Setting the record straight: sexually transmissible infections and sexual abuse in Aboriginal and Torres Strait Islander communities

Sexually transmissible infections in young people need to be viewed in the context of the underlying community prevalence and the age of sexual debut

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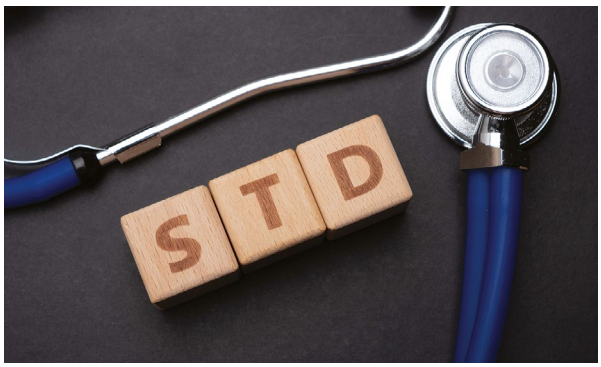
Aboriginal and Torres Strait Islander people (hereafter respectfully referred to as Aboriginal people) living in remote communities often face the brunt of public scrutiny because of careless reporting on sensitive issues. The consequence of such reporting can be stigmatising for individuals and communities, creating shame and potentially forcing the issues further underground, rendering them harder to manage. One such issue is the occurrence of sexually transmissible infections (STIs) in young people that is often depicted as demonstrating child sexual abuse.[1–3] While every case of child sexual abuse is a criminal act that demands the full force of the law, the context in which STIs occur in young people and minors is far more complex. Notifications of STIs among young people and minors may be the outcome of child sexual abuse, but others may be occurring in the context of sexual activity between consenting similar age peers no different from that found in non-Indigenous Australians in the same age group. While such activity is both unlawful and known to present health hazards, jurisdictions around Australia have recognised circumstances in which criminal proceedings are not in the best interest of those involved. In this article, we provide an overview of the epidemiology of STIs in remote communities, describe reported ages of sexual debut, outline mandatory reporting requirements and describe what has recently been reported about child sexual abuse. Our aim in bringing this information together is to set the record straight and form the basis for a healthier public discourse.

Sexually transmissible infections in remote Aboriginal communities

In the 25 years since the national reporting of notifiable diseases has included Aboriginal status, age-standardised notification rates for chlamydia, gonorrhoea and infectious syphilis in remote communities have been recorded at between three and 50 times that of non-Indigenous Australians.[4] About 80% of notified STIs in Aboriginal people nationally are diagnosed in outer regional and remote areas, where less than a quarter of the Aboriginal population resides (unpublished data, Kirby Institute). The highest notification rates are reported among people aged 15–29 years. The disparity between remote Aboriginal people and their peers (both Aboriginal and non-Indigenous) in urban and regional settings is far greater for gonorrhoea and infectious syphilis than it is for chlamydia.[4]



As a high proportion of these STIs are asymptomatic, diagnosis rates are dependent on testing that occurs predominantly in primary health care services. A major driver of STI transmission is underlying community prevalence. A study conducted in 67 remote Aboriginal communities in Australia in 2009–2011 found that the prevalence of chlamydia and gonorrhoea among people aged 16–24 years was 21% and 18% respectively.[5] In the same communities, among people aged 16–19 years, 33% of male and 49% of female health care centre attendees were diagnosed with either chlamydia, gonorrhoea or trichomonas in the previous year.[6] It is difficult to provide a clear comparison between these rates and other regions in Australia; however, the prevalence of chlamydia for young people attending general practice or other community settings was 4% among males aged less than 30 years and 5% in females aged less than 25 years.[7]

Sexually transmissible infections diagnosed in people aged less than 16 years

Between 2013 and 2017, 3190 cases of chlamydia, 1932 cases of gonorrhoea and 160 cases of infectious syphilis were notified among Aboriginal people aged less than 16 years. In the same period, 2287, 245 and three cases of chlamydia, gonorrhoea and infectious syphilis respectively were notified among non-Indigenous people aged less than 16 years.[8] Most of these infections, for both populations, were diagnosed in people aged 13–15 years (Box 1).[8]

Context of sexual behaviour in remote and non-remote Australia

STIs also need to be contextualised with sexual activity, particularly early sexual debut. A national survey of 2877 Aboriginal people aged 16–29 years,

1 Chlamydia, gonorrhoea and syphilis infections notified in people aged under 16 years, 2012–2016

Ethnicity	Chlamydia		Gonorrhoea		Syphilis	
	People aged < 16 years	People aged 13–15 years (%)	People aged < 16 years	People aged 13–15 years (%)	People aged < 16 years	People aged 13–15 years (%)
Aboriginal	3190	96%	1932	93%	160	94%
Non-Indigenous	2287	98%	245	81%	3	100%

which collected data in 2011–2013, described an overall mean age of sexual debut of 15.4 years (95% CI, 15.3–15.6) — 15 years for males (95% CI, 14.8–15.2) and 15.7 years for females (95% CI, 15.6–16.0). Most participants described having sexual relationships with similar age partners. Of people aged 20–24 years and 25–29 years, 1% and less than 1% respectively of respondents reported having sexual relationships with a partner aged less than 16 years.[9] Age at sexual debut is comparable to the Second Australian Study of Health and Relationships, which interviewed 20 094 Australian residents aged 16–69 years between October 2012 and November 2013. Among respondents aged 16–29 years, a mean age of sexual debut for Australian-born non-Indigenous people was 16.8 years for males (95% CI, 16.7–17.0) and 16.9 years for females (95% CI, 16.8–17.1); for Aboriginal respondents, the mean was 15.9 years for males (95% CI, 15.3–16.5) and 16.1 years for females (95% CI, 15.5–16.7).[10] Given the median age of sexual debut is about 16 years for Aboriginal and non-Indigenous Australians, this means that about half the population engages in first sexual activity earlier than the legal age of consent in most jurisdictions (currently 16 years). Therefore, young people living in non-remote areas are having sexual relationships too, but due to lower rates of infection, they may not encounter an STI at their first sexual relationship.[7] It is the diagnosis of these STIs which people are linking with child sexual abuse in the public discussion.[1]

Factors affecting sexually transmissible infections in remote Aboriginal communities

First, factors contributing to STIs among Aboriginal people living in remote areas include poorer outcomes in known determinants of health, such as education, health care access, income and employment.[11] Second, age is a specific risk factor for STI transmission; only one-third of non-Indigenous Australians are aged under 25 years, compared with over half of Aboriginal people.[12] Third, specific determinants of STI risk, such as age of sexual debut, number of sexual partners, mobility of population, alcohol and drug use, and condom use, contribute to the prevalence of STIs in Aboriginal people.[13] Finally, in most remote areas, STIs are tested and treated by busy remote primary health care clinics, with high staff turnover and with support from sexual health teams or specialists often located hundreds to thousands of kilometres apart.[14]

Mandatory reporting of child sexual abuse

Each jurisdiction has legislative requirements for the mandatory reporting of suspected cases of child abuse. These requirements vary in what constitutes reporting as well as who is legislated to report.[15] Unlike other jurisdictions, in the Northern Territory, mandatory reporting is the responsibility of all people, and for sexual abuse cases, it must be reported if there is a reasonable belief that a child has suffered or is likely to suffer harm or exploitation, if it is known that a person aged 14 or 15 years has a sexual partner who is more than 2 years older, and if the person is aged 16 or 17 years and their sexual partner is in a position of power.[15] Specific requirements for each state and territory are outlined in Box 2.

In 2017, the Royal Commission into the Protection and Detention of Children in the NT reported the number of notifications of suspected sexual abuse cases and the corresponding proportion, which were substantiated. In the NT, during 2015–16, there were 1786 notifications, of which 71 cases (4%) of sexual abuse were substantiated. Across all causes of reported child abuse (physical, emotional, sexual and neglect), sexual abuse represented 9% of notifications.[16] In 2015–16, at a national level, there were 5559 substantiated cases of sexual abuse in children (https://www.aihw.gov.au/getmedia/f6a9b7ef-bcff-4199-8ea0-82405fac31d1/child-protection-australia-2015-16-data-tables.xls.aspx).

Discussion

Remote Australia has experienced endemic rates of STIs for well over two decades, affecting mostly young people. For individuals younger than 16 years, higher rates of STIs were diagnosed in Aboriginal people than in non-Indigenous people, most in those aged 13–15 years. While we cannot be certain that all STIs diagnosed in young people aged less than 16 years — especially those aged 13–15 years — were the result of consensual sexual relationships with their peers, the age of sexual debut and underlying community prevalence contextualises STI rates to some extent and, in future, should be apparent in the public discourse on this issue. There should be no automatic assumption that STIs in young people mean sexual abuse; doing so further stigmatises young people and discourages them from presenting to health services for routine STI screening for fear of further investigation with authorities associated with mandatory reporting. Reporting on this issue should consider the underlying drivers of STI transmission,

2 State and territory mandatory reporting overview (adapted from the Australian Institute of Family Studies[15])*

State/territory	Who has to report?	What is reported?
Australian Capital Territory	A professional person such as a dentist, doctor, nurse, teacher, police officer, public servant who works with children or others whose work brings them in contact with children and their families	A belief that a child or young person is experiencing or has experienced sexual abuse or non-accidental injury, and this belief has arisen from paid or unpaid work
New South Wales	A professional person who provides health care, education, welfare or other services to children, or a person who holds a managerial position in an organisation that provides services such as welfare, education and health care to children	A belief that a child is at risk of significant harm and this belief has arisen from their work
Northern Territory	Any person	A belief that a child has suffered or is likely to suffer harm or exploitation. Health practitioners must report if they believe a child aged < 14 years has been/is the victim of a sexual offence, or a child aged 14 or 15 years has been/is the victim of a sexual offence, and the age difference between the child and their sexual partner is > 2 years
Queensland	An authorised person or public service employee, along with health and education professionals, police officers and child advocates	A belief that a child has suffered or is suffering significant harm caused by physical or sexual abuse
South Australia	Health professionals, education professionals, and any employee or volunteer who provides care for or interacts with children	A belief that a child is at risk of significant harm and this belief has arisen from their work
Tasmania	Health professionals, education professionals, and any employee who provides care for children	A belief that a child is experiencing or has experienced abuse, that there is a likelihood of the child being abused or neglected where the child resides or while a woman is pregnant
Victoria	Any adult, along with health and education professionals	A belief that a child is in need of protection and this belief has arisen from their work. A belief that a child aged < 16 years has been the victim of a sexual offence by another person or someone aged ≥ 18 years
Western Australia	Police officers, health professionals, teachers and boarding supervisors, and professionals working with families	Through the course of their work, a belief that a child has been or is being sexually abused, or is a risk of being abused, ill-treated, exposed or subjected to behaviour that may harm the child

* In some States and Territories, different classifications of people are mandated to report different types of abuse. These have been summarised as one here. ◆

early sexual debut, and the efforts required to bring about changes needed in reducing STI prevalence and early sexual debut through policy, clinical service delivery and community empowerment practices.

Child sexual abuse has catastrophic and long-lasting consequences for victims, and all efforts should be made at raising awareness of this issue and making it unacceptable in communities. Greater efforts are also needed to ensure young people in communities are aware of the age of consent, of the legalities regarding differences in age of partners, and of mandatory reporting. In addition, more transparent reporting on child sexual abuse, such as outlining the number of cases where the report is due to a 2-year age difference, would assist in the correct interpretation of the data, allowing targeted community education.

Conclusion

The conflation of child sexual abuse with STIs and vice versa is incorrect and continues to be reported. It is our hope that public discourse on this matter into the future is addressed more sensitively and that greater efforts are directed to dealing with these important issues by working in partnership with affected communities.

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