.

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S., & Thomson, R. (1991). *Pressure, Resistance, Empowerment: Young Women and the Negotiation of Safer Sex*, WRAP Paper 6, Tufnell Press, London.

Kovacs, G. T., Westcott, M., Rusden, J., Asche, V., King, H., Haynes, S. E., Moore, E. K. & Ketelbey, J. W. (1987). The prevalence of Chlamydia trachomatis in a young sexually active population. *The Medical Journal of Australia*, 147, 550-552.

Lucke, J., Dunne, M., Donald, M., & Raphael, B. (1993). Knowledge of STDs and Perceived Risk of Infection: A Study of Australian Youth, *Venereology*, 6 (3), 57-63.

Rosenthal, D. & Moore, S. (1991) Risky Business: Adolescents and HIV/AIDS, *Youth Studies*, February, 20-25.

Rosenthal, D. & Moore, S. (1994) Stigma and ignorance: Young people's beliefs about STDs, *Venereology*, 7 (2), 62-66.

Rosenthal, D. & Reichler, H. (1994). *Young Heterosexuals, HIV/AIDS and STDs,* Report prepared for the Department of Human Services and Health, Australian Government Publishing Service, Canberra.

Rotheram-Borus, M., Mahler, K. ,& Rosario, M. (1995). AIDS prevention with adolescents. *AIDS Education and Prevention, 7,* 320-326.

Thompson, S. (1995). *Going All the Way: Teenage Girls' Tales of Sex, Romance, and Pregnancy*, Hill and Wang, New York.

Waters, B. (1989). AIDS and Australian Youth, *The Bulletin of the National Clearinghouse of Youth Studies*, 8 (2), 25-30.

Wight, D**.** (1992). *Impediments to safer Heterosexual Sex: A Review of Research with Young People*, AIDS Care, 4 (1), 11-23.

Wyn, J. (1991). Safe from Attention: Young Women, STDs and Health Policy, *Journal of Australian Studies*, 31, 94-107.

APPENDIX A.

DISCUSSION THEME LIST - BOTH GROUPS

Note: there is never an assumption in these discussion groups that the young people involved are sexually active. Furthermore, the participants are advised not to disclose this information in the group. From our research in rural areas it seems that approximately 12 percent of year 8 (Vic) and 28 percent of year 10 (Vic) are sexually active. Clearly the majority of these young people are not sexually active. We are aware however, that cultural norms are in place well before young people are ready to become involved in an activity. For example, young people have many ideas about marriage, long before they contemplate it themselves. We do therefore assume that all participants have well formed ideas about sexual norms, and though we do discuss these, we do not discuss personal sexual activities in these sessions.

The main aim of this session is to find out about the special aspects of country life as the group members see it. It is important to always keep this in mind.

- Explain our research, the participants are the experts. We want to know about living in the country?
- Where do you live - in the town or on the outskirts?
- How difficult is it for you to get to Launceston?

- What is it like living in the country/how is it different from the city? (i.e.)
- How do you make friends.
- How do you meet boys/girls
- Where do you go when you go out
- What do you do after school
- What do you do on the weekend

- How is the country better than the city?
- How is the country worse than the city?

- Who do you talk to or what do you read etc. if you want to know issues about:
- values about sex
- boyfriends/girlfriends
- sexual matters
- STDs
- contraception
- pregnancy
- rape
- safe sex
- Who do you trust the most to talk about these things?

- What topics to do with sexuality do you often want to know more about?

- Where would young people in your town go who could they trust (i.e. you) if:
- they were pregnant
- had an STD
- had been raped
- if they wanted a condom/contraceptive