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Preface

Introduction to the special issue on the Second Australian Study of Health and Relationships

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Welcome to this special issue of *Sexual Health* that showcases findings from the Second Australian Study of Health and Relationships (ASHR2). The first study, conducted in 2002, and reported in 2003, was the first time that Australians were studied systematically and comprehensively in a national study of sexual values, sexual health, relationships, identities and behaviour. This was the First Australian Study of Health and Relationships (ASHR1).[1] It was described as 'an exciting beginning'[1] and echoed similar, comprehensive studies conducted in Britain, the US and France.[2–5] The findings from ASHR1 have been very widely used, both nationally and internationally, with several of the original ASHR articles having been cited over 100 times.[6–8]

Now, just over a decade later, we have a new ASHR. Many of the questions from the first study have been used again for consistency, allowing for interesting comparisons between then and now. However, the true value of this work lies in its documentation of current sexual values and behaviour. This special issue discusses the major areas of interest, and sometimes of concern, in the sexual lives of Australian men and women. What are their current attitudes towards sex, sexuality and relationships? How knowledgeable are they about sexual health issues? What is the current state of condom use and testing for sexually transmissible infections? How common are heterosexual, bisexual and homosexual experiences? What are the relationships between sexual identity, sexual attraction and sexual experience? Who has experienced sexual coercion and unwanted sex? Which sexual practises have become increasingly common over time? The second round of ASHR provides answers to all of these questions and more.

The first paper in this issue outlines the design and methods of ASHR2.[9] While the recruitment strategy remains basically the same as the earlier version of ASHR (relying primarily on telephone recruitment through fixed landlines), there have been appropriate modifications made to accommodate the changing patterns of telecommunications in Australia. In particular, ASHR2 used random-digit dialling to recruit participants through mobile phones. The success of this strategy is evident in the quality of data presented in the articles that follow. The large sample size of both the ASHR1 and ASHR2 studies means that even small differences between subgroups produce statistically significant results, although these differences may not always be significant in a public health sense. We encourage readers to bear this in mind when engaging with the results.

ASHR1 provided a comparative dataset for many other studies of populations of interest to sexual health specialists, including high school students, gay and bisexual men, HIV-positive people, people who inject drugs and attendees at sexual health clinics. Targeted studies of these subpopulations are often vital for designing culturally appropriate health promotion strategies, but can be hampered by non-random and unrepresentative sampling strategies and difficulties in determining the denominators of the populations in question. The data contained within ASHR2 is therefore extremely useful in providing a baseline against which smaller and more targeted studies can be compared. Of equal importance (and perhaps somewhat subversively) is the way that ASHR2 shines a light on the sexual lives of that very large, yet poorly understood group – the general population. This is perhaps where ASHR's contribution is most evident – reminding us that all Australians have sex lives, from the most commonplace relationships to the most esoteric sexual practises.

As Guest Editors of this Issue, we would like to congratulate the team who conducted the survey, pored over the data and wrote the articles presented here. The ASHR2 team includes members from the original team from the University of New South Wales, and LaTrobe University. They are joined by members from the University of Sydney and Sussex University. During the early stages of ASHR2, the lead investigator of the team, Professor Anthony Smith, died suddenly. The loss of Anthony's wisdom, collegiality and humour is still felt now. The work presented here is part of Anthony's legacy and a testament to the robust research partnerships he fostered.

The evidence presented in this issue only represents the initial findings from ASHR2. We expect that many further

insights will emanate from the study and that it will continue to inform researchers, clinicians, health policymakers, and education providers, nationally and internationally, for the next 10 years; at which point, it will probably be necessary to conduct the study all over again!

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