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Delivering positive youth sexual health services:

A realist evaluation

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Abstract

International and English scholars, youth advocates, policy makers and young people call for sexual health services which take a positive, holistic, comprehensive approach to support young people achieve sexual wellbeing. The enduring model of youth sexual health services is, however, orientated towards reducing the negative impacts of sexual activity.

There is limited evidence and theory to facilitate the widespread transformation of services to support sexual wellbeing. Specifically, current policy and academic outputs lack programme theory which describes how such a transformation might be realised. The current study aims to contribute to this gap by addressing the question - what works to deliver positive youth sexual health services, when, under what circumstances and why?

A realist evaluation was used to address the research question. Programme theory, providing specific ideas for local buy-in to positive services, was developed iteratively over four research cycles. This comprised theory building and refinement using data from two literature reviews, a comparative case study of three organisations where positive services have been attempted and thorough engagement with realist and existing formal theories of behaviour, organisation and social change.

Analysis demonstrated that local buy-in to positive services could be led by the following factors: *clarity* regarding what positive services are, and what one's individual role is in implementing it; *conviction* that the approach is the best way to bring support young people and cultural and structural *coherence* with local policy and practice. The results illuminated occasions when structural, cultural and agential entities were aligned to bring about positive changes.

The thesis illustrates a method for conducting a realist evaluation of a large scale, messy intervention which systematically utilises multiple existing formal theories and engages closely with mechanisms operating between cultural, structural and agential layers of society. This thesis contributes new programme theory for local buy-in to positive services, a critical step towards delivering positive youth sexual health services. It also provides detailed recommendations for policy makers, commissioners and practitioners. Wider lessons may also be drawn by those engaged with culture and structural change within public sector organisations, particularly where the new practice is emerging and may be culturally sensitive.

Candidate's statement

I declare that the work in this thesis was carried out in accordance with the regulations of Sheffield Hallam University and is original. No part of the thesis has been submitted as part of any other academic award. The thesis has not been presented to any other education institution in the United Kingdom or overseas.

Any views expressed in the thesis are those of the author and in no way represent those of the University.

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Katharine Shearn

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Publications

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Conferences

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Abbreviations

BASHH	British Association for Sexual Health and HIV
CASH	Contraceptive and Sexual Health Services
CCG	Clinical Commissioning Group
CIS	Critical Interpretative Synthesis
CMOc	Context Mechanism Outcome Configurations
COM-B	Capability Opportunity Motivation - Behaviour (part of the behaviour change wheel)
CSE	Child Sexual Exploitation
The Framework	Framework for Sexual Health Improvement in England
FPA	The Sexual Health Charity (formally Family Planning Association)
FSRH	Faculty of Sexual and Reproductive Healthcare
GUM	Genitourinary Medicine
IRPT	Initial Rough Programme Theories
KPI	Key Performance Indicator
LARC	Long Acting Reversible Contraception
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and others not identifying as cisgender or heterosexual
MiW	Making it work
MEDFASH	Medical Foundation for HIV and Sexual Health (closed 2016)
NEET	Young person 'Not in Education, Employment, or Training'
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NPT	Normalisation Process Theory
NVivo	A qualitative data analysis computer software package
PHOF	Public Health Outcomes Framework
SARC	Sexual Assault Referral Centre
STI	Sexually Transmitted Infections
STP	Sustainability and Transformation Partnerships
RSE/SRE	Relationships and sex education / Sex and relationships education
WHO	World Health Organization

Glossary of terms

Integrated sexual health services

Provision of all sexual health treatment, advice and contraceptive services within one system

Proportionate universalism

An approach where actions are applied to the whole population, but with a scale and intensity that responds to the level of disadvantage.

Sex positive

An approach which encapsulates notions of diversity, empowerment and choice in relation to sexuality

Sexuality

A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexual health / sexual wellbeing

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual health services

Sexual health services are commissioned at a local level to meet the needs of the local population. They provide information, advice and support on a range of sexual health issues such as sexually transmitted infections (STIs), contraction, relationships and unplanned pregnancy. Sexual health services can be divided into three levels: Level 1: sexual health and risk assessment, STI testing, HIV testing and counselling, pregnancy testing and referral, contraceptive information and services, Level 2: LARC fitting, testing and

treating STIs, vasectomy, partner notification and Level 3: complex/specialist testing and treatment, outreach prevention

Sex negative

An approach whose primary purpose is to prevent or respond to what are perceived to be the undesirable consequences of *some* sexual activity

Sexual subjectivity

a concept of one's own sexuality and embodied sexual desire

Sexual rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; the capacity to seek, receive and impart information in relation to sexuality; access to sexuality education; respect for bodily integrity; free choice of partner; the right to decide to be sexually active or not; the right to consensual sexual relations, the right to consensual marriage; the right to decide whether or not, and when, to have children; and the right to pursue a satisfying, safe and pleasurable sexual life.

Young people

A non-prescriptive term used to describe those who are between childhood and adulthood. Whilst commonly used in international policy and academic journals, this report does not use the terms *'adolescent'* and *'teenager'* because of the largely negative connotations that are often associated with these terms.

Chapter 1. Introduction

1.1 Chapter outline

This chapter presents the background for my study which aims to build programme theory for the delivery of positive youth sexual health services[1]. The rationale, outlining the need for such services, is based on the policy and academic literature related to the promotion of youth sexual health and wellbeing. This chapter first summarises the call for positive services. Concepts relating to youth sexual health and wellbeing are then described. Following this, the discourses, policy and practices currently dominating youth sexual health are outlined. This is contrasted with counter arguments for positive approaches. A summary of frameworks which aim to support the operationalisation of a sexual wellbeing approach then follows. I then make the case for the need for more theory and evidence to support the transformation from services which focus on sexual ill-health to those which promote wellbeing which leads on to the research aim and objectives. I will briefly then describe my standpoint in relation to the research before ending the chapter with an outline of the thesis

1.2 Background to the study

1.2.1 The call for positive youth sexual health services

There is a widespread call for youth sexual health services which support young people to achieve sexual wellbeing as opposed to merely preventing ill health (hereafter referred to as 'positive services'). This call is apparent in international (United Nations Population Fund, 2014b; United Nations & Sustainable Development Goals, 2016; World Health Organization, 2010a), English

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[1] A working definition for positive youth sexual health services may be comprehensive public services which support young people to achieve sexual wellbeing (Shearn, Piercy, Allmark, & Hirst, 2016)

(Department of Health, 2013a) and other national policies (Centers for Disease Control and Prevention, 2010a; Scottish Executive, 2005; Welsh Assembly, 2010). It is endorsed by academic research evidence from a variety of disciplines (Michielsen et al., 2016; Mitchell et al., 2016; Satcher, Hook, & Coleman, 2015; Schalet, 2011a; Wellings & Johnson, 2013), policy advisors and advocates for young people (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015; FPA, 2011; MEDFASH, 2008). Additionally a range of studies demonstrate that young people themselves demand services which are 'sex positive' (Aggleton & Campbell, 2000; Brook, 2016; Formby, 2011; J. Hirst, 2015; McGeeney, 2013). This term is used in a variety of ways (Williams, Thomas, Prior, & Walters, 2015) in response to what some describe as 'sex negative approaches' (Glickman, 2000). Sex positive is not necessarily pro-sex, as might be implied by the term (Williams et al., 2015). This will be discussed in full in section 1.2.3 and 1.2.4, but a working definition of 'sex-positive' and 'positive sexuality' for this thesis is an approach which encapsulates notions of diversity, empowerment and choice in relation to sexuality.

Various arguments underpin the call for youth sexual health services which support young people to achieve sexual wellbeing. These stem from a concept of youth sexual wellbeing (described at section 1.2.2) and from a critique of the discourses which currently dominate youth sexual health policy and provision (introduced at section 1.2.3). These will now be addressed in turn.

1.2.2   Concepts of youth sexual health and youth sexual wellbeing

The meaning of sexual health and sexual wellbeing
The term *sexual health* has been widely and increasingly used since it was defined by the World Health Organization (WHO) in 1975 (Giami, 2002; Parker et al., 2004) (see Figure 1). The WHO stresses the breadth of this concept (WHO, 2006). The current definition of sexual health, which is positioned by the WHO as provisional, refers to *physical, emotional, mental and social well-being in relation to sexuality.* This recognises that sexual health is not just about

sexual function or sexual behaviour. It also states that s*exual health requires a positive and respectful approach* and includes the *possibility of having pleasurable and safe sexual experiences* (WHO, 2006). These affirmative tenets reflect a widely held position that sexual health is not merely the absence of disease or dysfunction.
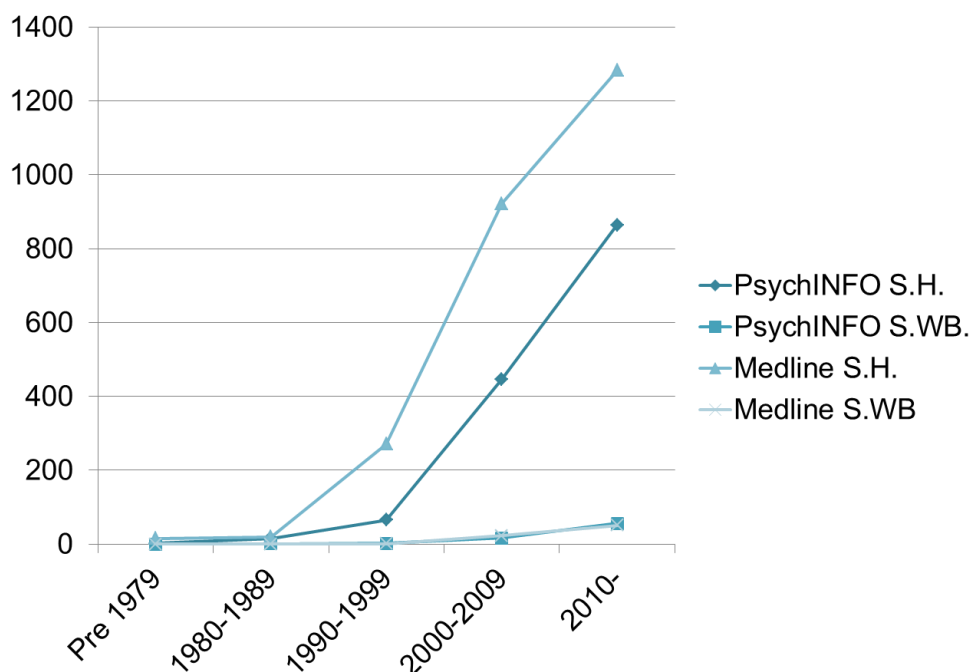
Figure 1. Usage of terms Sexual Health (S.H.) and Sexual Wellbeing (S.WB) in journal titles in PsychINFO and Medline (search updated October 2017)

Various international, national and charitable organisations have either adopted the WHO definition of sexual health (for example the European Centre for Disease Prevention and Control, 2013) or produced their own definitions, (Faculty of Sexual & Reproductive Healthcare, 2015; FPA, 2011; United Nations Population Fund, 2014b). Most of these definitions encompass a similarly broad conceptualisation of sexual health. They commonly reflect both positive and negative aspects of sexuality and sexual practices including the ambition to achieve 'well-being' and the possibility of pleasurable experiences, as well as avoiding negative impacts of some sexual activity such as sexually transmitted infections (STIs).

While the definitions of sexual health may be commonly cited in policy and academic studies, in practice, the breadth and complexity they are intended to

encapsulate are by no means universally understood and accepted. For some, the focus of sexual health interventions is exclusively on behaviour and resulting ill-health (Sandfort & Ehrhardt, 2004). This may be because the term 'health' has traditionally been understood primarily as a biomedical category and subsequently been seen through a medical lens. Giami (2002, p. 6), describes the 'medicalization' of sexual health as the:

> *"predominance of the clinical treatment of individuals and by the curative model in the context of a doctor-patient relationship".*

This had traditionally been accompanied by classification of sexual problems as medical syndromes of either the mind or body (Coleman et al., 2017; Giami, 2002)[2]. Foucault has argued that medical discourses about sexuality, in western cultures, are one expression of what he describes as *scientia sexualis,* that is, the 'science of sexuality' which privileges the accumulation of facts about sexuality (as opposed to *ars erotica* which is more concerned with human experience of sexuality) (1979). Although Foucault has argued that scientific analysis of sexuality may give pleasure in and of itself, the medical perspective on sexuality has attracted criticism. This is primarily related to associated ideas of 'normal' and 'not normal' and 'healthy' and 'unhealthy' behaviours which have been used to pathologise certain sexual behaviours, such as masturbation, promiscuity, prostitution and anal sex (Sandfort & Ehrhardt, 2004; Wellings, 2012). This study uses the concept of sexual health and sexual wellbeing to mean positive health in the broadest sense.

Sexual wellbeing is a concept increasingly used in academic and policy literature (Department of Health, 2013a; World Health Organization, 2010a), albeit at a much lower incidence than sexual health. For example, successive decades since the 1990s have seen a quadrupling of papers with sexual wellbeing in the title (see Figure 1). This has mirrored the global rise in the use of 'wellbeing' which is increasingly recognised as an important measure of a person's ability to flourish and lead a meaningful life (Ryff & Singer, 2000; Sen, 2004; United Nations & Sustainable Development Goals, 2016).

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[2] It should be noted that the most recent classification of sexual health in the International Classification of Diseases (ICD 11) makes a number of changes to allow practitioners to measure, assess and treat issues more holistically (Chou, Cottler, Khosla, Reed, & Say, 2015; Coleman et al., 2017).

Despite this rise in usage, the term sexual wellbeing also has no uniformly applied definition. In fact it is often not defined at all and is thus positioned as self-explanatory. Its usage has been synonymous with sexual functioning and sexual satisfaction in relation to ageing (Gupta, 1990), menopause (Frock & Money, 1992) or side effects of medical treatments (Pusic et al., 2009). Psychologists have also used the term to describe the cognitive and emotional evaluation of an individual's sexual life (Hooghe, 2012; Muise, Preyde, Maitland, & Milhausen, 2010; Snell, Fisher, & Walters, 1993; Weaver & Byers, 2013). Additionally, it has been used in relation to youth work (Paterson, 2007), human rights (Petchesky, 1993) and public health (Giami, 2015a) to refer to a state integral to being an effective social and political agent. In these cases sexual wellbeing means: having choice and control over one's sexual expression, suffering no discrimination on the basis of gender or sexual orientation and having the ability to develop egalitarian and democratic relationships with others. It is this latter conceptualisation of sexual wellbeing which is utilised in this study. It is appropriate because it directs attention away from solely individual behaviour (Harden, 2014) and, it has been argued, better encapsulates concepts which are critical to young people's sexual health, that of, *"personal security; attachment to others; appropriate functioning; self-determination; and respect for self and others"* (Fortenberry, 2016). The phrase *'sexual health and wellbeing'* are therefore used in this thesis to encapsulate the broadest domains of sexuality and emphasise the aspirational and positive.

Young people's sexual health and wellbeing as unique, personal and dynamic

The WHO definition points to the sexual rights of "all persons" (WHO, 2006). This suggests that we are born as sexual beings (FPA, 2011) and sexuality is important in all phases of life, including children and young adults (Braeken & Rondinelli, 2012). There is much evidence to suggest that attention to sexuality and sexual health matters increases over our youth (Associaton for Young People's Health, 2013; UNICEF, 2007) as part of the cognitive, physical, emotional, social and behavioural transition to an adult role (Blakemore & Mills, 2014; Hagell, Coleman, & Brooks, 2013; Smith, Chein, & Steinberg, 2013; The Society for Adolescent Health and Medicine, 2017). Some, however, have

questioned how the WHO definition may be applied to young people, for example how one should tally their entitlement *to the possibility of having pleasurable and safe sexual experience* (Sandfort & Ehrhardt, 2004) with legal frameworks specifying the age of consent?

The concepts articulated in definitions of sexual health and sexual wellbeing, therefore, need translating into practical terms and constructs that can be directly operationalised to guide clinical and public health practices for young people (Edwards & Coleman, 2004). Various scholars have proposed models or frameworks in response to this, which do one of two things. First, to operationalise what healthy sexual development or sexual wellbeing for young people might look like - and how it might be measured. Second, to establish the conditions, or principles which might underpin 'work' (that is, policy, practice and research), which promotes sexual wellbeing (described in section 1.2.5).

Operationalising the concept of healthy sexual development or sexual wellbeing is problematic. Social constructionists, such as Foucault (1979), challenged essentialist assumptions of sexuality suggesting instead that it is a product of social and historical forces, not simply innate or instinctual (Wellings, 2012). In this vein, there may be unlimited possibilities for sexuality, sexual expression, sexual health and wellbeing and our experience of them, which it has been argued makes constructs difficult to define, assess and compare.

Other scholars have tried to develop multi-dimensional measurements, based on the WHO definition. Some have done this to support population-level data gathering and identify trends (Smylie et al., 2013) or to demonstrate that sexual health and wellbeing is a coherent structure and important for health promotion initiatives (Hensel & Fortenberry, 2013). These measurements incorporate emotional, physical, mental and social health constructs[3] in relation to sexuality. Initial testing has demonstrated each of these domains (emotional, physical, mental and social health) contributes independently to overall measures of sexual health and wellbeing and to global wellbeing (Hensel & Fortenberry,

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[3] These constructs refer to a range of items informed by the work of other scholars for example desire, pleasure and danger (Allen, 2007; Cameron-Lewis & Allen, 2013; Fine, 1988), sexual rights (Aggleton & Campbell, 2000), knowledge and competence (Hirst, 2008), multidimensional measures or frameworks of sexual subjectivity (Harden, 2014; Zimmer-Gembeck & French, 2016) sexual function, satisfaction, body esteem and wellbeing (Weaver & Byers, 2013).

2013; Smylie et al., 2013). However it is possible to critique these measurements on grounds of inclusivity as other facets of sexual health and wellbeing could be included but are not currently incorporated in the measurements. For example, they do not explicitly include consideration of sexual identity[4] (Muise et al., 2010) or gender (Tolman, 2006) a broader scope expanding beyond sexual and reproductive aspects to include nutrition, injury and violence, mental health and substance use which may, nevertheless, have an impact on sexual wellbeing (Patton et al., 2016). What this body of work ultimately demonstrates is the difficulty in adequately reflecting sexual health, sexual wellbeing and sexuality in measurements given it is so complex and dynamic.

Sexual health and wellbeing as an important contributor to human flourishing

Despite the difficulty in assessing it, sexual health and wellbeing and positive sexuality expression could be described as a worthwhile pursuit in its own right, as well as a means to reducing potential negative impacts of some sexual activity (Hogben, Ford, Becasen, & Brown, 2014). Positive sexual attributes, such as sexual protection self-efficacy [5] (Smylie et al., 2013) and a broad conceptualisation of sexual health in its totality (Hensel & Fortenberry, 2013) are correlated with lower incidence of negative outcomes associated with sexual activity. These and other studies demonstrate that a wide range of health outcomes, mental health (Field et al., 2016) and 'overall wellbeing' (Anderson, 2013; Hensel, Nance, & Fortenberry, 2016) are also associated with positive aspects and experiences of sexual health in young people. Achieving positive sexual health and wellbeing may therefore be considered important for attaining the highest standards of health for all young people (Commission on Social Determinants of Health, 2011; Currie et al., 2012).

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[4] Sexual identity is defined in this study as the process of defining oneself as a sexual being and is not limited to sexual orientation (Muise et al., 2010)
[5] Self-efficacy refers to one's assessment of one's ability to complete a task (Bandura, 1977). Self-efficacy has been measured with regards to sexual protection, STI testing, communication, sexual limit-setting (Smylie et al., 2013) and pleasure (Zimmer-Gembeck & French, 2016). Protection self-efficacy relates to subjective assessment of one's ability and confidence to obtain and use protection.

In addition, youth sexual health has also been described as a basic right at the International Conference on Population and Development in 1994. The *Programme of Action of the International Conference on Population and Development* (United Nations Population Fund, 2014b) highlight links between sexual and reproductive rights, the rights of young people and health and social inequalities. The *Framework of Actions,* following this report highlights a priority to,

> *"protect and fulfil the rights of adolescents and youth to accurate information, comprehensive sexuality education and health services for their sexual and reproductive wellbeing and lifelong health"* (United Nations Population Fund, 2014a, p. 133)*.*

These arguments, to maximise young people's health and to fulfil their rights, may contribute to reasons why work to actively promote young people's sexual health and wellbeing has recently been included in international policy and practice guidelines. Another reason may be due to a rejection of discourses which currently dominate sexual health programming. I turn to these next.

1.2.3 Dominant approaches to providing sexual health services

Despite growing recognition of positive concepts of sexual wellbeing, other discourses associated with youth sexuality persist. Michelle Fine, whose ideas have been widely applied and extensively cited, was the first to coin the term 'the missing discourse of desire' (1988). Her work was developed in the context of radical feminism and primarily in relation to sexuality education, yet the perspectives that she outlined in society are also relevant for this thesis. Three of the perspectives concerning youth sexual health and wellbeing that Fine categorised will now be presented, and illustrated with examples of these discourses in sexual health practice. These, using terminology proffered by Fine, are: *sexuality as violence*, *sexuality as victimization* and *sexuality as individual morality* (1988)*.*

Sexuality as violence

The discourse of sexuality as violence reflects a perspective that adolescent sexuality is essentially violent and coercive. One response to this discourse is to resist the acknowledgement of young people's sexuality in the public sphere, attempt to suppress it and rely on the family to dictate sexual values and behaviours (Fine, 1988). The logic underpinning this response suggests that silence about sexuality will result in a decrease in sexual activity. In England, this approach is exemplified by the reluctance to make Relationship and Sex Education statutory, which has only recently been accepted (HM Government, 2017). This may also be born out through a lack of provision of sexual health services which young people can access and reflected in young people's fear of using services and concerns about confidentiality (Newby et al., 2017).

Silence and taboos associated with issues of young people's sexuality are actually negatively correlated with sexual health. Marston and King, conclude after a systematic review of 268 qualitative studies that young people often avoid speaking openly to partners about sex which makes safer sex difficult to negotiate (2006).

Sexuality as individual morality

The *sexuality as individual morality* discourse acknowledges young people as sexual beings but values sexual decision making as long as these reflect the 'right' values. These values have roots in religious concepts of purity and the nuclear family (Fine, 1988; Wellings, 2012) and relate to chastity, abstinence and subsequently monogamous, heterosexual sex within marriage. In this context, young people are urged to exercise self-control and self-respect. In addition, the health needs of young people who identify as LGBTQI may be systematically ignored or be stigmatised given they do not reflect these normative values (Formby, 2011).

This discourse was exemplified in the United States of America where federal state funding was only available for abstinence-only-until-marriage education from 1996 until 2010 and then combined with a sexual risk avoidance programme until the time of writing (Santelli et al., 2017). Santelli and colleagues, have twice demonstrated that abstinence only until marriage

approaches to sexual health education, results in a higher incidence of under-18 conceptions as compared to comprehensive sexuality education[6] (Santelli, Ott, Lyon, Rogers, & Summers, 2006; Santelli et al., 2017).

Sexuality as victimization

A third discourse is concerned with victimization; portraying young people as victims of sexuality and possible targets for adults to exploit (Fine, 1988). One response to this discourse is that young people are taught to 'defend' themselves against being a 'victim' of disease and pregnancy. Associated with this is a conceptualisation of young people as feckless and promiscuous, unable to make good decisions; the transition from childhood to adulthood is positioned as a period of 'storm and stress' (Hall, 1904), and developmental immaturity (Smith et al., 2013).

In practice this may mean that practitioners accept youth sexuality, but orientate policy and practice towards specific types of sexual activity as a cause of ill-health and social deprivation (Giami, 2002; Klugman, 2014). In classrooms young people may be taught about all the possible diseases associated with sexual intimacy and the economic and social risks which pregnancy can bring. In sexual health services delivery may focus solely on reducing 'risk-taking behaviours' such as condom-less sex[7] (Department of Health, 2013a) or preventing the adverse outcomes society wishes to avoid, for example, by promoting contraceptive methods such as long-acting reversible contraception (LARC) which reduces risk of unwanted pregnancy by removing user error.

One further consequence of this approach is to focus on identifying individuals or groups 'at risk' and develop interventions that seek to modify their risk-taking

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[6] I use the term *comprehensive* in this thesis as an approach to sex and relationships education that goes beyond biological facts and prevention messages to promote sexual subjectivity and wellbeing (Gubrium & Shafer, 2014).
[7] This should not be conflated with 'health risk' associated with structural and cultural conditions, such as deprivation, which constrains the choices of some people within the population increasing their risk of poor sexual health (Coleman & Hagell, 2015) which will be discussed at further at section 1.2.5.

behaviour[8]. The British Government's 'Teenage Pregnancy Strategy', which operated in England between 1999 and 2010 (Social Exclusion Unit, 1999), exemplifies this position. This document and subsequent framework for action positioned teenage pregnancy as a severe problem for individuals and society. In addition to health risks for mother and child, 'teenage pregnancy' may also have been the focus of public health initiatives on the basis of economic arguments relating to the cycle of deprivation associated with adverse health outcomes (Collumbien, Datta, Davis, & Wellings, 2012) - a positioning that is contested (Duncan, 2007[9]). As a result teenage pregnancy 'must' be tackled to benefit the potential young parents, their child and society as a whole. Within this strategy young parents and those 'at risk' of teenage pregnancy due to deprivation or geographic location were targeted for interventions.

Another response to the discourse of victimization is to focus on the potential threat posed by other young people and adults by increasing vigilance over young people's lives. One example is the 'Spotting the Signs' proforma introduced to sexual health services in 2014 (Ashby, Rogstad, Forsyth, & Wilkinson, 2015). This proforma encourages practitioners to explore young people's relationships, school and family life, with the purpose of recognising cases of Child Sexual Exploitation (CSE). Those that developed the proforma acknowledge that it can be seen as intrusive for some, leading to feelings of criticism, and irrelevant to those who are not sexually active (Rogstad & Johnston, 2011). Nevertheless, it has been recommended for widespread use following high profile cases in the media relating to the abuse of young women by organised groups, as illustrated by Jay (2014) in her report of CSE in Rotherham.

The *sexuality as victimisation* discourse has at least three interlinked weaknesses which may impede initiatives on sexual health and wellbeing (Berkeley & Ross, 2003; Coleman et al., 2017). First, it can force a narrow focus

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[8] This approach, it could be argued, also reflects utilitarianism (in as much as actions are good insofar as they benefit the greatest number of people, whether or not they are in the interest of individuals) (Bessant, 2014; Kelly, Heath, Howick, & Greenhalgh, 2015) and neoliberalism (in that they emphasise the choices of individuals and ignore the structural constraints which limit individual choice). It is also consistent with a dominant health policy paradigm which, arguably, emphasises economic development (Harris, Kemp, & Sainsbury, 2012).
[9] Duncan (2007) argues that teen birth has little impact on future deprivation, beyond that which is experienced by those from similar backgrounds.

on 'risky' sexual behaviours such as unprotected sex, anal sex or promiscuity ignoring other aspects of sexuality and sexual health that are important to young people such as pleasure and relationships (Bailey et al., 2015; McGeeney, 2013). Second, it can pathologise 'undesirable' outcomes, such as teenage motherhood (Duncan, 2007), and problematise the behaviour of young people (Aggleton & Campbell, 2000), without consideration of their sexual cultures or the impact of such pathology on their wider status in society. Conversely, it can ignore the sexual health needs of those deemed less 'at risk' for example women who exclusively sleep with other women (Formby, 2011). Third, by targeting those who might partake in 'risky behaviour' it reinforces the stigma associated with sexual health. Positioning ill-health as a result of 'deviance', as opposed to 'personal tragedy' (Scambler, 2006) can increase feelings of shame and embarrassment and, therefore, reluctance to seek help, advice or to communicate about sexual health issues (Fortenberry, 2013, 2016).

It is undeniable that we need to support young people to alleviate their vulnerability to sexual risk and exploitation. However, by focussing solely on their potential as victims and/or denying their access to knowledge and opportunities to learn and become competent sexual beings, we are, it has been argued, increasing their vulnerability (Hirst, 2008; Robinson, 2008).

This section has outlined three dominant discourses in youth sexuality: violence, individual morality and victimisation. Responses to these discourses in public health services relate to: silence or repression, encouraging restraint and self-control, mitigating potential risk to self or others and protection from others. Collectively, these discourses have been described as sex-negative responses (Fine, 1988; Glickman, 2000) in so far as their primary purpose is to prevent or respond to what are perceived to be the negative consequences of sexual activity.

Current theory and policy increasingly promotes alternative discourses, so called sex-positive approaches. These, it is argued, may supersede, sex-negative approaches with a focus on wellbeing (Michielsen et al., 2016) rights (Giami, 2015; 2002) and capabilities of young people (Caballero, 2016; Dixon & Nussbaum, 2012).

1.2.4 The rationale for positive approaches to youth sexual health and wellbeing

The rationale for positive approaches to youth sexual health and wellbeing may therefore be based on a theoretical alignment of agendas. It has been argued that theories, which promote understanding of sexual health and expressions of sexuality as multi-dimensional, holistic and dynamic, affected by and impacting on the wider society (as described in section 1.2.2), necessitate a move away from single issue, narrow or individual interventions to consider comprehensive assessments and integrated responses (Coleman et al., 2017; Fenton, 2010). In addition, agendas which highlight the inadequacy of 'sex-negative' approaches to supporting young people's sexual health call for an alternative approach (Aggleton & Campbell, 2000). This alignment is reflected in a consensus statement from a recent international conference on 'adolescent sexual health' which describes a shift in current thinking, within academia, from theories of risk to wellbeing and from targeted and individual interventions to comprehensive and structural interventions (Michielsen et al., 2016).

A positive approach to sexual health policy and service delivery typically embraces young people's sexuality as a natural part of their development (FPA 2011). This approach is characterised by a discourse and activities which address all aspects of a young person's sexual health including, but not restricted to, the negative outcomes of sexual activity. Proponents argue that a positive approach works with, not against, youth sexual culture, making it more relevant and acceptable to young people (Aggleton & Campbell, 2000). It is orientated towards optimising health and wellbeing, for example by giving attention to emotional health and respecting the diverse needs of all young people (Fortenberry, 2016).

There may be some discrepancies in the way in which a positive approach has been conceptualised. One interpretation is emancipatory and supports young people to make informed choices for themselves; another interpretation retains, implicitly, inherited concepts of 'healthy' and 'unhealthy' choices. Bay-Cheng (2003), a critical feminist, has argued that young people's ability to achieve sexual wellbeing, is less about conforming to society's inherited ideas about sexual wellbeing and more about developing a concept of one's own sexuality

and embodied sexual desire (described as sexual subjectivity) and agency to be self-directed. Alternatively, Schalet, who has provided comparative empirical work juxtaposing the approach towards health service delivery, amongst a multitude of other factors, between the Netherlands and the United States (Schalet, 2011a, 2011b) suggests that the cultural logic and social norms operating in the Netherlands supports the acceptance of youth sexuality. This is predicated, however, on the expectation that young people will self-regulate, consult parents/carers and professionals on their decisions and protect themselves from STIs and unwanted conceptions (Schalet, 2011b, pp. 181–190). These contrasting conceptualisations and their impact on the delivery of positive services will be explored through the course of this thesis.

1.2.5 Principles of a positive approach to youth sexual wellbeing

There remains a gap in both policy and practice around how best to engage and support young people to achieve their optimal sexual health and positive sexuality which goes beyond a focus on individual behaviour change (Collumbien et al., 2012). A range of scholars have considered what principles[10] should underpin this work (that is policy, practice and / or research). There is a great deal of overlap between the principles stated within their proffered frameworks. Central to most is the acknowledgement that young people are sexual beings, whether or not they are sexually active (Dixon, Nussbaum 2012). Further overarching principles place an emphasis on 'wellness' (Satcher et al., 2015), 'inclusivity' (Williams et al., 2015) and 'acknowledging sexual health as an element of overall health' (Ivankovich, Fenton, & Douglas Jr., 2013; Satcher et al., 2015; Williams et al., 2015). One of the frameworks unambiguously recognises the connections between sexual health and a variety of health outcomes, which the authors claim, necessitates a flexible, holistic and multi-faceted approach to support young people (Ivankovich et al., 2013).

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[10] The idea of principles will become a recurrent theme throughout the thesis but will only be introduced briefly here. As the thesis progresses, their pracitical application, meaning and interpretation will be developed.

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A number of these frameworks explicitly advocate an ecological approach to sexual health and it is implicit in others. These urge policy makers and practitioners to consider principles across different facets of social structure relating to individual, relational, community and societal 'levels' (Ivankovich et al., 2013; Svanemyr, Amin, Robles, & Greene, 2015; Williams et al., 2015). These levels will be briefly elaborated below.

At an individual level, the principles described are consistent with the multi-dimensional models (described in section 1.2.2) which recognise individuals' sexual health as 'unique and multifaceted' (Williams et al., 2015, Fortenberry, 2016; Svanemyr et al., 2015) which is dynamic and can be experienced in different ways over the life-course (WHO, 2010).

Spanning individual and relational levels, McKee et al (2010, p. 14), with a group of researchers from different disciplines, suggested fifteen domains were found to be acceptable to all.

> *"freedom from unwanted activity; an understanding of consent; education about biological aspects; understanding of safety; relationship skills; agency; lifelong learning; resilience; open communication; sexual development should not be "aggressive, coercive or joyless;" self-acceptance; awareness and acceptance that sex [can be] pleasurable[11]; understanding of parental and societal values; awareness of public/private boundaries; and being competent in mediated sexuality".*

Many of these domains are reflected in similar work by other scholars, for example Williams and colleagues at the 'Centre for Positive Sexuality' (2015). However, where some focus on desirable outcomes such as 'positive and respectful relationships' between prospective partners (Satcher et al., 2015; Svanemyr et al., 2015), McKee and colleagues seem to emphasise the young person's awareness, understanding and capability to achieve the outcome, as

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[11] The original text reads 'awareness and acceptance that sex *is* pleasurable', McKee et al (2010). It has been noted that advocating pleasure in discourses concerning sexual health education and service provision has had some unintended consequences (Allen, 2011). One is the 'pleasure imperative' which can impose an obligation or benchmark to judge the relative success (or not) of sexual experiences (Hirst, 2013). Given this, the principle is reworded slightly, in this text, to recognise the variety of possible experiences, whilst not obscuring the point that sexual partners may pursue pleasure in sexual activity if they want to.

opposed to the outcome itself. This approach, arguably, better encapsulates individual choice and agency central to emancipatory conceptualisations of sexual health and wellbeing.

Principles at a community level relate to 'social norms', 'gender equity' (Ivankovich et al., 2013; Svanemyr et al., 2015) and the need for an 'integrated response' to prevention (Satcher et al., 2015). For example, WHO outlines a framework for programming to create the conditions for a sexually healthy society which include legal, education, societal, economic and health systems (2010a).

Principles at a societal level rest on 'human rights' or 'sexual rights' and notions of flourishing (Fortenberry, 2016; Svanemyr et al., 2015; Williams et al., 2015) where social and political factors are very much taken into account as determinants of health (Giami 2015).

These individual, relational, community and social principles may present a framework for action, but further work is needed to translate these to practical working models of service, which I turn to next.

1.2.6 Delivering services to support youth sexual wellbeing

Health services are uniquely placed to support young people
It is well recognised that multiple factors relate to sexual wellbeing (Kirby & Lepore, 2007) which requires holistic framing (Fenton, 2010) and a multi-sector response (Centers for Disease Control and Prevention, 2010b; Department of Health, 2013a; Hadley, Ingham, et al., 2016; Satcher, 2013; World Health Organization, 2010a). Ivankovich, Fenton and Douglas (2013), however, single out sexual health services highlighting their unique positioning to serve the population across the dimensions of sexual health and throughout the life-course.

International policy and other academic sources also detail sexual health services as a fundamental pillar to realising young people's human rights in relation to sexuality (Braeken & Rondinelli, 2012; United Nations Population Fund, 2014b; United Nations & Sustainable Development Goals, 2016; World

Health Organization, 2010a). As a result, and to provide a practical scope appropriate for a PhD, this study focuses on the delivery of youth sexual health services as a potential contributor to young people's sexual wellbeing. It does however; preserve the idea that health services, in isolation, may have a limited impact on young people's sexual wellbeing and that effectively supporting them necessitates a collaborative approach.

Positive youth sexual health services are, as yet, unrealised in many places

There is a degree of consensus for the urgent need for more efficient, high-quality, interdisciplinary collaborative care for young people and greater access to it (Braeken & Rondinelli, 2012). It is what young people want. Brook (2016), a sexual health charity in England, catering for young people have run a sex:positive campaign for several years which engages extensively with young people in an inclusive and positive way . Other researchers, in consultation with young people, have argued that pleasure and other expected benefits of sexual activity should be included and prioritised in the delivery of sexual health services (McGeeney, 2013; Ott, Millstein, Ofner, & Halpern-Felsher, 2006).

Policy advocates for positive youth sexual health centre on four key aspects of health services: health promotion, accessibility, participation and quality (including youth appropriateness) (Braeken & Rondinelli, 2012; United Nations Population Fund, 2014b; United Nations & Sustainable Development Goals, 2016; World Health Organization, 2010a). These sources also reflect the broad principles for developing services, described above, such as ensuring they are youth-friendly, recognising and respecting diversity, acknowledging gender inequality and making a conscious effort to strengthen positive social and cultural values (United Nations Population Fund, 2014a).

Different parts of the developed world offer models of service which reflect these principles to a greater or lesser extent. For example, many scholars have contrasted the service models offered in the Netherlands and Scandinavia, which are positioned as positive, with service models offered in parts of the UK and US (Berne & Hubermann, 2000; European Centre for Disease Prevention and Control, 2013; Schalet, 2011b). Schalet (2011b) posits that the structural

conditions in the Netherlands are conducive to more positive cultural norms. They highlight the long standing multi-party government from national to local level, resulting in a politics of accommodation. This means that the democratic process values the citizenship and freedom of each individual and whilst intense political debates can and do shape everyday life, politics is geared towards compromise. Notably, commitment to this principle in the Netherlands has included taking into account the needs of those with less power, such as young people.

Some claim an overall failure of public health establishments, in other parts of the world, to shift in favour of sexual wellbeing, sexual rights and sexual satisfaction (Heimburger & Ward, 2008; Klugman, 2014). This protraction may be related to a limited attempt to address complexity inherent in sexual health services and the lack of a systematic approach to gather evidence (United Nations Population Fund, 2014b). Herzog (2009) has argued that liberalisation, that is overcoming obstacles to sexual freedom, may be occurring, but not at a steady pace. Their historical analysis of change within Western Europe has demonstrated that any movement towards liberalisation is peppered with periods of conservativism (Herzog, 2009). They argue that the presence, or otherwise of positive services, may be explained by a complex range of historical, cultural, structural and political factors meaning that causation in each location is undoubtedly different (Herzog, 2009).

Change at three levels: at the cultural, economic and service organisation levels may be needed to alleviate barriers at the level of the individual (Berkeley & Ross, 2003). This may not be easy to achieve. For example, in creating new structures or adapting existing ones, a clash between existing professionals and organisational cultures can arise - as was observed during the integration of family planning and genitourinary medicine (GUM) services in East Yorkshire (Berkeley & Ross, 2003).

1.2.7 Need for theory and evidence to support the delivery of positive youth sexual health services

The current English policy, *The Framework for Sexual Health Improvement in England* (hereafter referred to as *The Framework*)*,* introduces the notion of sexual wellbeing in its executive summary.

> *"The Government wants to improve sexual health, and our ambition is to improve the sexual health and wellbeing of the whole population"*
> (Department of Health, 2013a, p. 4)*.*

This may represent a change in emphasis compared to the previous policy documents such as *The Teenage Pregnancy Strategy* (Social Exclusion Unit 1999) which were arguably, rooted in sex-negative conceptualisations of young people's sexual health and wellbeing, as mentioned above.

The Framework was followed by *Making it Work: A guide to whole system commissioning for sexual health, reproductive health and HIV* (Hereafter referred to as MiW) (Public Health England, 2014). This document illustrates implementation strategies for bringing different areas of health improvement under the local authority which may mean greater interdisciplinary collaboration (Bailey et al., 2015). Other policy guidance specifically promotes the interests of young people. For example *You're Welcome* is both a guidance document and an accreditation which services can target to demonstrate they have thought about young people in the design and delivery of their work (Department of Health, 2011).

None of these documents summarise what is meant by sexual health, wellbeing, or the conditions which should be promoted to ensure overall sexual health and wellbeing for young people. Within the documents, however, there is some suggestion that broad, positive, conceptualisation of sexual health is intended. For example, they adopt a life course approach outlining specific events for people of all ages, including children and young people (Department of Health, 2013a) thereby recognising a sexual identity prior to initiating sexual relations.

However, in contrast to this ambition, the directives emanating from the documents may reinforce a sexual-risk approach to youth sexual health. This

approach can be seen in three examples set out in detail in Chapter 3. They illustrate that:

- 'Indicators' for sexual health are focussed on 'negative' outcomes for example, increasing chlamydia diagnoses (Public Health England, 2014).
- Prevention models refer to recurrent risk of people already in the services and make limited reference to preventing initial outcomes or promoting the positive aspects of sexuality (Public Health England, 2014).
- There is a focus on 'high-risk groups' to target and change their behaviour, not fully addressing the influential social, cultural and societal factors which constrain their choices. This focus is arguably incompatible with the Government's ambition to reduce stigma, (Department of Health, 2013a) associated with sexual health.

In addition, there is little mention of comfort, acceptance, pleasure, perceived non-discrimination on the basis of gender identity, gender expression, body image, and emotional wellbeing which arguably reflects the dominant discourses of risk, victimisation and general silence rather than discourses of positive youth sexuality.

The dissonance, which is reflected globally (Klugman, 2014; World Health Organization, 2010a), between the policy ambition to improve sexual health and wellbeing for the whole population and the, largely risk-based, aspects of the policy which are translated into actions, suggest the need for closer attention to the development and articulation of programme theory[12]. The lack of clear direction to inspire work towards youth sexual wellbeing also highlights a lack of evidence to translate the declared positive ambition into practice.

There are some examples of sexual health services which take a positive stance rooted in the sex-positive approach. For example, the WHO Framework for Sexual Health Programming (2010a) reported a case study of sexual health services in South Africa. It highlighted interventions that include training for

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[12] for the purpose of this thesis the definition of programme theory refers to how a specific intervention may lead to a specific goal (Shearn et al., 2017)

service providers, improvements for clinics so that they would be youth-friendly, community based activities to generate demand and careful monitoring of quality, impact and coverage of sexual and reproductive health services. The Oregon Youth Sexual Health Plan, in the United States, released in 2009, focused on sexuality as a natural part of young people's development (Nystrom, Duke and Victor 2013). In England, there are some anecdotal examples of services which claim a positive approach to sexual health. These include Sexual Health Sheffield and the Palatine Centre in Manchester. Others take a holistic approach, such as the Well Centre in Lambeth (Hagell & Lamb, 2016), which is described as addressing multiple aspects of youth wellbeing, including mental health and alcohol and drug use as well as sexual health.

The study reported in this thesis involves a detailed theoretical and empirical investigation of the underlying mechanisms contributing to the successes (and barriers) faced by such organisations in delivering positive services. There have been numerous previous studies looking at young people, sexual health and links with esteem, resilience, assets. For example, reviews of youth development programmes in the US (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004) and the UK (Wiggins et al., 2009) provide an overview of their effectiveness. There are far fewer studies looking at the decision making of those who hold relative power over young people, that is, those who decide where resources are allocated and what kind of service is provided. Indeed, whilst both negative and positive aspects of sexual health are present in international and national policy, the WHO (2010) recognises that, in practice, both theoretical and empirical work needs to be done to shift the approach from treating sexual ill-health to promoting sexual health and wellbeing.

The aim of this research is therefore to elicit theory that could contribute clear frameworks for the development of services. This will be complemented by an evaluation of some current sexual health services in England, on the basis of these theories, leading to an evidence and theoretical base on which future policy and practice can make a more coherent stance.

1.2.8 A note on current sexual health funding in England

It is not possible to discuss the provision of youth sexual health services in England, in 2017, without addressing the impact of austerity measures of consecutive Conservative led governments (2010 in coalition with the Liberal Democrats, 2015 and 2017). This has had a deleterious effect on the NHS and in particular on GUM services (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015; House of Commons Health Committee, 2016; Robertson, Wenzel, Thompson, & Charles, 2017). Access to 'open comprehensive GUM services' is mandated in England, but what this looks like is up to local systems. Robertson and colleagues (2017), for the Kings Fund, an independent health charity in England, found that on average, spending in 2015/2016 fell by 3.5%, and in some parts of England this figure was 20%. In many areas this has been in addition to cuts amounting to up to 40%, brought about through tendering services over the previous three years. In response to budget reductions, a minority of services have developed new efficient models of care, for example, by developing innovative digital solutions (Bailey et al., 2015). In many cases, clinics have been closed or moved to less convenient locations with reduced operating hours. Health advisor and health promotion worker posts have been cut in greater proportions than clinical staff. There is also much evidence of fragmented commissioning and poor staff morale (Robertson et al., 2017).

Whilst the resources available will inevitably affect the provision of public services, it is the way in which the financial constraints have driven decision making that will be explored in the context of this study. In addition, despite this obvious crisis, it is the ambition of this thesis is to look beyond the temporary, funding situation to consider other factors at play regarding the delivery of positive youth sexual health services.

1.3 Research aims and objectives

Aim:

- To increase understanding of what works to deliver positive youth sexual health services, for whom, under what circumstances and why?

Objectives:

- To propose principles and characteristics of positive youth sexual health services.
- To develop and test programme theories which lead towards successful delivery of positive youth sexual health services.
- To provide evidence and theory to critique policy and inform future models of practice.

1.4 My standpoint

Concepts of positive sexual health services are unavoidably political and value laden, as described above. This study is underpinned by a realist philosophy with a feminist lens (as will be described in Chapter 2) which seeks, inter alia, to render visible the power dynamics and normative values affecting the delivery, or otherwise, of positive youth sexual health services.

This section will make my own position, in relation to the research topic transparent. It will also include critical reflections of the research process, in keeping with best practice in both realist (Sayer, 2000, p. 61) and critical feminist research (England, 1994). It is hoped that this section will support the reader to understand the beliefs and values that have informed the development of this project and to help them draw conclusions about its credibility (Kelly et al., 2015).

As such, I will now set out both my position in relation to the choice and choosing of this area of study and the socio political context in which it was

conducted. I have included my own critical reflections on this standpoint to make it clear how I have tried to ensure that these values and beliefs did not cause problems or occlusions.

I am a white, British, middle class woman. I am a mother of one girl and one boy who, at the start of this study were 4 and 3, respectively. I undertook this PhD because of an interest in young people's sexual health resulting from previous research conducted for the NHS looking at under 18 conceptions. In particular, I was interested in young women's self-efficacy, self-esteem and aspirations for the future. This became even more important to me when I became a mother, thinking about what sort of young adults I hoped my children would become. As may be apparent by this preceding introduction, my reading around the topic and discussion with my supervisors encouraged me to broaden my initial ideas to look at the factors that may mediate young people's experience of sexual health and sexual health services. I became much more conscious of the way in which young people's choices may be constrained and was drawn to attend to the forces and powers operating in the fabric of society, and specifically in decision making about sexual health services.

I have no clinical or professional experience in delivering positive sexual health services; as such I have no vested interest in the outcomes of this study. I also have no applied insight to draw on. To mitigate for this I spent a number of months at the start of the programme engaging with local sexual health networks, attending events and meetings, speaking to local stakeholders and shadowing services. I feel that this grounding gave me some understanding of the day to day activities of the services as well as their tensions, conflicts and priorities.

My viewpoint continued to change over the course of the PhD, and I have reflected on my personal development, and how it may have influenced the research design and analysis at various points in this document, and in particular in chapter two and nine. Where relevant, I have taken steps to mitigate for any personal bias, particularly in the theory development, by seeking alternate explanations and by illustrating multiple viewpoints as will be seen in chapters four, six, seven and eight.

The timing of this study, which looks at positive sexual health may seem incongruent to the prevailing political and social context. England, at the time of writing, is ten years on from the financial crash of 2007/2008. It has faced seven years of austerity, which has seen dramatic reductions in funding for public services and in particular those for sexual health. Media attention, in particular, that given to CSE within the timeframe of this research study, appears to have brought about moral panics and subsequent policy attention, arguably, reinforcing sex-negative discourses. Positive sexual health seems far off the political agenda. Yet the emerging agreement from a wide range of advocates in policy, academia and the charity sector points towards a more progressive approach and is united in its frustration at the lack of progression. This inspired me to pursue explanations, relating to the delivery of positive sexual health services that acknowledged and incorporated the prevailing cultural and structural conditions. This, in turn, facilitated my critique of the methodological literature on realist evaluation as will be detailed in Chapter two.

1.5   Outline of the thesis

This thesis is prepared in nine chapters. This first introductory chapter sets out the rationale for the study, the research aims and objectives. It also describes where I started from, personally, and in terms of my skills and ambitions, for completing this study.

The second chapter sets out the methodology I used to respond to the research question and objectives. It describes why realism was an appropriate theoretical perspective in which to frame the research activities and how key tenets of realism were applied to this study. The overall approach to the data collection and analysis is presented at the end of this chapter. This describes four realist cycles, utilising various research methods and analytic procedures to culminate in refined programme and middle range theory corresponding to the research objectives.

The third chapter sets out the methods for conducting two literature reviews with the purpose of proposing principles and characteristics of positive services.

The account of the first literature review describes the systematic approach to selecting articles from the academic journals which were about the delivery of positive services. The second review interrogated policy affecting sexual health service delivery in England at the time of the fieldwork. Concepts from the two reviews were synthesised to propose a definition of positive services. This is described in terms of positive principles and characteristics.

The fourth chapter describes the methods used to develop initial rough programme theories, that is, the specific ideas about what works to deliver positive services. A broad conceptual framework from pre-existing substantive theories of social, organisational and behaviour change was constructed. This was used in conjunction with data derived from the literature reviews (described in chapter three) to develop the initial propositions. Three broad initial theory themes were developed relating to 'clarity', 'conviction' and 'coherence'.

Chapter five introduces the empirical research which was conducted over two realist cycles. The first part of the chapter describes the methods used to select, recruit and gather data from services which were operating a model of positive sexual health services for young people. The second part of the chapter provides an overview of the characteristics of each of the case studies. This is followed by a descriptive history of the case studies, over a time-frame relevant to exploring the proposed theories. This sets the scene for the following three chapters which refine the theories developed in chapter four.

Chapter six presents the data relevant to the theory theme, referred to as 'clarity'. This data is primarily illustrative of how structure, culture and previous experience influence actors' viewpoints. This chapter culminates in refined theory towards clarity of positive principles and characteristics at an agent level.

Chapter seven presents the data relevant to the theory theme 'conviction'. Data here illuminates the internal processes within individual agents that form the basis for conviction in positive youth sexual health services. Refined theories describe how conviction can lead to action at an agent level.

Chapter eight presents the data relevant to the theory theme 'coherence'. This describes data which shows how actors, with agency, can influence the organisational culture and structure leading to cultural and structural

elaboration. This chapter also presents data which help explain the fragility of this elaboration in the context of structural and cultural threats from outside the organisation, and within.

Chapter nine draws the refined theories together with a commentary relating to theories from the broader literature. It then sets out the contributions to knowledge made by this thesis and recommendations for policy and practice follow. A discussion of the strengths and limitations follows. The chapter, and thesis, culminate with implications for future research.

Chapter 2.   Methodology

2.1   Chapter outline

This chapter presents the theoretical and philosophical perspectives underpinning the research methodology and design. First, I set out the rationale for a realist meta-theoretical framework. This will be followed by a description of the key tenets of realist philosophy as applied to this project. A novel theoretical model used in this thesis to support an understanding of social action will then be introduced. The chapter will then provide an overview of the cyclical, iterative and longitudinal research design used to address the research aims and objectives.

2.2   Rationale for a realist meta-theoretical framework with a feminist lens

In chapter one (1.4) I stated that this study is underpinned by a realist philosophy of science and adopts a feminist lens. I now expand upon this to explain firstly, why a realist approach is appropriate and then how I applied a feminist lens to this study.

This study aims to increase understanding of what works to deliver positive youth sexual health services, for whom, under what circumstances and why. There were two key aspects of this research aim which needed to be adequately addressed in the research methodology. First the *nature* of what is under investigation, that is youth sexual health services. This is a question of what exists and can be the object of scientific study; hence it is a question of ontology. The second aspect is *how* we can accrue knowledge about what exists, which is a question of epistemology.

An account of realist social ontology, based on the work of various critical realist scholars (Archer, 1995; Bhaskar, 2008; Collier, 1994; New, 2005; Sayer, 2000)

will be discussed in full at section 2.3 and 2.4. In short, realist social ontology suggests that there exists a world beyond our experience of it. This world is stratified consisting of underlying powers and mechanisms which combine to produce events, of which only a portion can be observed (2.3.1). It further posits that social structure is made up of parts (such as agents, roles, processes, practices, ideas, norms, and resources) with properties and powers (that is capacities or liabilities) to produce effects (2.3.2). These parts interact with other parts in social structure to give rise to new entities with emergent properties (2.4.1). However, these parts do not operate in entirely consistent and predictable ways which gives rise to the complexity inherent in social systems (2.4.2).

Youth sexual health services can be described as 'complex social interventions'; they have multiple parts in that they cater for all young people, with different needs and experiences and they are delivered in a range of settings by a variety of clinically and non-clinically trained staff (Shearn, Allmark, Piercy, & Hirst, 2017). They are also the product of, and interact with, political, historical, social and geographical contexts (as outlined in Chapter 1) (Clark, 2013b). The complexity inherent in youth sexual health services means that intervening at one part of the system, for example, by decision makers attempting to implement change in practice towards positive approaches, can have unpredictable effects (Rutter et al., 2017).

Realist epistemology suggests that if part of what exists, the underlying forces and powers of entities, are unobservable, the task of a realist inquiry is to state theories about these underlying powers. These theories are fallible and partial because we cannot get direct access to that world to test if they are true or not. Therefore we test the theories indirectly via empirical research, in a bid to get a deeper appreciation of the world. The study thus begins and ends with theory. For example, teams may be considered more effective if there are high levels of interpersonal trust between team members. We cannot see the team members' feelings of trust, nor the prior experiences that contributed to its presence, but our theories about its importance to performance would direct us to consider such factors in data collection.

Realist evaluation has been proposed as an appropriate alternative to experimental designs in explaining the effects of social interventions. It is argued that realism offers a framework to explain patterns of outcomes where many causal factors may interact (Clark, 2013a; Pawson & Tilley, 1997; Westhorp, 2012). Realist approaches, such as realist evaluation and realist synthesis have been increasingly utilised over the last decade (Wong et al., 2017; Wong, Westhorp, Pawson, & Greenhalgh, 2013) on topics which are aligned to the current project. For example, Willis and colleagues (2014; 2016) undertook a realist review to derive guiding principles for sustaining cultural change in healthcare settings and Hardwick (2013) conducted a realist review of one stop shops for women with complex needs. Most closely related to this study is the realist evaluation undertaken by Greenhalgh et al (2009)[13] which looked at modernising health services including a sexual health service. These studies create a precedent for realist approaches to investigate the transformation of health services which this study aims to build upon.

In the course of this inquiry I have adopted a feminist lens in order to be sensitive to the powers through which young people may systematically experience inequality, for example through conceptualisations of adolescent health which are tied to adult society and expectations for successful transition to adult roles (Slater, Guthrie, & Boyd, 2001). In contrast to much feminist research I will offer explanations for these with reference to underlying causal (but not deterministic) forces (Lawson, 1999; New, 2005). Whilst acknowledging that this is a contested viewpoint, summed up elsewhere (Gunnarsson, Martinez Dy, & van Ingen, 2016), I argue that this causal explanation, referring to underlying mechanisms, makes it possible to identify the changes needed to transform services.

Further to this, I also recognise the significance of power and knowledge in social systems and discourses that systematically form them (Foucault, 1979; Stickley, 2006). In keeping with critical realism, I attempted to look behind the structures which might bias my research (Collier, 1994). My standpoint, with relation to this study, was also made explicit (as already noted) and my analysis

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[13] This study is referred to extensively in chapter three, four and nine as the findings informed the development of initial programme theories.

and interpretation of the findings interrogated for bias (Collier, 1994; Kelly et al., 2015; Sayer, 1992) by sharing early iterations of my results with supervisors and participants for discussion.

Three questions of realist theory were important in the development of the methodology for this study. The first relates to *social ontology* which defines the constituents of the social world in relation to youth sexual health services. The second relates to a *general explanatory framework,* that is, a broad set of ideas about how the world works which, in itself, explains nothing but suggests how to go about explaining. The third relates to the development of *practical social theory* or *programme theory* which does explain how positive services might be developed and sustained. Each of these aspects of theory is now described below.

2.3   Realist social ontology and epistemology

Realist ontology posits that there is an external reality independent of our minds (Bhaskar, 2008; Collier, 1994, p. 42). This is further developed with specific assumptions about the world relating to:

- *Depth ontology*, which suggests that human experience captures only a small part of a deeper and vaster reality (Fletcher, 2016).
- *Social phenomena,* which suggests that social structure is made up of structural, cultural and agential entities (Archer, 1995).

These are now explained in more detail and considered in relation to my study.

2.3.1   Depth ontology

Realist scholars argue that reality is made up of three layers. What we can observe (the empirical layer), what happens (the actual layer) and the potentialities, capacities and liabilities of objects, which are a function of their internal structure and relations (the real layer) (Collier, 1994; Elder-Vass, 2012). For example, we may observe a woman sitting with a book to her side

(empirical layer) she has decided she would prefer to watch passers-by than read (actual layer). She does, however, retain the capacity to read the book as she was taught to as a young girl, whether or not she is currently reading it (real layer). These layers are illustrated in figure 2. Further to this, realism holds that events, which lie in the actual layer and which may or may not be observed, or observable, in the empirical layer, occur when the capacities or liabilities of objects are activated. When such power is exercised we can say that a mechanism is fired (illustrated by the solid arrows in figure 2) (Collier, 1994 p43).
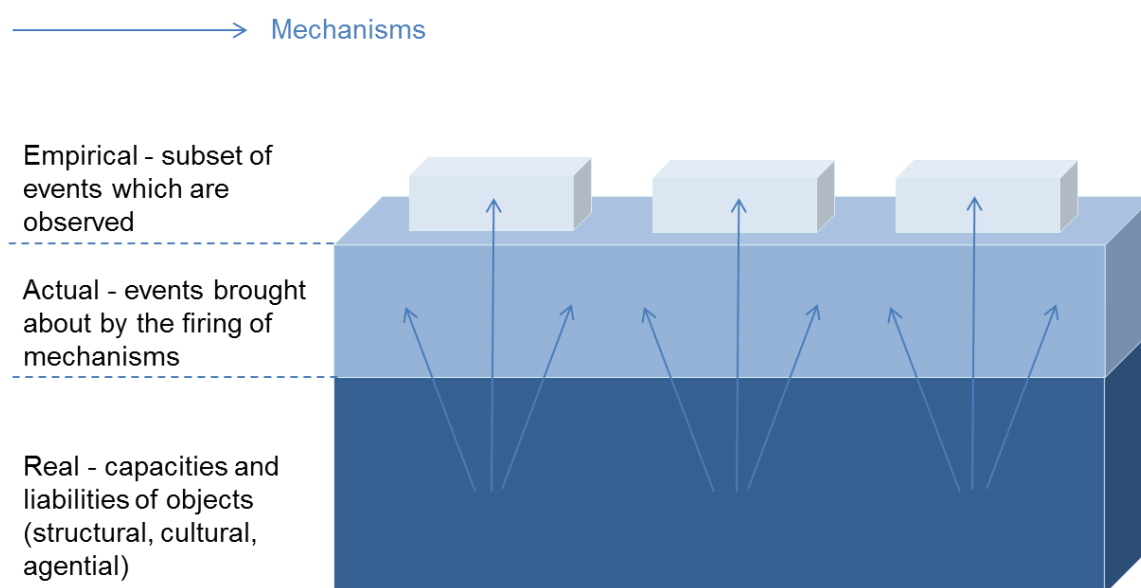
Figure 2 Realist notion of stratified nature of reality and depth ontology

Accordingly, in seeking to explain how and why decision makers adopted certain models of care for youth sexual health services, in this study, I did not only aim to describe what they did, that which could be directly observed, but also theorise about the underlying mechanisms that brought about change. This involved describing the parts within the system and the way in which they fit together to make those decisions possible (Danermark, Ekström, Jakobsen, & Kar, 2002, p. 70).

2.3.2 Social phenomena

The objects of science in this study were primarily social phenomena. Realist scholars argue that because social phenomena have causal power and real effects they can be defined as real even if we cannot see or measure them (Sayer, 2000 p11).

In this study aspects of *structure*, *culture* and *agents* operating within and influencing the delivery of positive youth sexual health services were considered the objects of science, under investigation. Figure 3 provides the base of a model which will be built upon in the course of this chapter illustrating that structure, culture and agency can be considered as separate entities. This is in line with Pawson & Tilley (1997, p. 70) who claim that a full understanding of the way in which a new intervention works in a defined context would include the workings of structure, culture, agency and the interplay between them.
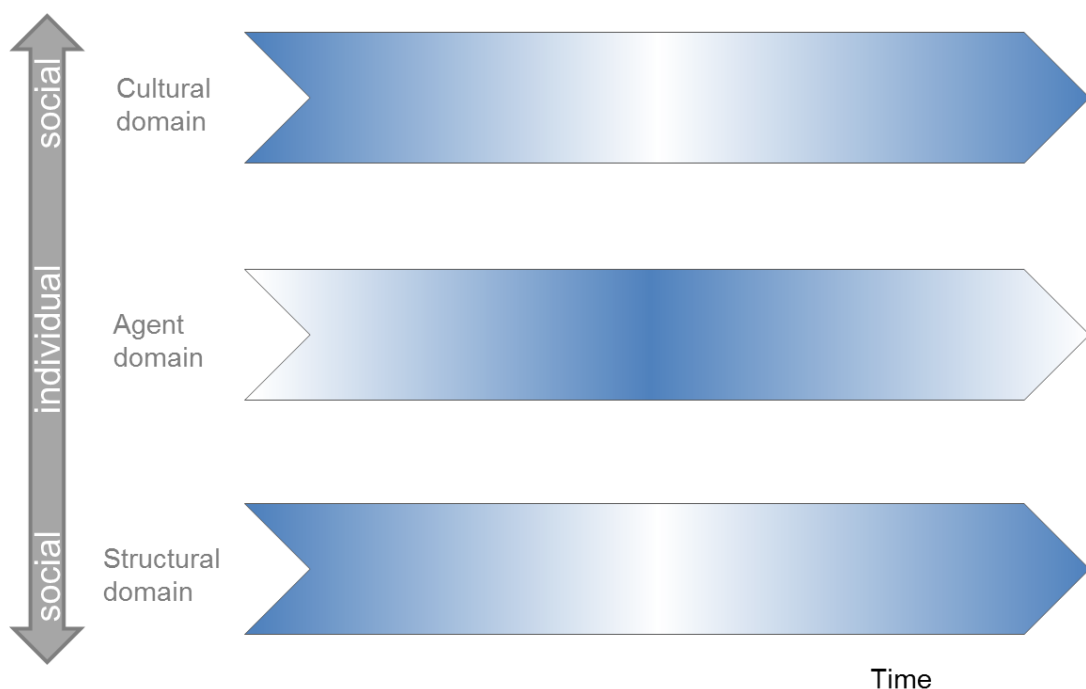
Figure 3. Cultural, agential and structural realms.

The definitions utilised for *structure*, *culture* and *agents*, in this thesis, are drawn from De Souza (2013), who in turn has been influenced by the work of Margaret Archer and other critical realist scholars.

Structure is used to refer to institutional properties which are internally related and without which public institutions and organisations could not exist. These are: *roles*, such as clinical or managerial roles, *practices*, such as the methods for undertaking a sexual health consultation, *resources,* such as training materials, time or financial assets and *processes,* within and between institutional properties, such as alignment between methods for consultation and time allocation.

Culture is used to refer to ideas. Emergent properties of culture are theories and arguments about society that affect social actions. The ideas about youth sexual health and sexuality such as *victimisation*, *violence*, *pleasure* or *individual morality* and the varied interpretations of the role of sexual health services, outlined in chapter one, are examples of such ideas that may influence practice.

Agency is used in this thesis to refer mainly to the actions of social actors which are constrained or enabled by structure and culture*.* Social actors may be both *primary* and *corporate agents.* Primary agency refers to the constraints or enablement brought by involuntary social placement (such as opportunities and privileges, or lack thereof, due to parentage or social context). Corporate agency is brought about by collective organisation (such as the power one is afforded through the job role one adopts).

2.4 General explanatory framework

The previous section provided a realist account of what constitutes the social world, I next turn to outlining a general explanatory framework, that is, a broad set of ideas about how the world works, which provides suggestions of how to go about explaining social action. These refer to concepts of stratification, emergence, causation and complexity.

2.4.1 Stratification and emergence

Structures, culture and agents may be considered analytically separable, but they are, nevertheless, interdependent. Structure and culture could not exist without the actions of social agents. Ideas, practices and processes in the social layer of society are made up of other parts and their interrelationships. Pawson & Tilley (1997) have suggested that it is helpful to think of social strata, naming them the '4 Is': infrastructural, institutional, interpersonal and individual contexts. These are stacked, in that smaller parts may make up larger parts. Whilst some contest that the layers are more likely interwoven (Elder-Vass, 2012) it is this internal structuring (of parts coming together) which gives the new entities emergent properties, powers and susceptibilities (New, 2005). The powers and susceptibilities of the new entities cannot be explained through an explanation of the properties of its parts alone (Sayer, 2000 p. 12). This phenomenon is called '*emergence*'. For example, the health system might be described as a structure with emergent properties within the social world for it is made up of individuals and interpersonal relations but its properties are more than the sum of the properties of the individuals that make it up.

Actions, carried out by agents are, however, always carried out in and constrained by the social context. So, whilst structures and culture can be considered to be real, they have their effects through the actions of agents (Glass & McAtee, 2006; Scambler, 2013a). There is some debate about exactly how or through what processes structure and culture influence social events (Elder-Vass, 2012). Whilst acknowledging this wider debate, for the purpose of this study, I am using the idea that structure and culture may actualise their potential, through their parts. For example, the organisation may be causally influential through the actions of an individual employed by the organisation. The employee acts in accordance with their own beliefs, but their beliefs include those related to their roles within the organisation (Elder-Vass, 2012). This effect has been broadly characterised as *'conditioning'* (Archer, 1995) and can be described as rules, norms, values and conventions. In figure 4 this is depicted as a dashed arrow from the cultural / structural domain to the agential.
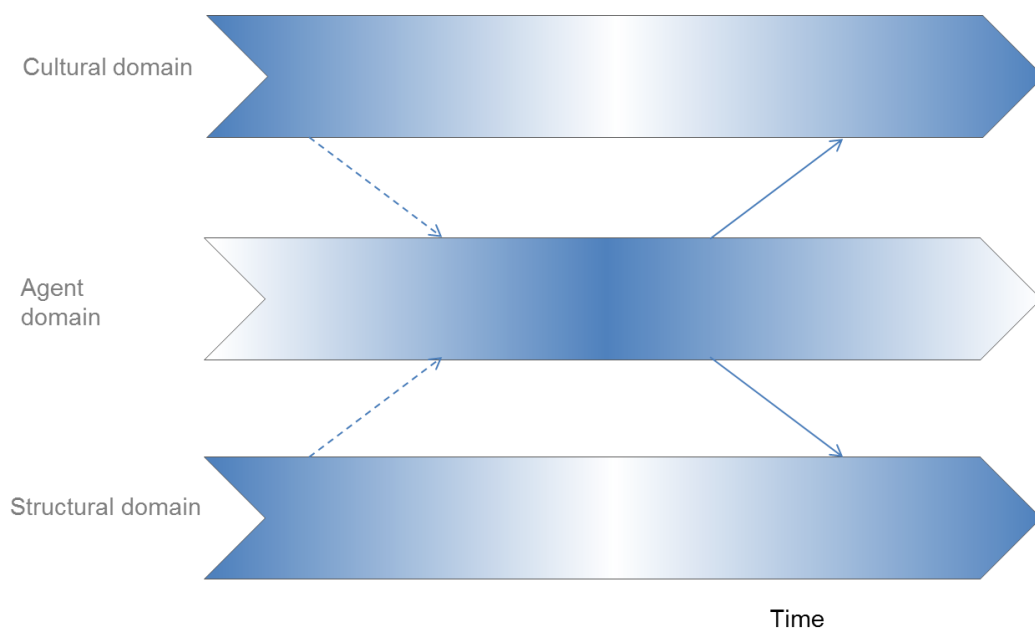
Figure 4 Interrelationships between structural, cultural and agential domains.

Agents can choose to act in line with designated practices or customs or adopt new ones. Their actions will subsequently either reproduce or transform structure and culture (Archer, 1995; Elder-Vass, 2012). In figure 4 this is depicted as a solid arrow from the agential domain to the cultural and structural domains.

To analyse structure, culture and agency we can divide them into their constituent parts to be able to explain their ways of working and relations between them (Danermark et al., 2002, p. 59). One abstraction necessary for this analysis is to include a temporal dimension, illustrated in figure 4 as the continuous block arrows from left to right. The alternate shading indicates the diachronic influence of structure/culture on agency and vice versa. In this model, social phenomena are the pre-conditions of human agency, and human agency reproduces, or transforms the social phenomena through their action and so on (Archer, 1995 p.150).

2.4.2 Causation and complexity

Thus, any given social event can be influenced by a range of roles, processes, practices, norms, rules, conventions, beliefs, dispositions and judgements

(Elder-Vass, 2012). This is not a linear relationship, whereby A leads to B, but more like a web of causal processes which, in combination, leads to the event (Sayer, 2000). This is called *generative causation* (Bhaskar, 2008), the process whereby forces and potentials in the real layer generate events. For example, a decision maker in local government can simultaneously be a member of a professional body and be a parent; they may be influenced by a range of norms and values. Any decision they make may also take into consideration the intended impact and coherence of subsequent actions with other competing priorities, processes and practices.

This range of influences which may lead to events gives rise to *complexity.* Different combinations of mechanisms could lead to the same event, or indeed, a slightly different combination could lead to an entirely new and unexpected event. In realist terms this is where the same mechanism can produce different outcomes according to context or, more precisely,

> *"according to its spatio-temporal relations with other objects having their own causal powers and liabilities which may trigger, block or modify"* *(Sayer, 2000, p. 15).*

Despite this complexity these interactions are not endlessly random or chaotic; some patterns can be observed within them (which Lawson (2013) has called *demi-regularities*). The aim of this research is therefore to explicate the ways in which the diverse contexts operating in the delivery of youth sexual health services interact and affect the way it is delivered via an investigation of key mechanisms (Pawson & Tilley, 1997).

2.4.3 Critical realist meta-theory and scientific realist application

Thus far the philosophical ideas underpinning the methodology have been drawn from *critical realist* scholarship. There are in fact many divisions within realism. In designing the research approach I was also influenced by the work of Ray Pawson (2006, 2013) with Nick Tilley (1997) and others who have developed *scientific realist* approaches which also has roots in critical realism (Wong et al., 2017, 2013).

Realist evaluation appealed due to the methodological framework offered to operationalise realist philosophy. This will be detailed in section 2.5 but, in short, this is the development of guidance for each stage of a realist evaluation project (Pawson, 2013; Pawson & Tilley, 1997) which has recently been developed into a set of publication standards and training materials relating to the evaluation's: purpose, application of generative causation, construction of realist programme theories, research design, data collection methods, sample recruitment, analysis, and reporting (Wong et al., 2016, 2017).

I have argued elsewhere (Shearn et al., 2017) that approaches for realist evaluations may need to vary according to the intervention they are applied to and the purpose of the project. For example, some interventions are relatively discreet, have distinct boundaries and clear outcome measurements where others may be more formative, large scale and/or messy. This evaluation falls into the latter category because:

- *the 'intervention' is not well-defined.* 'Positive approaches' consist of a collection of ideas about positive approaches to young people's sexual health services, which have no universal definition as described in the introduction (chapter 1). To this end, the evaluation is seeking in many ways to define the intervention(s) - that is, to identify the unique aspects of a positive model of youth sexual health services which relate to the overall policy direction - as well as explain in what ways they came about.

- *the 'intervention' being evaluated is not a discrete programme.* Related to the last point, the likely intervention(s) which are the subject of this study are not something that may be bolted on to standard practice, as a new health technology might be, but rather is one that would be interwoven into the fabric of health services.

- *the 'intervention' relates to a 'whole system'.* Multiple stakeholders and decision makers are involved in the service delivery chain. This differs from other examples of realist evaluation which might focus on one level at a time, or a key interaction between certain stakeholders.

The nature of the potential intervention(s) of interest and the formative nature of this study called for some elaborations to the general explanatory theory offered

by Pawson and Tilley (1997). I undertook this elaboration drawing on the theoretical contributions of critical realist scholars, particularly Andrew Sayer (1992, 2000, 2011) and Margaret Archer (1995, 1996, 2007).

Previously, others have sought to combine critical realism and realist evaluation/synthesis. For example De Souza (2015), as part of a realist review, undertook a thorough analysis, using critical realist principles, of institutional structures which she argues repeatedly constrained education reform. Similarly, Herepath and colleagues (2015) incorporated Realist Social Theory (from Archer) with realist evaluation to provide an innovative conceptual framework to address implementation of a patient safety intervention in the NHS. Building on this work, I argue that interventions concerning large-scale, multifaceted, seemingly intractable issues of policy change, such as this current project and in the examples given above, may require additional attention to questions of how the social system came to be this way in the first place. This also favours my aim to pay particular attention to the power structures within the system which may systemically reproduce health inequalities for young people.

Furthermore, the structure and cultural aspects which may constrain policy change may need to be explicated in order to adequately explain the inputs, outputs and outcomes at the local organisational level. This, I argue, justifies the blending of critical realist theory with realist evaluation.

2.4.4 Theoretical model of social action

Part of this blending involves the general theoretical model utilised to frame and structure theories about what is working, where and why.

According to Pawson and Tilley (1997) an intervention offers resources which, under certain contextual conditions, can affect the reasoning of social actors to bring about the intended or observed outcomes. They summarise this in the heuristic C+M=O (or M+C=O) where C refers to context, M refers to mechanism and O refers to outcome (Pawson & Tilley, 1997 Introduction). This is typically represented as a rugby ball (see Figure 5). The CMO heuristic has become a central, or even defining, characteristic of realist evaluation, whereby quality is

judged based on the outputs being presented in this format (Marchal, van Belle, van Olmen, Hoeree, & Kegels, 2012; Salter & Kothari, 2014; Wong et al., 2017).
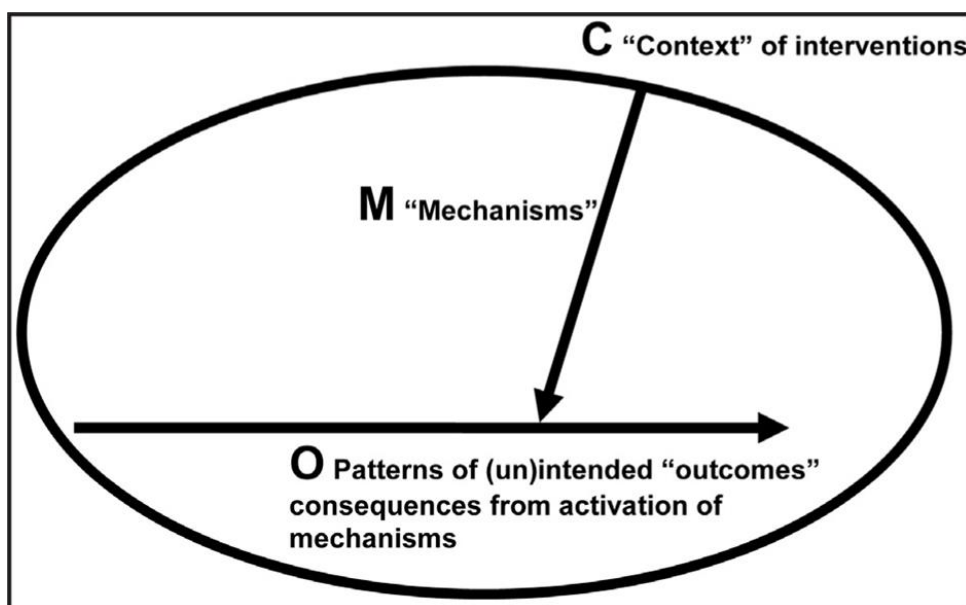
Figure 5. CMO model of causation, according to Pawson and Tilley (1997)

However, for this evaluation which is formative, large scale, interwoven and messy the CMO heuristic has limitations. This is for four reasons:

First, mechanisms, according to Pawson and Tilley (1997, p. 67) are about people's 'choices and the capacities they derive from group membership'. Explanation of causal mechanisms for scientific realists therefore, involves reaching down to layers of individual 'reasoning' and 'up' to collective 'resources' on offer (Wong et al., 2017). It is arguably unhelpful to think of mechanisms being both 'resources and reasoning', when these are distinct and potentially analytically separable as I have outlined above. This critique has led to several attempts at elaboration of the basic CMO, for example, Dalkin and colleagues (2015) advocate the distinction of resources and reasoning in their revised heuristic C + M(resources) + M(reasoning) = O. Similarly, Herepath, Kitchener & Waring (2015, p. xxvii), drawing substantively from Archer's Realist Social Theory, suggest the heuristic could be I (intervention), C (context), M (mechanism), A (agency) and O (outcome).

The second critique of the CMO, which is not entirely compatible with the first, concerns the possibility of different 'types' of mechanism. Here, the critique is on the basis that causal power may reside in a range of entities within the social realm, not just in individuals. Pawson and Tilley concur that there is causal potential in both **'micro**' (for example decision making) and **'macro'** (for example social cohesion/marginalisation) social processes' (1997, p. 65). In particular, other scholars specify mechanisms that work both between and within different layers of social structure. Astbury and Leeuw (2010), describe situational mechanisms (working from social to individual levels), action-forming mechanisms (working within the individual level) and transformational mechanisms (working from individual to social levels). De Souza, (2013), as noted above, expounds structural mechanisms, cultural mechanisms, agency mechanisms and relational mechanisms.

A third critique is that 'reasoning' is an inadequate conceptualisation of the possible thought processes and emotional responses which might bring about action. Westhorp broadens this informally, suggesting that reasoning is 'a catch-all term for anything that happens inside the intended beneficiary's head' (Westhorp, 2014). Sayer (2011), although not in direct response to Pawson and Tilley, highlights four aspects of 'practical reason' important for understanding human action and value which include:

- Embodied and intuitive characteristics: referring to a set of innate dispositions or those acquired over life (or *habitus* - after Bourdieu) in which action may be taken that is not based on deliberation (Sayer, 2011, p. 74).
- *Knowledge* of particulars: referring to acquired concepts and schemata which are relational and contextual in which action may be taken due to an understanding of how the world works (Sayer, 2011, p. 78). For example, if I do A, B is likely to happen, if I do C, D is likely to happen.
- Judgements about ends or *internal conversations*: referring to assessments people make about ends in themselves (Sayer, 2011, p. 80). For example, with reference to the above, do I prefer B or D? This can include making assessments about incommensurable activities. And as a result these assessments may be beyond rational choices.

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- Ethics: a subset of *internal conversations,* this refers to our treatment of others in a way which is suited to their particularities (Sayer, 2011, p. 82). For example, would B or D be better for people Y. This is not to say that practical reason is always ethical, because that also depends on power and whether people can bring about what they believe to be right (Sayer, 2011, p. 84) (i.e. depends on the context).

A fourth limitation of the CMO can be levied regarding the ability of this heuristic to represent generative causation. The 'C' in Pawson and Tilley's model is represented as a 'rugby ball' which is meant to signify a myriad of contextual features at different levels of social structure. However, what is not clear in this model, is which liabilities, powers, and potentials within the myriad of contextual features this rugby ball is meant to represent, or how these factors interact with the 'mechanism' to bring about the outcome.

For the purpose of the current study I developed a more comprehensive model (see figure 6 below) to support the production of realist theory regarding what works to deliver a positive approach for youth sexual health. This model, influenced by Archer's morphogenetic approach (Archer, 1995) was designed to:

- Represent entities that span the social world, *culture*, *structure* and *agency*, demonstrating that these realms are continuous (represented by the outer block arrows).
- Highlight that ideas, processes, practice, beliefs, knowledge and judgements about youth sexual health services are a subset of other interactions operating at any one time (represented by the inserted block arrows).
- Demonstrate that structural and cultural properties objectively shape the situations that agents find themselves in, and possess generative powers of constraint and enablement in relation to agents' own constellation of concerns (Scambler, 2013a) (represented by the dashed arrows from cultural and structural to the agential realms).
- Situate *action* in time and space. Such action is subjectively determined through *practical reasoning* and influenced by habitus, knowledge and internal conversations (represented by the central oval).

- Illustrate the way in which causal processes bring about change. including maintenance of the status quo. In particular by highlighting that multiple processes are working at the same time (represented by the confluence of multiple arrows prior to the action oval).

- Depict the way in which agential action can reproduce or transform cultural, structural and agential properties based on the extent to which it reconstitutes existing properties (represented by the solid arrows from action to each of the realms).
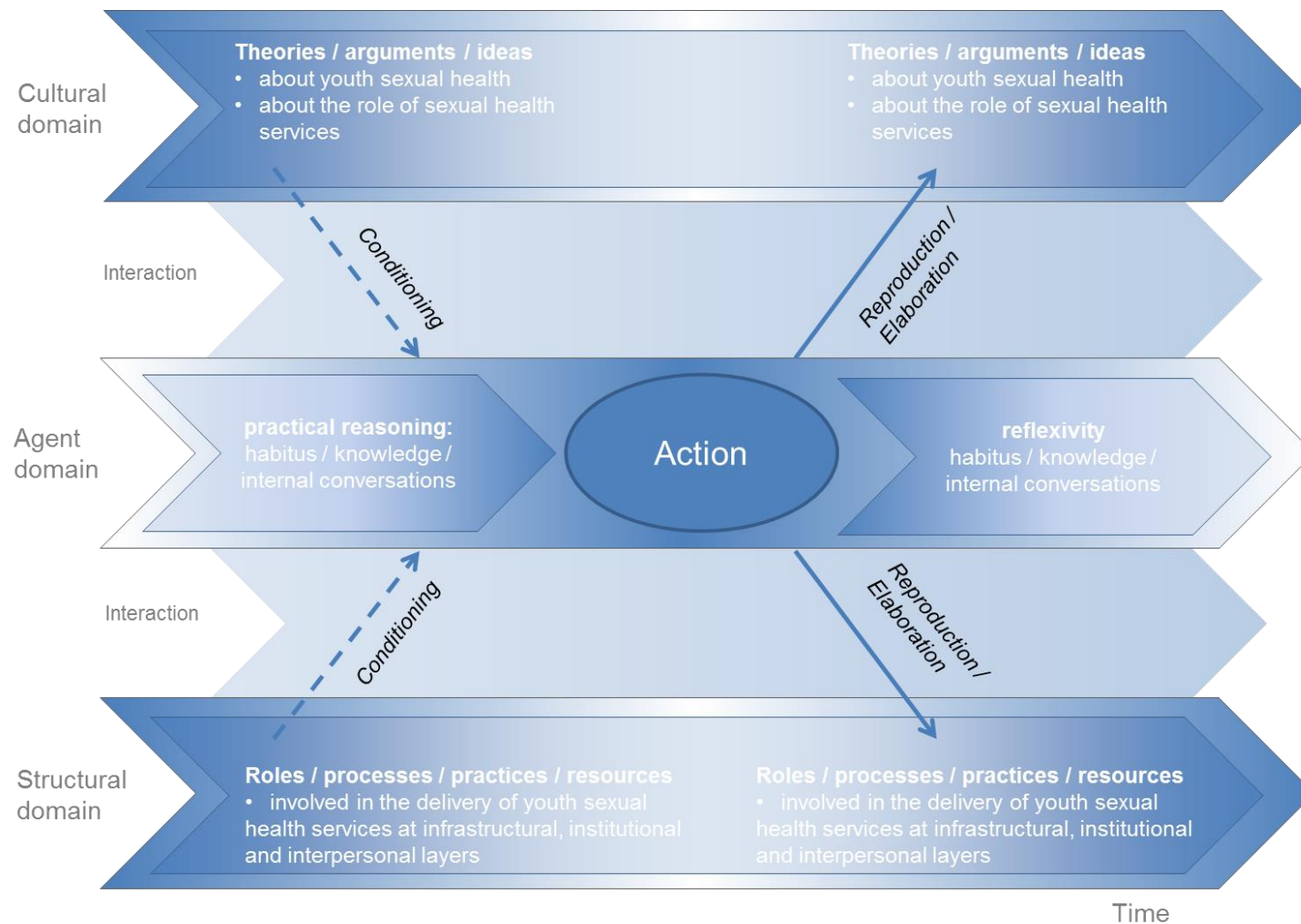
Figure 6. Overarching model of social action

This model will be used in the thesis as an explanatory framework supporting practical theory building. It will be used instead of the CMO heuristic. Whilst there are synergies between the CMO and this more elaborate model, one key difference is arguably in the definition and usage of the term 'mechanism'. This thesis recognises that causal forces emanate from structural, cultural and agential domains, in other words, mechanisms (which cause change or reinforce the status quo) are everywhere. For this purpose therefore, the study seeks to explain social change by identifying the underlying causal forces in each of the separate realms and the impact of their interactions. The theories developed for explaining local buy-in to positive approaches will therefore refer to:

- prior (and enduring) cultural, structural and agential conditions which have effects, through conditioning, on individual's actions (this includes an account of agency relative to other individuals within the social system).
- habitus and/or knowledge skills and internal conversations of actors which lead to actions.
- emergence of transformed agential, structural or cultural states, or alternatively reproduction of 'prior' conditions.

2.5 Developing programme theories

The third aspect of realist theory relevant to this chapter on methodology is how to develop practical social theories which will support the project aim to build an understanding of how positive services might be developed and sustained. This broadly relates to the overall research design and research process, as well as the methods which may be suitable to build such an understanding.

2.5.1 Iterative and cyclical research design

As I have established a realist evaluation is, overall, a purposive exercise insofar as it seeks out evidence and ideas to deliver ever better explanations of

the underlying causal processes that lead to change (Pawson & Tilley, 1997, p. 115). This deepening of understanding (Sayer, 2011) necessitates an iterative and cyclical approach whereby the design facilitates the various modes of inference, including *retroduction* that is, developing hypotheses based on how similar events or entities have been achieved in other circumstances and *abduction* that is, developing hypotheses on the basis of data which are not explained by current theories (Oh, 2014).

My study utilised a cyclical and iterative approach over four realist cycles (see figure 7). Each cycle incorporated theory generation, hypothesis setting, observations and theory refinement/programme specification (Pawson & Tilley, 1997, pp. 84–85). As the cycles progressed the theories became increasingly refined.
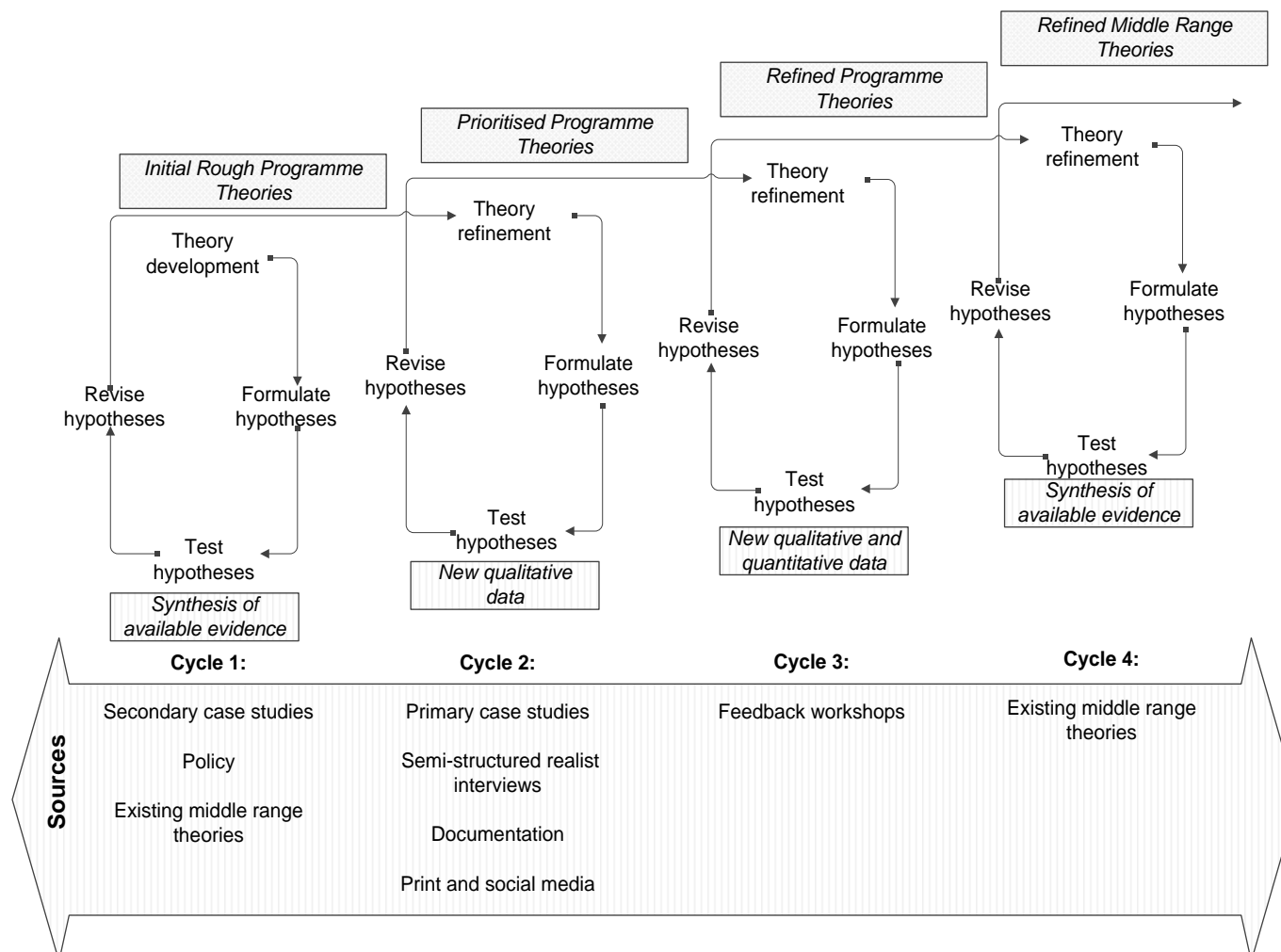
Figure 7 Research approach for the study including key data sources

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2.5.2 Intensive empirical procedures

The choice of methods in a study governed by a realist ontology is based on the extent to which the various techniques can convey knowledge about generative mechanisms (Danermark et al., 2002, p. 163; Pawson & Tilley, 1997, p. 85). There is generally no preference therefore for qualitative or quantitative techniques.

Sayer (1992, p. 243) distinguishes between 'intensive' and 'extensive' empirical procedures where intensive research relates to how a process works in a particular case or small number of cases and extensive searches for regularities, patterns and distinguishing feature. This study was primarily concerned with improving conceptual understanding of what positive services are and asked questions about what produced a certain change; what the agents actually did and why. It was therefore largely an intensive procedure that required longitudinal and multi-level data collection in order to deliver integrated theories and testable hypotheses.

2.5.3 Overview of methods

Realist research embraces mixed methods (Danermark et al., 2002; Pawson & Tilley, 1997; Sayer, 2000). This allows for combinations for data and theory from different sources to be compared and contrasted (Plowright, 2011).

The next six chapters contain reports and analysis of the research cycles. A brief overview of the key tasks and methods used for each of the cycles is set out below.

Cycle one: building initial rough programme theories (for full details see chapters three and four)
Two tasks were accomplished in cycle one. First, a working definition of positive youth sexual health services was established. This was fundamental to articulating the concepts under investigation and any shared or contested

understanding of them (Pedersen & Rieper, 2008). A systematic search of four academic databases and hand searches of national and international policy archives uncovered three case studies where attempts to implement positive services had been recorded. Data referring to the overarching aim, outcomes of interest, characteristics, and principles were extracted. These were then synthesised, informed by the principles of Critical Interpretative Synthesis (Dixon-Woods et al., 2006), and principles and characteristics distinguishing positive approaches from other models of care were identified.

Second, rough programme theories were developed to provide an initial explanation of what works to deliver positive sexual health services. A scaffold of existing middle-range theories was built to provide a broad conceptual framework within which to situate theories specific to the research aim (Shearn et al., 2017). I then mapped these concepts to data from the literature reviews and using abductive and retroductive inferences developed initial propositions to explain how and why positive services might be implemented.

Cycle two: prioritising programme theories (for full details see chapters three and five, six, seven and eight)

The theories were then refined within a cycle of empirical research. Three case studies of services which had attempted implementation of positive approaches were purposively recruited. A wide variety of data were collected from each case study including service documentation, evaluations, print and social media, academic outputs and interviews with a number of decision makers from across the implementation chain (total participants n=24). I made specific efforts to collect historical context data, for example, by interviewing people who no longer worked at the service, in order to build an understanding of previous contexts and decisions which might influence current practice.

Data were analysed against a framework based on the initial rough programme theories. Cross and within case analysis and triangulation helped to elaborate upon the initial ideas to improve their explanatory power. This empirical cycle culminated in a set of prioritised theories which could be further tested in the third cycle.

Cycle three: refining programme theories (for full details see chapters three and five, six, seven and eight)

The prioritised theories were then refined again within a further cycle of empirical research with the same case study sites but with a broader range of stakeholders and employees, which included some of the original sample (total participants n=63).

I delivered three feedback workshops in which the theories were presented to the audience. They were given time to deliberate amongst peers and provide individual and/or group feedback. This broader sample allowed me to refine the theories further and answer questions about how positive services can be sustained, for whom and under what circumstances.

Cycle four: refining middle range theories (for full details see chapter nine)

The final cycle involved the mapping of the refined programme theories to existing substantive theories. This was in order to further enhance the explanatory power of the refined (albeit partial and incomplete) programme theories which may support the development of similar initiatives in the future. This analysis also supported the production of abstract middle range theories which might apply across a range of contexts.

2.6   Chapter summary

This chapter has offered justification for a realist approach to support development of plausible explanations of what works, (might work, does not work) to deliver positive youth sexual health services, for whom, under what circumstances and why. These explanations were based on a realist understanding of what constitutes the world and how these social entities may interact to bring about change.

This chapter has introduced a novel explanatory model for developing realist theories. This model was informed by a number of influences from both critical realist scholarship and realist evaluation. This will be used throughout the thesis in place of the CMO heuristic.

Finally, this chapter has introduced the iterative and cyclical research design which was used to develop practical social theories, that is realist programme theories, relevant to the research aim. The thesis now provides a full description of each stage of this realist project.

Chapter 3. Defining positive approaches to youth sexual health services

3.1. Chapter outline

This chapter is primarily concerned with conceptual clarity of what positive services are. It builds on the ideas presented in the introduction chapter (1.2.5 and 1.2.6). Within this chapter I identify cultural and structural outcomes, that is, practices, processes, roles and formalised ideas, which may exemplify the general ambition for positive services. This chapter also illustrates shared or contested understanding of such practices, processes, roles and ideas.

Two literature reviews were used to develop conceptual clarity as part of the first realist cycle. The overarching method for both was informed by principles of Critical Interpretative Synthesis (Dixon-Woods et al., 2006). This, I argue was appropriate to support the development of a provisional theory of what positive youth sexual health services are. First, a review of academic literature is presented. This seeks to identify and interpret how positive youth sexual health services have previously been defined in practice. From this review three interrelated principles and associated defining characteristics were expounded which may distinguish positive services from other models of care.

This chapter then sets out the review of national policy and guidance regarding youth sexual health services. This review was orientated to identify and explain the extent to which the principles and characteristics were reflected in policy and whether conceptualisations were shared or contested.

The chapter concludes with a synthesising argument presenting an evidence-based, yet provisional, theory of what positive services are. This is followed with a discussion of the findings and the implications they held for the subsequent empirical research phase.

3.2 Overarching review methodology

As part of the initial realist cycle I sought to establish a theory of what positive sexual health services are, using two literature reviews. The aim was to identify positive services in practice and understand how these have been characterised. Conceptual clarity is acknowledged as an important first step in realist studies (e.g. Harris, Sainsbury, & Kemp, 2014; Rycroft-Malone et al., 2012), however, no specific approach is recommended. I used principles of Critical Interpretative Synthesis (CIS) (Dixon-Woods et al., 2006; Entwistle, Firnigl, Ryan, Francis, & Kinghorn, 2012) to inform the design of the review. It has previously been argued that CIS is grounded in constructivism (Barnett-Page & Thomas, 2009; Petticrew et al., 2013) which may make it an unusual choice for a realist study. However, I felt it was an appropriate method for this particular task for the following reasons. First, as an emerging practice, data about how positive approaches have been interpreted and applied, were likely to come from a range of heterogeneous sources. CIS involves a broad and iterative search strategy (Dixon-Woods et al., 2006; Entwistle et al., 2012) which supported me to locate possible sources. Second, CIS does not include highly specified quality assessment of papers but focuses on relevance to the search question as a key inclusion criterion (Barnett-Page & Thomas, 2009; Entwistle et al., 2012). This ensured that possible sources of rich descriptive data such as protocols or reflective accounts could be included in the review. Third, based on my background reading, I was aware that the sources were unlikely to define positive approaches in a uniform way. This lack of a universal definition meant the use of a highly structured *a priori* framework for conducting the synthesis, such as might be used in framework synthesis (Barnett-Page & Thomas, 2009), was not appropriate. That is not to say it was an entirely inductive process and some initial themes were established based on the background theories discussed in chapter one, as would be expected in a realist project (Pawson, 2006; Wong et al., 2017, 2013).

The aim of the synthesis was to produce a theory of the characteristics that comprise a positive approach. CIS supports this end in three ways. First, as a critical approach I was able to contextualise findings and offer an interpretation

of their meaning. This allowed me to highlight and provide a tentative explanation for any inconsistencies as well as refine the distinction between positive and other models of care (Entwistle et al., 2012). Second, using an iterative process for the analysis and synthesis, I was able to propose initial themes and theories and then revisit the data in light of these (Entwistle et al., 2012). Third, using 'lines-of argument' synthesis (Dixon-Woods et al., 2006) I was able develop to a theoretical construct comprised of three interrelated principles, which is grounded in the literature but was an interpretation of the whole body (Barnett-Page & Thomas, 2009; Petticrew et al., 2013).

As noted in the chapter summary, this review is in two parts. First a review of the academic literature is presented and second, a review of policy. This is then synthesised to set out a provisional account of the characteristics of positive services.

3.3   Review of academic literature

3.3.1   Search statement

The aim of this review was to describe how youth sexual health services characterise a positive approach in practice. The search of the academic databases therefore aimed to identify accounts of youth sexual health services which explicitly claim a positive approach to youth sexual health sexuality.

3.3.2   Search strategy

A broad search strategy was developed to capture literature about positive youth sexual health services from a wide range of sources. This was an iterative process which fitted the exploratory nature of the review question (Dixon-Woods et al., 2006). The key concepts were derived from the search statement initially. The first search terms were thus established as: "sexual health", "sex positive", "young people" and "service". I included other synonyms and applicable terms that I was aware of, through background reading, for

example, "holistic" or "rights" which may imply comparable approaches to "positive".

The index of MEDLINE was also used to identify further potential Medical Subject Headings for "sexual health". Finally, this search strategy was piloted on one academic database, Scopus. A foray into the literature identified through this initial search allowed me to expand the search terms further to include controlled vocabulary; "adolescence", and applicable terms; "integrated", "preventative" and "comprehensive". I built the search by combining terms utilising the connector words AND between key concepts and OR between synonyms. The final search terms are illustrated in Table 1.

The strategy involved searching electronic databases; citation and reference searches; and contact with authors. This breadth was necessary because through background reading I was aware that accounts of local service approaches or transformations, which may be messy, organic and multi-faceted, may rarely appear in detail in many academic journals, which favour experimental designs and have restrictive word limits.

Table 1: Search terms for positive youth sexual health services

	Key Concept: "Sexual Health"	Key Concept: "Sex Positive"	Key Concept: "Young people"	Key Concept: Service*
Synonyms Use 'OR'	"Reproductive Health"	"Sex-positive"	Young	Intervention*
		"Sexual subjectivit*"	Youth	Framework*
		"Sexual rights"	Teen*	Paradigm*
		Holistic	Adolescen*	Program*
		Integrated		Model*
		"Human rights"		Trial*
		"Reproductive rights"		Pilot*
		Preventative		
		Comprehensive		

3.3.3 Searches

Database searches

The search was run on four academic databases: MEDLINE, CINAHL
Complete, Scopus and PsychINFO on 21.04.2015.

Inclusion / exclusion criteria

The search identified 1162 articles after removing duplicates. The following
inclusion and exclusion criteria were then applied to select the most relevant
sources.

Contemporaneousness: A start date was not included for three reasons. First
because the relative modernity of the concepts of sexual health and sex-
positivity would provide a natural start towards the latter half of the 20th century.
Second, it might have been possible to unwittingly discount positive
approaches, established a number of years ago, when academic accounts
might have been generated, that were still operating. Third, as services are
influenced by historical, political and societal norms and values, progression
towards certain ideas is not necessarily chronologically linear (Herzog, 2009),
such that services may have been more positive in the past compared with now.

Geography: Only accounts from developed countries were included. This was
primarily because of the need to limit the possible confounding influences on
service design and delivery which may be critical in developing countries but
less so in the developed world. For example, decision making about service
design and delivery in the developing world may be more concerned with
transport infrastructure, vast inequalities and the need to meet other basic
needs such as accommodation and food (Patton et al., 2016). These issues
could still be present in many developed countries but are arguably less acutely
influential.

Study design: As noted above, there were no exclusions on the basis of article
type or study design. My interest was in accounts of service design and
delivery which could have included a range of sources including opinion pieces,
primary studies or evidence summaries.

Service characteristics: I only included articles which related to routine sexual healthcare or support. As such there were four specific exclusions. These were articles which concerned **only**:

- Education or information. This, although important, was outside the scope of my thesis.
- Specific aspects of sexual health, such as under-18 conceptions or HIV. This was because my thesis concerns a broad conceptualisation of sexual health and I wanted to identify how this had been applied, if at all, to practice.
- Youth development programmes. This is a generic term used to refer to formal programmes or interventions often lasting several sessions to which young people are referred to or sign up for. The aims and intentions of these programmes are often to affect specific behaviour change, for specific clients, which is also outside the scope of the study.
- One-off interventions, which would not support my understanding of the characteristics of universal services.

I included youth sexual health services which distinguished their approach from other models of care with reference to positive sexual-wellbeing and related approaches labelled 'holistic' and 'comprehensive'.

Clients: Articles relating to services that provided universal services for young people, under the age of twenty five, in either standalone settings or as part of their general provision were included. Articles which described services targeted at specific client populations *only*, such as care leavers or young people identifying as LGBT were excluded.

After applying the inclusion and exclusion criteria I was left with two articles in the academic literature which referred to positive youth sexual health services.

Later, as I reviewed realist methods papers, I identified a further article which referred to a positive approach to sexual health services. This had not been picked up in the initial search strategy because it related to whole system transformation of three services and not just youth sexual health. Neither sexual health, nor young people, or synonyms were mentioned in the title,

abstract or key words. On reading the detailed report it was clear that transformation to a positive approach for all clients, including young people, in the general provision, was the intention of the initiative, thus it met the inclusion criteria.

I set up an alert on the academic databases used to conduct the original search, to provide notification for any further articles that might come to light over the remainder of the research period. This did not highlight any other positive youth sexual health services.

Reference and citation searches

The three articles were about three unique services which I will refer to as the Oregon, Lothian and London case studies. I conducted further reference and citation searches for kin papers, in order to gain contextual richness for each of these case studies (Booth et al., 2013). This located multiple accounts of the same service transformation. The kin papers included internal reports, evaluation reports, promotional material and other academic papers. They related to different time periods. This allowed me to compare and contrast descriptions of the services from different perspectives (and for different purposes). This was useful for developing a deeper understanding of the characteristics reported and highlighted any inconsistencies.

In addition, contact with authors was possible for two of the case studies. For Oregon, an email exchange between myself and a current employee of the local public health department produced further detail regarding the development and characteristics of that service and directed me to other resources that they had used to demonstrate impact. For London, an email request was made to one of the authors who directed me to a number of further papers relevant to my theory development. The full search process is illustrated in the modified Prisma diagram in Figure 8.
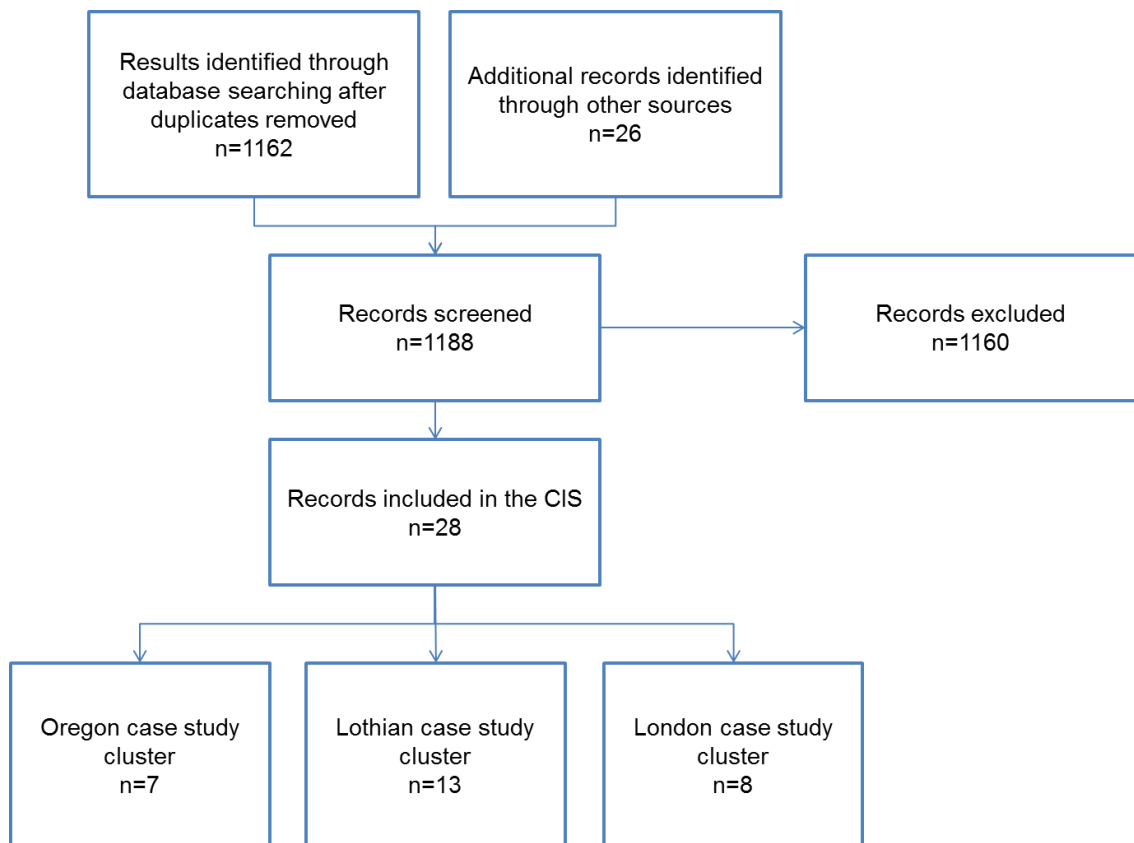
Figure 8 Modified PRISMA diagram illustrating the search results

3.3.4 Data extraction

Passages of text were extracted which described specific foundational beliefs or aspects of practice. Data was coded to a pre-defined coding template, which I developed based on approaches to 'concept definition' and 'defining attributes' advocated by Walker and Avant (2005). In addition, broad initial principles and characteristics, based on the background theories, related to wider conceptualisation of sexual health, human flourishing and sexual wellbeing were considered. Initial codes were therefore broad, relating to "overarching aim", "outcomes of interest", "characteristics", and "principles". On reading the accounts, further sub codes were identified and the coding framework was modified iteratively. The coding framework can be found in Appendix 1.

3.3.5 Analysis and synthesis

All documents were uploaded to qualitative analysis software NVivo version 10 to support the process of identifying patterns, themes and categories across the different types of sources (Dixon-Woods et al., 2006).

However analysis was also a creative, interpretative and critical endeavour. I read the passages critically in order to understand how the texts portrayed the service approach as positive and, where relevant, distinguished it from other models of care. I asked myself the question 'why are these particular characteristics and principles important to a positive approach?' and inferred meaning based on my understanding of the text as a whole, its purpose, tone, and any biases. I also referred to the competing background theories relating to young people's sexual health established in chapter one to support my inferences (Paley, 2016).

3.3.6 Results of the literature search

A body of literature relating to each of the three case studies was built up. The documents are summarised in the Table 2 below.

Table 2: Results of the literature search

Case study	Title (reference)	Year	Provenance	Topic area
Oregon	Oregon Youth Sexual Health Plan (Oregon Department of Human Services, 2009a)	2009	Grey (reference)	State-wide strategy document for youth sexual health
	Oregon Youth Sexual Health Plan appendices (Oregon Department of Human Services, 2009b)	2009	Grey (reference)	Appendices including reports of specific data gathering activities to inform the Oregon Youth Sexual Health Plan
	Shifting the paradigm in Oregon from teen pregnancy prevention to youth sexual health (Nystrom, Duke, & Victor, 2013)	2013	Academic database (search strategy)	Public health report on the Oregon Youth Sexual Health Plan.
	Youth participatory action research curriculum (Institute for Community Research, 2014)	2014	Grey (hand searching)	Adapted curriculum report to support practitioners undertake youth participatory action research to promoted positive youth development in Oregon
	Oregon Youth Sexual Health Plan: Five Year Update (Oregon Public Health Division, 2014)	2014	Grey (hand searching	Progress report on Oregon Youth Sexual Health Plan
	Personal communication by email (anonymous)	2015	Email exchange	Detail by email given in response to specific questions posed by the researcher
	Oregon Guidance for the Provision of High-Quality Contraception Services: a Clinic Self-Assessment Tool (Oregon Preventative Reproductiv	2017	Grey (hand searching)	Self-assessment and resource pack for sexual health clinics delivering contraceptive services including guidance for young people

	Health Advisory Council, 2017)			
Lothian	Enhancing Sexual Wellbeing in Scotland: A Sexual Health and Relationships Strategy (Scottish Executive, 2003)	2003	Grey (hand searching)	Consultation document on the draft National Sexual Health and Relationships Strategy
	All I want. A review of specialist sexual health services for young people: young people's report (Healthy Respect, 2004)	2004	Grey (hand searching)	Report of research carried out to understand young people's views about sexual health clinics and drop-in services
	Respect and Responsibility Strategy and Action Plan for Improving Sexual Health (Scottish Executive, 2005)	2005	Grey (hand searching)	Scottish National Sexual Health Strategy
	Final summary report of the external evaluation of Healthy Respect, a national health demonstration project (Tucker, Penney, Van Teijlingen, Shucksmith, & Philip, 2005)	2005	Grey (hand searching)	External evaluation of the Healthy Respect National Demonstration Project. Observation period November 2000-2004
	Healthy Respect Phase Two (Healthy Respect, 2005)	2005	Grey (hand searching)	Proposal for phase two of the Healthy Respect National Demonstration Project on Young People's Sexual Health
	An evaluation of the impact of a national health demonstration project on testing and management for chlamydia trachomatis infections in two regions of Scotland (Penney, Brace, Cameron, & Tucker, 2005)	2005	Academic database - (reference searching)	Clinical audit of practice against national standards for good quality care comparing intervention region with another region
	Health demonstration projects: Evaluating a community-based health intervention programme to improve young people's sexual health (Tucker,	2006	Academic database (search strategy)	Methodological opinion piece on evaluating the Healthy Respect National Demonstration Project

	Van Teijlingen, Philip, Shucksmith, & Penney, 2006)			
	Healthy Respect drop-ins: a guide to accredited status and how to achieve it (Healthy Respect, 2007)	2007	Grey (hand searching)	Guidance for organisations that want to become Healthy Respect accredited
	The effect of the national demonstration project Healthy Respect on teenage sexual health behaviour (Tucker et al., 2007)	2007	Academic database - (citation searching)	Primary research report of the before and after cross-sectional surveys of secondary school pupils in 10 Healthy Respect intervention schools
	Tackling sexual health inequalities: work in progress with young people at risk (Paterson, 2007)	2007	Academic database - (citation searching)	Description of a range of pilot initiatives underway and evaluation processes to tackle sexual health inequalities
	Healthy Respect Dissemination Programme (NHS Health Scotland, 2010)	2010	Grey (hand searching)	Final report of the programme developed to share implementation, experiences and evaluation reports from the Healthy Respect National Demonstration Project
	Evaluation of healthy respect phase two: final report (Elliott et al., 2010)	2010	Grey (hand searching)	Final evaluation report of phase two of the Healthy Respect National Demonstration Project
	Healthy Respect Website (Healthy Respect, 2017)	2017	Google search	Website
London	A new approach to sexual health in South London (Kings College Hospital Media Team, 2007)	2007	Google search	Press release
	King's Sexual Health Centre wins top NHS Award (press release Kings College Hospital Media Team 2007)	2008	Google search	Press release
	The Modernisation Initiative: independent evaluation final report	2008	Grey (contact with authors)	Final evaluation report of the Modernisation Initiative

	(Greenhalgh et al., 2008)			
	How do you modernize a health service? A realist evaluation of whole-scale transformation in London (Greenhalgh et al., 2009)	2009	Academic database - (serendipity)	Realist evaluation of the modernisation initiative
	An independent evaluation of Lambeth's modernised sexual health service delivery model (Miles, 2010)	2010	Grey (hand searching)	Evaluation of the sexual health service model that had been implemented as part of the Modernisation Initiative (evaluation period December 2009 - 2010)
	A new workforce in the making? A case study of strategic human resource management in a whole-system change effort in healthcare (Macfarlane et al., 2011)	2011	Academic database (citation searching)	Realist evaluation of whole-system workforce development as part of the Modernisation Initiative evaluation
	If we build it, will it stay? A case study of the sustainability of whole-system change in London (Greenhalgh, MacFarlane, Barton-Sweeney, & Woodard, 2012)	2012	Academic database (citation searching)	Mixed-method case study of a three year follow up of the Modernisation Initiative
	Achieving and sustaining profound institutional change in healthcare: case study using neo-institutional theory (Macfarlane, Barton-Sweeney, Woodard, & Greenhalgh, 2013)	2013	Academic database (citation searching)	Secondary analysis of case study data derived from the Modernisation Initiative evaluation

3.3.7 Overview of the case studies

Key characteristics, pertinent to theory building, for each of the case studies are outlined in Table 3.

Table 3: Characteristics of the case studies built through the literature search

Feature	Oregon	Lothian	London
Approach stated in marketing collateral or evaluation documents	Positive and holistic	Positive and holistic	Positive and holistic
Approach heritage	Recently established. Policy launched in 2009	Established in 2001, mainstreamed by 2008	Established in 2003 with redevelopment of services by 2007
Extent of integration of clinical services	Various	Integrated	Integrated
Leadership	State and private partnership	Public health-led	Collaboratively-led by clinical and community partners
Size	Very large (state-wide intervention)	Large (region-wide intervention)	Medium (Three London borough-wide intervention)
Separate youth clinic	Various	Various	No

A brief descriptive overview of each of the literature case studies is given below.

Oregon case study

The *Youth Sexual Health Plan* was launched in 2009 (Oregon Department of Human Services, 2009a). Previous state-wide initiatives had focussed on pregnancy prevention but from 2005 onwards, via community action and youth engagement, the approach was reframed and centred on youth development and all aspects of sexual health (Nystrom et al., 2013). The plan was intended to be a shared vision for numerous agencies operating in Oregon including the clinical sexual health services, social work agencies, education services and other partners. Five overarching goals were established for the plan: *1) youth use accurate information and well-developed skills to make thoughtful choices about relationships and sexual health. 2) rates of unintended pregnancy are reduced 3) rates of sexually-transmitted infections are reduced, 4) non-consensual sexual behaviours are reduced, 5) sexual health inequities are eliminated.* A five year review of its impact was published in 2014 (Oregon Public Health Division, 2014). This report showed moderate progress towards goals. This plan was still in place at the time of my literature review.

Lothian case study

Healthy Respect was launched in 2001 (Elliott et al., 2010) following Scottish national policy that had highlighted young people's sexual health as a key area of inequality (Tucker et al., 2007). The project aimed to integrate education, health services and information to help young people develop *"a positive attitude to their own sexuality and that of others, and a healthy respect for their partners"* (Elliott et al., 2010, p. 19; Healthy Respect, 2005). The plan included an overarching communications strategy that included branding and media campaigns.

There were two phases to the programme; 2001-2004 and 2005-2008. There was a transition period between the two (Elliott et al., 2010). The first phase included nineteen separate education and health service interventions which ranged from improving contraceptive services in abortion services, to sexual health promotion in Further Education colleges, to young men's sexual health interventions (Tucker et al., 2005). These were supported financially by the national demonstration project budgets. This initiative was evaluated by an

independent team looking at sexual health outcomes, partnership working and implementation of component projects (Tucker et al., 2005; Tucker et al., 2007). In phase two the Healthy Respect team continued to work across the region, including the clinical services, but was more focussed with explicit ambition for tackling health inequalities, targeting professionals working with vulnerable young people and targeted geographic areas (Elliott et al., 2010). A key strategic objective of this phase was to create an environment for sustainable change.

Healthy Respect, at the time of writing, had been integrated into NHS Lothian (Elliott et al., 2010). It consisted of a small team which coordinate a network of, and provide resources for, organisations and services dedicated to young people living in Lothian. It maintains a website for young people to access for sexual health advice and support (Healthy Respect, 2017).

London case study

In 2003, sexual health services across three districts in inner London successfully bid to be part of a wider transformation project. The overall project was funded by a charitable donation which paid for programme leadership, management and support posts, consultancy work, project development activities, back-fill for local clinicians, pump-priming for new services, resources, training and equipment. The objectives were to 'modernise' the services (Greenhalgh et al., 2008). Key principles specified at the outset were to achieve tangible improvements to the nature of services, culture of services, the balance of power and quality of care and service provision (Greenhalgh et al., 2008).

Compared to Oregon and Lothian, this service transformation only related to the clinical and community health services (and did not include the education sector). Service objectives were to reduce rates of STIs and unintended pregnancy, increase screening opportunities, increase self-management, improve knowledge, especially in high need communities, improve clinic environments, develop additional capacity and establish a network enabling services to work together (Greenhalgh et al., 2008). The revised service model had three tiers, community and GP partners providing 'basic' essential services, four sexual health centres providing integrated STI and contraceptive provision

and retained specialisms in complex sexual and reproductive health and complex genitourinary medicine.

3.3.8 Characteristics of positive approaches used in practice

This chapter is about aspects of practice that could be identified as indicators of positive services. There was a great deal of heterogeneity in how positive services have been defined across and within the descriptive and evaluative accounts of the case studies. In addition, many of the documents did not specifically define the principles or characteristics that the services were working to. Despite these limitations, through my synthesis I have identified three interrelated principles (that is foundational beliefs), which supported an initial theory of what positive services are. These are to *acknowledge young people's sexuality*, to *support young people achieve sexual wellbeing* and to *be person-centred*. Each of these has been expounded, below, with typical characteristics, (that is practices, processes and roles) which exemplify positive approaches and distinguish them from other models of care.

Principle one: to acknowledge young people's sexuality
The first principle relates to the acknowledgement that young people are sexual beings and that their emerging sexuality is not shameful or something that should be hidden.

In Oregon several policy documents (Oregon Department of Human Services, 2009a, 2009b; Oregon Preventative Reproductiv Health Advisory Council, 2017) made it clear that young people's sexuality should be accepted. For example the Oregon Youth Sexual Health Plan (Oregon Department of Human Services, 2009a, p. 10) was explicit: *To foster sexual health we must unequivocally communicate to young people that sexuality is a natural part of human experience.*

Various sources in Oregon, related this acknowledgement of a young person's sexuality, to a general reframing of views - from young people and their behaviour as a problem towards young people as potential positive change agents, able to contribute to society (Institute for Community Research, 2014; Nystrom et al., 2013; personal communication by email, 2015). Insight,

gathered into young people's wants and needs from the sexual health services, as part of an in depth engagement exercise informed the view that young people's rights should be respected. For example, when asked, young people said they wanted their autonomy and choices to be acknowledged, without judgement (Oregon Department of Human Services, 2009b).

Characteristics of the services that were underpinned by this principle included a welcoming environment, friendly and non-judgemental staff. Perhaps more fundamentally, were recommendations for adjustments in thinking, programmes and policies and a reframing of the language staff used to talk about and talk to young people regarding their sexuality. For example, rather than talking about 'risks' staff were encouraged to emphasise *well-developed skills and thoughtful choices* (Oregon Department of Human Services, 2009a)*.*

In Lothian, the acknowledgement of young people's sexuality was implicit in the overarching vision to promote positive sexual health (Tucker et al., 2006). The Scottish Executive, in the 2003 consultation paper (Scottish Executive, 2003) (which preceded the Sexual Health Strategy (Scottish Executive, 2005), described a consensus amongst the reference group on the key values which informed the consultation. These include,

> *"a real and meaningful commitment to promote and reinforce the rights of people to have mutually respectful, happy, healthy and fulfilled sexual relationships free from abuse, violence or coercion" (Scottish Executive, 2003, p. 2).*

That all people, including young people, have rights with regards to sexual health was further reflected in the evaluation protocol for Healthy Respect One (Tucker et al., 2006).

There appeared to be a difference in positionality about young people's sexuality in the execution of the health demonstration project in Lothian compared to this strategic ambition. For example, holistic services were centred on young people 'respecting themselves' and 'acting responsibly', which was further interpreted in the policy detail as having sex within the context of loving relationships and always using protection (Healthy Respect, 2005; Tucker et al., 2005). This implies that positive sexuality was interpreted by

those delivering the project as making choices to drive down ill-health with specified routes to 'happiness' and 'fulfilment'.

In London, *The Independent Evaluation of Lambeth Sexual Health Services* (Miles, 2010) acknowledged sexual health as integral to people's lives and the role that services can play in supporting them. Young people's sexuality was not drawn out specifically. This may be because, despite serving a high proportion of young people (Greenhalgh et al., 2012), these services were not specifically redesigned for young people alone.

In sum, this principle suggests that positive services would acknowledge young people as sexual beings with sexual needs. How this may be characterised requires further testing given the contrasting views over young people's choices in these case studies. This theme will be further explored in chapter six.

Principle two: to support sexual wellbeing

All three service improvement initiatives used the WHO (2006) definition as a basis for conceptualising sexual health and wellbeing. This included an emphasis on physical, mental, emotional and social health and wellbeing with regards to sexuality, not just freedom from disease, unwanted conceptions and possible harm (Greenhalgh et al., 2012; Macfarlane et al., 2013; Nystrom et al., 2013; Penney et al., 2005). The intention to support sexual wellbeing appeared to be exemplified through further characteristics which suggested changes at different levels of the social system. At an individual and interpersonal level: *taking a holistic approach* and *prioritising prevention* and at an institutional and infrastructural level considering *proportionate universalism* to *reduce health inequalities*, and; aiming to *reduce social stigma* associated with youth sexual health matters. Examples from each case study will now be given in turn.

The approach in the Oregon case study claimed to be 'holistic' (Oregon Department of Human Services, 2009a). The Oregon state strategy outlined an ambition to work to integrate the broadest conceptualisation of sexual health, sexual wellbeing and sexuality in a wide range of agencies, because these facets can be *positively enriching and enhance personality, communication and love* (Oregon Department of Human Services, 2009a). Holistic approaches for

individuals were subsequently described as providing health advice, attending to emotions and relationships, skill building as well as clinical treatment and support (Oregon Department of Human Services, 2009a). The explicit approach to support wellbeing did not mean that possible negative consequences were neglected or played down. Rather, the emphasis in these areas was on supporting young people to recognise risk and develop strategies to mitigate it (Oregon Department of Human Services, 2009a). The broadening of scope of what comprises sexual health and wellbeing also meant broadening the outcome measures of interest. This included the intention to develop measures of youth development such as choice and autonomy, and attitudes towards and usage of sexual health services (Nystrom et al., 2013; Oregon Department of Human Services, 2009a). However, this ambition may not have been fully realised as most of the key measures that were reported in the five year update related primarily to negative health outcomes such as reducing unwanted conceptions (Oregon Public Health Division, 2014). Unrealised ambitions such as these will be explored in chapters four and eight.

Furthermore, in Oregon, the state wide strategy placed equal importance on the infrastructure and complementary policy making for supporting sexual wellbeing (for example in education and social support) as it did on the specific services for young people and their families (Oregon Department of Human Services, 2009a). A reflective public health report of the strategy argued that approaching sexual health from multiple directions simultaneously was likely to be more successful at supporting and promoting sexual health in young people than single approaches (Nystrom et al., 2013).

Further to the principle to support sexual wellbeing, in Oregon it was recognised that certain groups were more likely to experience sexual ill health than others (Oregon Department of Human Services, 2009a). The broad approach to tackle this was to universally improve the infrastructure and sexual health service offer to improve sexual wellbeing across the board. Attempts were made to reduce stigma associated with youth sexual health by training and community initiatives aimed at transforming adults' attitudes towards young people and sexuality generally (Oregon Department of Human Services, 2009a). Supporting documentation for the Youth Sexual Health Plan recommended that in promoting wellbeing for specific groups, great care must be taken to "*avoid*

inaccurate and harmful generalisations" (Oregon Department of Human Services, 2009b). Their rationale was that universal improvements would reduce the possible cultural, socio-economic and gender related barriers to sexual health which would, in theory have greatest benefit for those currently prevented from accessing support (Oregon Department of Human Services, 2009b).

The London service also aimed to be holistic. This was not consistently defined across the sources, and often left as self-explanatory, but an academic report of workforce development in the intervention interpreted holistic services as referring to the whole person and not just one identifiable characteristic such as a persons' sexual health status or their demographic background (Macfarlane et al., 2011). Academics involved in the evaluation of the service, MacFarlane et al. (2011, 2013) and Greenhalgh et al. (2012), reported that one group in London believed that a holistic approach was necessary because they perceived that many negative consequences of sexual activity, such as unwanted pregnancy, STIs and psychosexual problems had common root causes (such as abusive or coercive relationships or low sexual health literacy) which needed to be identified and addressed in order to prevent reoccurring health issues (Macfarlane et al., 2013). It should be noted, however, that this was not the universal view of how the services should be prioritised in London, where some consultants preferred to retain a traditional medical model of care based on disease specific approaches (Greenhalgh et al., 2012; Macfarlane et al., 2011, 2013).

Further to the principle to support sexual wellbeing, in London, approaches to improve the clinic environment and provide greater choice, were introduced for all groups, with a view to reaching people who might be put off by a traditional service. These efforts included, for example, increasing possibilities of self-management through self-service machines for pregnancy testing and condoms (Greenhalgh et al., 2012; Macfarlane et al., 2013). In addition, the initial (Greenhalgh et al., 2008) and follow up (Greenhalgh et al., 2012; Miles, 2010) evaluations also commented that the service tried to tackle community stigma through service design, which changed the branding, look and visibility to be more user-friendly, open and welcoming. This rebranding won a service

redesign award for its ambition and reputedly increased footfall by 73% in the first nine months of opening (Kings College Hospital Media Team, 2008).

Similarly, the Healthy Respect project in Lothian aimed to take a holistic approach to supporting young people. This appeared to be driven, in part, by user input, gathered at the start of phase one of the Healthy Respect project which reported that young people wanted services that would "*look at the whole young person, not just their sexual health*" (Healthy Respect, 2004). The project set up an accreditation scheme for partner services to improve their offer to help achieve *"the best possible wellbeing of young people"* (Healthy Respect, 2007). The standards within this scheme included having staff who attend multi-disciplinary training and shared-learning opportunities (Healthy Respect, 2007) which reflected the need for staff to be able to respond to a wide range of issues. This ambition to provide a holistic service appears to have been maintained at least in the policy and programme documentation across the project lifespan, for example, Healthy Respect (2007) describe their drop-ins as a place primarily where *young people can access (as a minimum) free advice, support and information on all health issues, including sexual health, in a local setting.*

Healthy Respect, in Lothian, aimed to contribute to the long term improvements in sexual health and wellbeing of young people reflected in the national strategy (Scottish Executive, 2003, 2005). As with Oregon and London, initial strategy recommendations suggested an understanding at policy level that sexual wellbeing would not be achieved by individual efforts alone, but by also attending to sexual health rights, creating an enabling environment and raising sexual health on the political agenda (Scottish Executive, 2003). The final evaluation reflected that the project had tried to combat sexual health taboos in society by raising awareness through media campaigns to encourage a dialogue about sexual health issues (Elliott et al., 2010).

However, other reflective accounts suggested that over time, the intervention efforts became more and more focussed on individuals, with a tendency to focus on single strands of the delivery, 'risk factors' and a narrow range of outcomes (Paterson, 2007). The approach to reducing health inequalities exemplifies the dilution of these broad policy ambitions both in practice and

evaluation efforts. It was commonly recognised, across the sources in Lothian, that certain groups of young people were more likely to experience sexual ill health (NHS Health Scotland, 2010; Penney et al., 2005). In Healthy Respect One a universal approach was taken to raise all young people's aspirations. In contrast, in Healthy Respect Two high risk groups were targeted by working directly with advocacy groups with established relationships with disadvantaged young people, such as those in state care (Healthy Respect, 2005). Paterson (2007) reflected that this approach was unproven in reducing health inequalities and considered that it risked further problematizing young people, contributing to stigma associated with young people's sexual wellbeing. In fact, the final evaluation of Healthy Respect Two suggests that this approach had not been a success (which will be discussed further in chapter four). Paterson (2007) reminded readers of the initial strategy nearly a decade earlier *"those who developed Scotland's national strategy found that addressing sexual health in Scotland requires a holistic approach where moral, ethical, cultural and social issues must be addresses alongside faith, spirituality and physical aspects"* and that this work is still in progress.

In sum, these case studies suggest that one principle of positive services would be to support young people to achieve sexual wellbeing. This might be characterised by holistic services which aim to treat the whole person, with a focus on both positive and negative aspects of sexual health and are delivered via a support package with multiple interventions. It may also recognise that sexual wellbeing requires structural and cultural changes, particularly with regard to reducing taboo associated with youth sexual health and creating a welcoming environment, with universal actions that benefit everyone but are proportionate to the level of disadvantage.

Principle three: to be person-centred

The third principle relates to services being person centred. In the context of this synthesis this means placing the needs of the young person at the centre of decision making. Again this principle is multi-faceted. Key features identified in the literature include steps to ensure that stakeholders *respect diversity, including users in the design and evaluation of services* and to *shift attitudes*

from professional or political interests to that of the user. Actions taken by each of the case studies in line with this principle are outlined below.

One of the key messages in Oregon was to reject normative assumptions about young people's sexuality. Supporting documentation for the Oregon Youth Sexual Health Plan included a call to action for: *"challenging definitions of what it means to be male or female and encourage openness to sexual diversity"* (Oregon Department of Human Services, 2009b).

Involving users in the service design appeared to be core to the approach in Oregon. This appeared to have been driven by both demand from young people and as a point of principle. For example, when consulted, young people in Oregon requested that they were more closely involved in the design, delivery and evaluation of their services (Oregon Department of Human Services, 2009b). Nystrom and colleagues (2013), who were embedded in the implementation of the Oregon Youth Sexual Health Plan and wrote up their reflections in a peer reviewed journal, argued that if a service is truly person-centred there should be commitment to engaging young people and including the user voice in both the service design and evaluation phases. Oregon public health department sub contracted a community participation organisation to support youth participatory action research (Institute for Community Research, 2014; Oregon Department of Human Services, 2009b). This organisation stated that user involvement should incorporate a conscious transfer of power towards service users both in terms of their ability to manage their own health and of informing decisions that are made about them and their services (Institute for Community Research, 2014).

Similarly, in Lothian early user engagement, at the start of phase one of Healthy Respect, revealed that young people wanted to inform decisions that were made about them or their services (Healthy Respect, 2004).

Healthy Respect's proposal for the second phase acknowledged the diversity of the possible audience for their service and the need to cater for them via tailored services (Healthy Respect, 2005). Paterson (2007), in their paper reflecting on the strategies used in Lothian to reduce health inequalities, interpreted this as the need for sexual health practitioners and managers to strengthen cultural competence, by which they meant building capacity for

understanding sexual health issues from the young person's perspective. Paterson (2007) suggested that one such capacity building exercise was to appreciate that learning about sexual health, sexual wellbeing and sexuality is a lifelong undertaking. This, they argued, had practical implications for sexual health services as it meant accepting that education may be required at any point and via a range of activities including those outside of school (Paterson, 2007).

Healthy Respect (2007) highlighted that a broadened scope tests the limits of what any one individual or agency is able to do. This recognition is significant because it means that, in order to support the young person, practitioners need to work closely with others both within and across organisational boundaries. Many of the sources describing this case study were explicit about this referring to the general concept in various terms such as: interagency collaboration, partnership working (Penney et al., 2005), multi-agency approach (Healthy Respect, 2005), and co-operating in the exchange of specialist resources (Healthy Respect, 2007).

Healthy Respect (2007) described practical features of their approach which supported the principle of working together. For example they developed a network for different stakeholders to share experiences and perspectives (Paterson, 2007) and aimed to facilitate information, local access and signposting to other services (Healthy Respect, 2007) as well as having co-ordinator roles who worked across settings (Healthy Respect, 2017; Scottish Executive, 2003).

In London the principle to be person-centred was operationalised in a variety of ways. There was a strong drive to be user-led in terms of design. This meant involving users in decision making. Greenhalgh and colleagues (2008) highlighted that explicit attention was given to include a diverse range of users, in terms of need and orientation, to inform the development of the new services. The evaluators outlined that services aimed to meet user's needs by improving accessibility of the user-friendliness of services and increasing possibilities of self-management (Greenhalgh et al., 2012; Macfarlane et al., 2013). The evaluation of this service, which took a realist approach, provided programme theory which will be described in more detail in chapter four.

In summary, being person-centred, is one key principle that distinguishes a positive approach from other models of care which may, explicitly or implicitly, be based on political, professional or societal needs. This includes being youth-friendly, non-judgemental and ensuring access via appropriate clinic times. But supporting this principle also means designing services to meet the holistic needs of each and every individual. The literature highlights several other sub-principles corresponding to this principle: respecting diversity and evolving needs over the life course; breaking professional silos and working together seamlessly, and fully involving users in the design and evaluation of services.

3.3.9   Section conclusion and limitations

Three principles are suggested which may underpin characteristic features linking the ambition for positive services to practice. These are an acknowledgement of young people's sexuality, an ambition to support sexual wellbeing and a commitment to person-centred approaches.

Figure 9 maps these principles and characteristics to the overarching theoretical model of social action. This figure also demonstrates a gap where programme theory will be developed over the coming chapters. The limited number of case studies, lack of consistency between them and, to some degree, inconsistency within the sources that describe them mean that these principles and characteristics should be considered provisional. These were further developed through my review of policy, described below, and my empirical work, described in chapters five, six and seven.
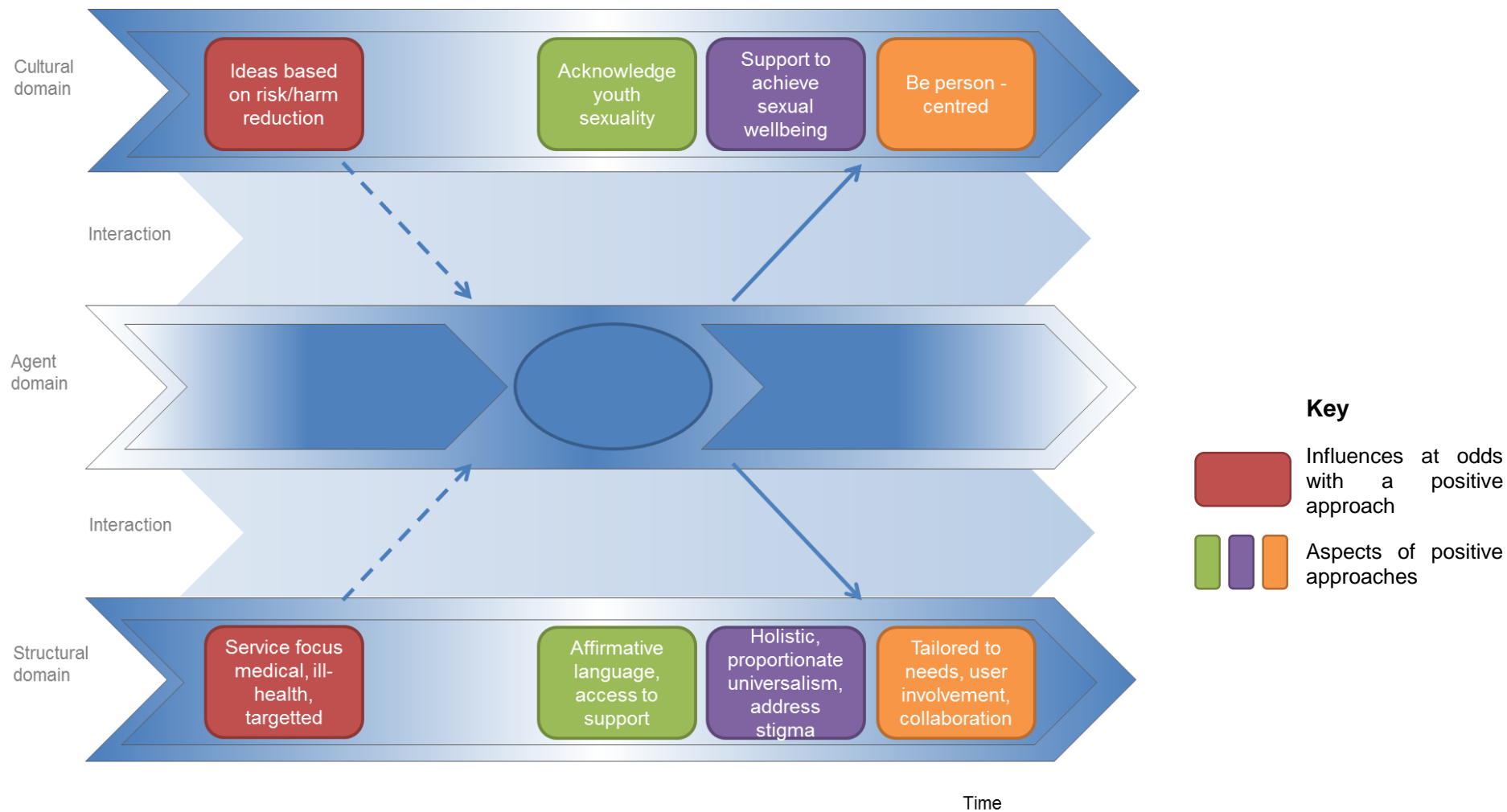
Figure 9. Principles and characteristics of positive approaches mapped to the overarching theoretical model of social action.

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3.4   Review of policy

The second review built on the first. It aimed to locate the proposed principles (foundational ideas) and characteristics of positive services (roles, processes, resources and practices) in policy and guidance documents which relate to the delivery of sexual health services in England. This review had two key purposes. First, this was to identify the prevalence and interpretation of these proposed principles and characteristics, to further establish their shared or contested meanings. Second, the review served to expound some of the cultural and structural contexts in which current services, in the empirical case studies, were operating.

3.4.1   Search statement

My search was designed to identify current sexual health policy documents in England with the search question "to what extent are positive approaches reflected in current English sexual health policy and guidance?"

3.4.2   Search strategy

My search for sexual health policy and guidance documents used snowballing and hand searching techniques. I started with the current sexual health strategy for England *The Framework for Sexual Health Improvement in England* which had been published by the Department of Health (2013a) and, from this key document, I sourced documents which were cited as informing its strategic objectives and recommendations. In addition, I searched the Department of Health website which includes a webpage of links to other guidelines, policies and resources which they have published. The site also links to other organisations which may be influential to decision making at a local level. I searched these partner websites for "sexual health" and/or "young people" and relevant synonyms using their internal search facilities. A Google search, including the additional search term "policy" also led me to potentially influential organisations.

The combined search approaches revealed 16 organisations / groups which cover English governmental departments, best practice guidance, professional bodies and advocacy or charitable groups. The organisations are detailed below in Table 4.

From these organisations' websites I retrieved 31 documents. These documents had been developed for a range of operational purposes. They included policy statements, best practice and implementation guidance, tools to support delivery, service specifications, consultation and evaluation reports. In addition, a small number of past policy documents because they help to build a picture of the historical context which may have shaped the current structural and cultural conditions. A summary of these documents is provided in section 3.4.5.

3.4.3 Data extraction

I read the texts in order to identify passages which described the principles or characteristics of youth sexual health services. These passages were coded according to a pre-defined coding template which reflected the positive principles and characteristics taken from the review of literature from academic databases. Additional codes were added where the data did not fit into the existing framework.

3.4.4 Analysis and synthesis

The documents were uploaded to qualitative analysis software NVivo version 10. In line with principles of CIS, I read the passages critically in order to identify first, if and how the texts portrayed a positive approach, second where, within the document, these ideas were represented and third whether the principles were applied consistently throughout the texts (Dixon-Woods et al., 2006; Entwistle et al., 2012). This review therefore reflects my interpretation of the policy statements, which I arrived at after considering the purpose of the document, the 'lens' through which the policy agents may be viewing the topic (Harris, Friel, & Wilson, 2015) and the background cultural theories which might

have influenced them (Paley, 2016). It should be noted that whilst I was looking for shared meaning of the terms to refine the definition of positive approaches, I recognised that there might be contested meaning where terms have been utilised in different contexts and for different purposes. It was therefore my intention to also surface and explain contested meanings of the terms in relation to the current policy.

An early iteration of the defining features drawn from the academic and policy literature was shared with a network of sexual health practitioners. Their comments enabled me improve the coherence of the defining principles and characteristics.

3.4.5 Results of the policy literature search

Thirty one policy documents were selected to form the review. These are summarised below:

Table 4 Results of the policy literature search

Category	Title (reference)	Year (Year of operation)	Provenance	Topic area (as defined within the document)
Current National policy / Acts of Parliament	Sex and Relationship Education Guidance (Department for Education and Employment, 2000)	2000 (ongoing)	Reference Searching	Guidance for sex and relationship education in schools. Arising out of the Personal, Social and Health Education (PSHE) framework and Teenage Pregnancy Strategy
	Health and Social Care Act 2012 (Department of Health, 2012a)	2012 (2013)	Google search	Act of Parliament detailing a substantial revision of the NHS. Established Clinical Commissioning Groups, Public Health England and transferred commissioning of sexual health services from the NHS to the local authority
	Framework for Sexual Health Improvement in England (Department of Health, 2013a)	2013 (ongoing)	Hand searching	Framework document to support those involved in sexual health improvement work together effectively. Replaced the Teenage Pregnancy Strategy and National Strategy for Sexual and Reproductive Health
	Five Year Forward View (NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, 2014)	2014 (ongoing)	Hand Searching	Shared vision of national leadership for a better NHS and steps to take to get us there.
	Health promotion for sexual and reproductive health and HIV: strategic action plan, 2016 to 2019 (Public Health England,	2015 (2016-2019)	Department of Health website	Strategic action plan setting out Public Health England's approach to improving the public's sexual and reproductive health. Works within the Framework for Sexual

	2015)			Health Improvement in England and the Public Health Outcomes Framework
	Improving young people's health and wellbeing: a framework for public health (Public Health England & Association for Young People's Health, 2015)	2015 (ongoing)	Hand Searching	Framework to address the specific needs of young people (10-24 years old) containing practical support to councillors, health and wellbeing boards, commissioners and service providers.
Past National policy (selected)	Teenage Pregnancy Strategy (Social Exclusion Unit, 1999)	1999 (2000-2010)	Reference searching	Report setting out the analysis of the teenage pregnancy in the UK and decisions made to tackle it
	Teenage Pregnancy Strategy: Beyond 2010 (Department for Children Schools and Families, 2011)	2011 (2011-2013)	Reference searching	Interim strategy document to build on learning of Teenage Pregnancy Strategy
	The National Strategy for Sexual Health and HIV (Department of Health, 2001)	2001 (2001-2010)	Hand Searching	First national strategy for sexual health and HIV
	Progress and priorities - working together for high quality sexual health (MEDFASH, 2008)	2008	Citation searching	Review of the National Strategy for Sexual Health and HIV commissioned by the Independent Advisory Group on Sexual Health and HIV
National professional bodies	Better Care, Better Future: a new vision for sexual and reproductive health care in the UK (Faculty of Sexual & Reproductive Healthcare, 2015)	2015	Hand searching	Vision statement from the multi-disciplinary membership faculty of sexual and reproductive healthcare professionals
National advocacy bodies	Young People (FPA, 2011)	2011	Hand searching	Policy statement on young people

	Guidance for using the sexual behaviours traffic light tool (Brook, 2015)	2015	Hand searching	Resource to categorise sexual behaviours of young people
	Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV service in England (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015)	2015	Hand searching	Report of the inquiry to understand the impact of the new structures established as part of the Health and Social Care Act 2012.
	Be Sex : Positive Hello (Brook, 2016)	2016	Hand searching	Pack to explain about the Sex:Positive Campaign
National Guidance / guidelines	Contraceptive choices for young people (Faculty of Sexual & Reproductive Healthcare, 2010)	2010 (ongoing)	Reference searching	Guidance for health professionals on providing contraceptive services to young people. Recommendations based on available evidence and expert consensus
	Spotting the signs: a national proforma for identifying risk of child sexual exploitation in sexual health services (Rogstad & Johnston, 2011)	2011 (ongoing)	Recommend-ation	National proforma to help health professionals working with young people identify and assess the risk of child sexual exploitation (CSE).
	You're Welcome - Quality Criteria for young people friendly health services (Department of Health, 2011)	2011 (ongoing)	Reference searching	Quality criteria for youth-friendly health services
	Integrated Sexual Health Services: National Service Specification (Department of Health, 2013c)	2013 (ongoing)	Hand searching	National service specification to help local authorities commission effective, high-quality, integrated sexual health care

	Commissioning Sexual Health services and interventions: best practice for local authorities (Department of Health, 2013b)	2013 (ongoing)	Hand searching	Guidance document for local authorities to fulfil legal requirements related to sexual health commissioning following the Health and Social Care Act 2012
	Service standards for sexual and reproductive healthcare (Faculty of Sexual & Reproductive Healthcare Clinical Standards Committee, 2013)	2013 (ongoing)	Hand searching	Service standards aims at commissioners and providers of services in relation to sexual and reproductive health commissioned of contracted by the NHS
	Making it work: A guide to whole systems commissioning for sexual health, reproductive health and HIV (Public Health England, 2014)	2014 (ongoing)	Department of Health website	Guide for commissioners of sexual health, reproductive health and HIV services in local government, clinical commissioning groups and NHS England outlining responsibilities set out in the Health and Social Care Act 2012
	Standards for the management of sexually transmitted infections (STIs) (BASHH & MEDFASH, 2014)	2014	Hand searching	Guidance bring together the best practice that people seeking help in relation to STIs are entitled to expect
	Developing strong relationships and positive sexual health (Health, 2014)	2014 (ongoing)	Citation searching	Pathway and guidance to support school nurses, sexual health service providers and partners working to support the contraceptive and sexual health needs of young people
	Preventing sexually transmitted infections and under-18 conceptions overview (NICE, 2014b)	2014 (ongoing)	Hand Searching	NICE pathway bringing together all NICE guidance, quality standards and materials to prevent sexually transmitted infections and under 18 conceptions
	Contraceptive services with a focus on young people aged up	2014 (ongoing)	Hand Searching	NICE pathway bringing together all NICE guidance, quality standards and materials

	to 25 overview (NICE, 2014a)			on contraceptive services for young people aged up to 25
	Sexual health commissioning in local government (Local Goverment Association & MEDFASH, 2015)	2015 (ongoing)	Reference searching	Nine cases studies showcasing local government experience of commissioning sexual health services since April 2013
	Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children (Department for Education, 2015)	2015 (ongoing)	Hand Searching	Guidance to help professionals understand what they need to do and what they can expect of one another to safeguard children.
Key data and statistics	Public Health Outcomes Framework (Department of Health, 2013d)	2013 (ongoing)	Hand searching	Overarching vision for public health, outcomes that the NHS, social care, voluntary sector want to achieve and the indicators intended to help to measure progress
	Improving outcomes and supporting transparency (August 2016)	2016 (ongoing)	Hand searching	Technical specifications of the Public Health Outcomes Framework indicator set.
	Sexually Transmitted Infections and Chlamydia Screening in England, 2016 (Public Health England, 2017)	2017 (data to 2016, key trends)	Hand searching	Key trends in testing and diagnosis of STIs.

3.4.6 Overview of the policy landscape

The results illustrated a multitude of policy and guidance documents associated with commissioning, designing and delivering young people's sexual health services. This may reflect the range of agencies who were involved in delivering services following the Health and Social Care Act 2012 (Department of Health, 2012a).

At the time of writing, governmental bodies, the Department of Health and Public Health England provided the overarching policy and guidance documents for sexual health commissioning and delivery. *The Framework for Sexual Health Improvement in England (hereafter referred to as The Framework)* (Department of Health, 2013a) set the overall vision and objectives. *Making it work: A guide to whole systems commissioning for sexual health, reproductive health and HIV (hereafter MiW)* (Public Health England, 2014) provided more detailed guidance which set out the responsibilities of each of the commissioning bodies (that is, Local Authorities, Clinical Commissioning Groups and NHS England) responsible for delivering sexual health services and the *Public Health Outcomes Framework (hereafter PHOF)* (Department of Health, 2013d) which detailed the outcomes the NHS, social care and the voluntary sector wanted to achieve and indicator sets which were used to measure progress.

The Department of Health and Public Health England also provided policy and guidance on particular issues (for example, on health promotion (Public Health England, 2015)) about particular populations (for example, a framework for young people's health and wellbeing (Public Health England & Association for Young People's Health, 2015)), and directed at particular agencies, (for example, best practice examples for local authorities (Department of Health, 2013b)).

The key documents, *The Framework*, *MiW* and *PHOF* were informed by and, in turn, informed various other government agencies, professional and advocacy bodies. For example the National Institute for Clinical Excellence (NICE) provided pathways, standards and guidance for specific topics such as contraceptive services for under 25 year olds (NICE, 2014a). Professional bodies, the British Association for Sexual Health and HIV (BASHH) and Faculty

of Sexual and Reproductive Healthcare (FSRH) provided guidelines on service standards for STIs (BASHH & MEDFASH, 2014) and sex and reproductive health (Faculty of Sexual & Reproductive Healthcare Clinical Standards Committee, 2013) respectively. These bodes also contributed to setting the vision for future work (for example, FSRH, 2015). Charitable sector organisations such as Brook (2016), and FPA (2011) provided insight from young people, guidance and toolkits for delivering care for young people (Brook, 2015).

I now turn to the results which highlight the extent to which policy and guidance documents reflected the principles and characteristics identified in the first literature review of the academic case studies.

3.4.7 Positive characteristics reflected in policy

It is noticeable how the policy discourse surrounding young people's sexuality has changed over the last 27 years. The *Teenage Pregnancy Strategy* (Social Exclusion Unit, 1999) appeared to reflect normative morality and values. For example, the record of under-20 conceptions, compared to other European nations, was described as *'shameful'*. This document implied normative notions of sexual activity that are within monogamous, loving long-term relationships. *The National Strategy for Sexual Health and HIV* (Department of Health, 2001), (which was one of the first of its kind globally (Giami, 2002)), recognised that sexual health is important to overall wellbeing but did not specifically go into detail about sexual wellbeing or holistic approaches. An interim evaluation of *The National Strategy for Sexual Health and HIV* (MEDFASH, 2008)*,* which was conducted by an independent advisory board, included suggestions for improvements on the strategy that may reflect the positive principles and characteristics for example,

> *"networks should be person-centred and exist to meet the holistic needs of service users" (MEDFASH, 2008)*

The ministerial follow up to the *Teenage Pregnancy Strategy* (Department for Children Schools and Families, 2011) gave examples of best practice which demonstrated that emotional wellbeing had entered the curriculum, and

recognised the impact of stigma on sexual health advising that we 'changing how we communicate' as a result.

This brings us to policy and guidance which is current today. Positive principles and characteristics, outlined in the first literature review, were present, but not consistently so across the policy landscape. There were very few explicit references to positive approaches, 'sex-positive' approaches or positive sexuality. Where these were identified they were in case studies of best practice within the guidance documents (Local Goverment Association & MEDFASH, 2015). There were many references to 'positive' within the policy and guidance documents but these primarily referred to receiving 'positive' test results for STIs (BASHH & MEDFASH, 2014) or developing 'positive' relationships.

The terms and ideas which the previous literature review had identified as aspects of positive services in practice were present in some of the policy and guidance documents. Each of the three principles will therefore be considered in turn. The results highlight where positive principles and characteristics were present and in these cases, infer what was meant by the terms used.

Principle one: to acknowledge young people's sexuality

The Framework (Department of Health, 2013a), which was the lead policy document for England at the time of the review, acknowledged youth sexuality. For example, section 2 of *The Framework* was entitled *'sexual health across the life course'.* This section included 'sexual health ambitions' for different age groups, illustrating an acceptance that young people are sexual beings, with sexual health needs. In particular it highlighted the ambition that "*young people know how to ask for help and are able to access confidential advice and support"* (Department of Health, 2013a, p. 13)*.*

The Framework did not, however, acknowledge that sexuality is natural and is something young people have a right to explore and express. It directed the reader to the then Secretary of State for Education's *'Sex and Relationships Education Guidance*', which was written at the same time as the *Teenage Pregnancy Strategy*, for the 'positive values and strong moral framework

provided' (Department of Health, 2013a, p. 13). The positive values and moral framework outlined in this document appear to be rooted in heteronormative notions of the nuclear family: favouring education that focusses on the *importance of marriage for family life*, *stable and loving relationships* and whilst it advocated teaching of sex, sexuality and sexual health, it was explicitly not about *the promotion of sexual orientation [as] this would be inappropriate teaching* (Department for Education and Employment, 2000, p. 5). Accordingly, within *The Framework* (Department of Health, 2013a) young people's sexuality was primarily presented as a *challenge*, presumably to be overcome, or navigated. This was illustrated in the life course model within the appendix which described the various 'challenges' by age group. 'Challenges' to age 10 included being` *'naturally curious'* and between 11-15: *'developing sexuality, self-esteem, emotional resilience'* (Department of Health, 2013a, p. 49).

Other current policy documents framed youth sexuality in a similarly negative fashion in parts. The service specification template, for example, referred to young people as carrying the 'burden of sexual ill-health' (Faculty of Sexual & Reproductive Healthcare Clinical Standards Committee, 2013). Some sources affecting English sexual health services published after *The Framework* did appear to take a more progressive viewpoint. The Faculty for Sexual and Reproductive Health (FSRH), which is a multi-disciplinary professional body, described the right,

> *"to expect individualised, holistic sexual and reproductive health care across the life-course"* (Faculty of Sexual & Reproductive Healthcare, 2015, p. 6).

The FSRH's vision for sexual and reproductive health care outlined that care and support should always be provided in a "*non-judgemental way irrespective of sexuality and behaviour"* (Faculty of Sexual & Reproductive Healthcare, 2015, p. 6). In another example, Public Health England, along with the Association for Young People's Health (2015) placed young people's relationships at the centre of their health and wellbeing framework, including their 'romantic/sexual partners'. This document also acknowledged inequalities experienced by young people that may be related to sexual identity and sexual

orientation and suggested additional support is offered to those affected by them (Public Health England & Association for Young People's Health, 2015).

Several of the sources from professional bodies and advocacy charities explicitly acknowledged that all individuals, including young people, are sexual beings and have rights with regards to sexual health (Brook, 2016; Faculty of Sexual & Reproductive Healthcare, 2015; FPA, 2011). For example Brook, an English charity, which campaigns on behalf of young people and provides youth sexual health advice and contraception, placed an emphasis on valuing children and young people. Their 'Sex:Positive' campaign advocated a young person's right to express and enjoy their sexuality (Brook, 2016). The FPA stated that,

> *"young people need to be equipped with the knowledge and skills to develop sexual behaviour that is safe and enjoyable for them and for others" (FPA, 2011(online))*

Several sources indicated that 'young person-friendly' services are one way to demonstrate to young people that they have a right to access services and should not be ashamed to do so (Brook, 2016; FPA, 2011; Public Health England, 2014; Public Health England & Association for Young People's Health, 2015). Others referred to the 'You're Welcome' criteria (Department of Health, 2013a; Health, 2014) which clarified this concept and outlined a set of general competencies that services should exhibit to provide appropriate care for young people (Department of Health, 2011). These competencies included accessibility (and choice), publicity (and content which is tailored for young people), confidentiality and consent, environment (ensuring the service is comfortable and welcoming), staff training, skills, attitudes and values (which stress the need to understand health needs in the context of their lives and relationships, and support young people to make their own informed choices), joined-up working, young people's involvement in monitoring and evaluation of patient experience (Department of Health, 2011). The criteria included a specific section on sexual health, thereby acknowledging young people's sexuality as an important aspect of healthcare provision (Department of Health, 2011). *You're Welcome* stressed the need for staff to provide unbiased information and non-directive support as well as reminding staff that they can

discuss the options of delaying sex and resisting peer pressure, where needed (Department of Health, 2011).

In summary, the review of the policy and guidance literature, in relation to the first principle, suggests that young people's sexuality was increasingly acknowledged, over time, although in many of the documents this was an implicit rather than explicit acknowledgement. Few policy documents clearly acknowledged positive aspects of sexuality and most equated sexuality with risk. However, more recent policy documents and advocacy groups stressed a positive approach to youth sexuality. Advocacy groups and international policy documents in particular highlighted the need for positive affirmative approaches. The policy documents suggested this may be characterised through friendly and welcoming environments and genuinely non-judgemental attitudes from staff members. There was, however, little further inclusion of guidance for example regarding positive, affirmative language, practices and policies.

Principle two: to support sexual wellbeing

The extent to which policy and guidance reflected the principle to support young people's *sexual wellbeing* is now reported. This section also covers sub principles and characteristics of services which may support wellbeing at different levels within the social system: taking a *holistic approach*, a *broad range of prevention initiatives*, *universal proportionalism*, and other *efforts to reduce stigma.*

The Framework and *MiW* included references to 'sexual wellbeing' (Department of Health, 2013a; Public Health England, 2014). These references often fell in the initial paragraphs of the document or ministerial forward which claimed to underpin the policy or guidance document. In *The Framework*, for example, the executive summary suggested:

> *"The Government wants to improve sexual health, and our ambition is to improve the sexual health and wellbeing of the whole population"*
> (Department of Health, 2013a, p. 4)

The Framework, also suggested that *support about wellbeing, relationships and sexual health* was a key ambition for young people (Department of Health,

2013a, p. 13). This arguably recognised that sexual health is an important part of overall wellbeing. However, *The Framework* and other central documents did not define what they meant by wellbeing, sexual wellbeing or refer to a broad definition of sexual health. There were references to 'wellbeing' in a wider context; for example the *PHOF* (Department of Health, 2013d) specified the role of various governmental bodies to assure the *health and wellbeing* of the population and to set up *health and wellbeing boards* to drive local commissioning and integration of all health services based on local needs. These references did not, however, directly link sexual health to wellbeing.

It is unclear therefore what was meant by 'wellbeing' in *The Framework* and *PHOF*. The key objectives of *The Framework* did encompass broad and somewhat positive aims see Figure 10 (Department of Health, 2013a, p. 10) such as t*o build an open and honest culture* and for people to *remain healthy as they age*. This constituted a move away from the previous strategies, in particular from the narrow focus of the previous *Teenage Pregnancy Strategy* (Social Exclusion Unit, 1999). The mandates for action within *The Framework* concerned only four of the eight objectives initially set out. These four related only to reducing incidence of sexual ill-health (reducing rates of STIs, onward transmission of HIV, unintended pregnancies and reducing the rate of under-18 conceptions).

Subsequent policy then prioritised these four objectives. For example, Public Health England's strategic action plan for sexual health promotion (2015) did reference the WHO definition (2006) of sexual health. It appeared, however, to have selectively omitted specific references to positive aspects of sexuality, such as 'pleasurable experiences' as illustrated in the following extract.

> *"WHO has defined sexual health as "…a state of physical, emotional, mental and social wellbeing in relation to sexuality, it is not merely the absence of disease dysfunction or infirmity"…"* (Public Health England, 2015, p. 7)

This document then proceeded to focus on groups at risk and health promotion priorities which referred only to the four objectives emanating from *The Framework* and PHOF associated with possible negative outcomes of sexual activity, to reduce:

"onward HIV transmission, acquisition and avoidable deaths, rates of
sexually transmitted infections, unplanned pregnancies and rates of
under-16 and under-18 conceptions" (Public Health England, 2015, p. 9).

The positive ambitions, for example those concerning building an open culture, were not developed into examples of activities that might be recommended. This may reinforce that whilst the key policy is beginning to recognise the breadth of sexual health as a concept, as it relates to individuals, this is not reflected in the directives for action emanating from government.
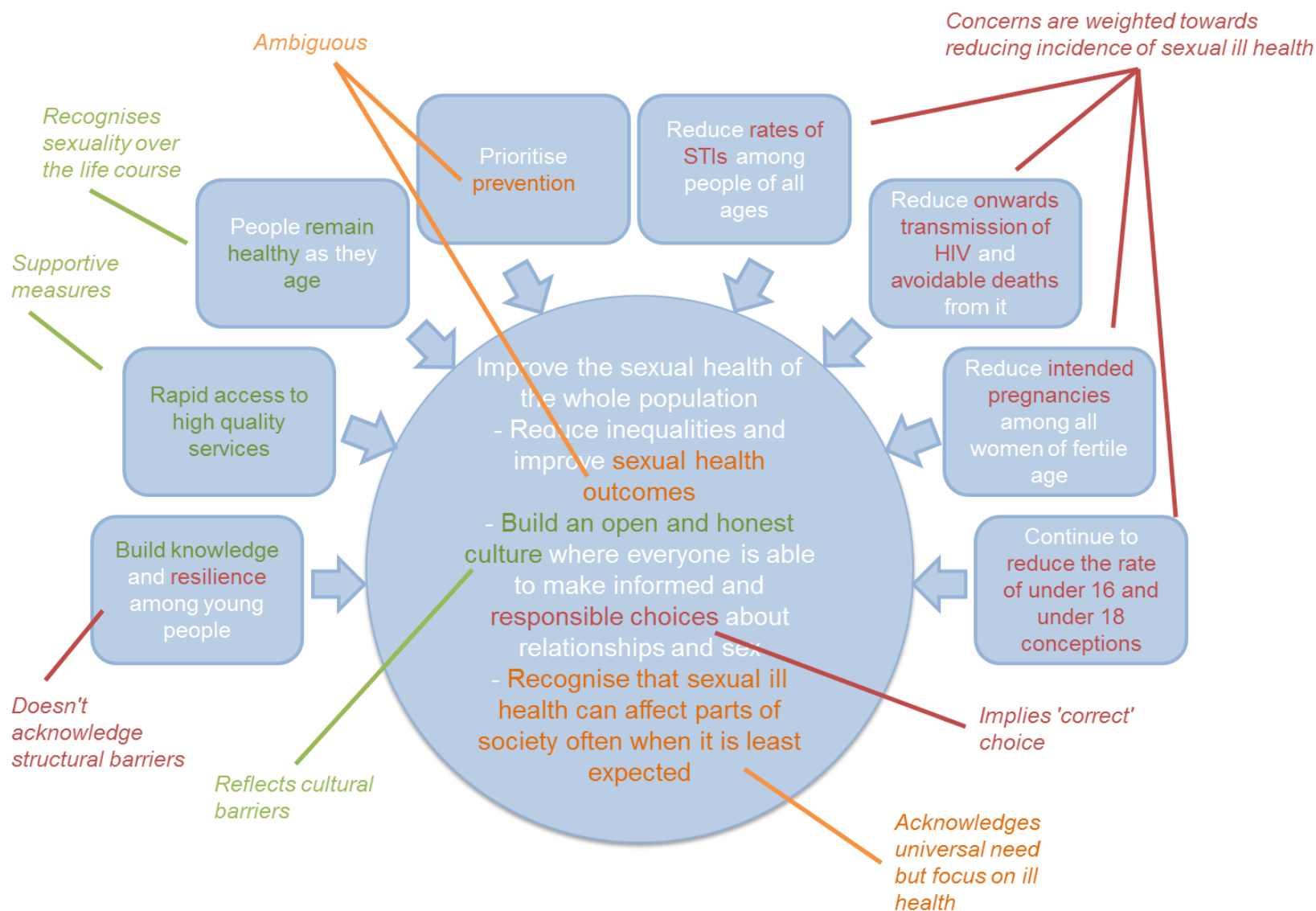
Figure 10. Aspects of sexual health reflected in The Framework objectives. Red text denotes policy reflecting risk/protection based objectives, green text denotes policy reflecting wellbeing objectives and orange text denotes policy which may be ambiguous. (Original diagram adapted from (Department of Health, 2013a, p. 10) *annotations added by current author).*

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Some sources from the professional bodies (Faculty of Sexual & Reproductive Healthcare, 2015), young people's advocacy (Brook, 2016; FPA, 2011)) and government themselves (Department of Health, 2014) called for a broadening of the scope of what constitutes and contributes to young people's sexual health. These sought to establish a comprehensive definition of sexual and reproductive health which reflected positive aspects of sexuality such as expressing a sexual identity, the possibility of pleasurable experiences, building emotional health and developing positive attitudes and values, having a choice and potential for informed decision making.

Policy and guidance documents did not, however, spell out what services which prioritise sexual wellbeing would look like. The key documents *(The Framework, MiW, PHOF)* did not suggest that services should take a *holistic* approach. Guidance issued by the National Institute for Health and Care Excellence (NICE) and service standards issued by professional bodies reflected narrow condition specific pathways (BASHH & MEDFASH, 2014; Faculty of Sexual & Reproductive Healthcare Clinical Standards Committee, 2013; NICE, 2014a, 2014b). The exception, perhaps, was one of the most recent documents specifically looking at improving young people's health and wellbeing which described the need for services to work together in a holistic way, because young people think about their health holistically (Public Health England & Association for Young People's Health, 2015). It proposed that a wide range of actions and initiatives would be needed as well as long term investment in support to build life skills. This policy appeared to have been driven by the views of young people themselves.

> *"[evidence from participation exercises suggests that young people] want an integrated, youth friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope" (Public Health England & Association for Young People's Health, 2015, p. 6).*

In this example, the policy suggested a holistic approach would encompass a wide range of issues from the young person's perspective, including mental health, physical activity, using alcohol, drugs and smoking as well as sexual health *(Public Health England & Association for Young People's Health, 2015)*.

The key policy documents may not have used the word holistic but they did use the term *comprehensive.* *The Framework* and *MiW* suggested that people's needs should be comprehensively met; that all people, including young people, should have access to *comprehensive* services which includes: contraception, STI testing and treatment, psychosexual counselling, and 'specialist' services which include outreach, sexual health promotion and services in schools, colleges and pharmacies (Department of Health, 2013a; Public Health England, 2014). The difference between the meaning of comprehensive and holistic may therefore be one of perspective. Policy and guidance directed at commissioning for sexual health may focus on the services one can procure and thus aim to ensure *comprehensive* coverage and a multi-care package. Guidance directed at setting the vision and ideals for the sexual health of the population may acknowledge that aspects of sexual health (and wider determinants) are interrelated and suggest that *holistic* approaches looking at the whole person are needed.

Whilst definitions of sexual health and wellbeing stressed that the concept is not merely the absence of disease, dysfunction or unwanted pregnancy, avoiding these ends did feature heavily in policy and guidance. Prevention was therefore a key thread of the sexual health policy documents (Department of Health, 2013a; Public Health England, 2014) which reflected the general direction for the NHS as set out in the overarching strategy, the *Five Year Forward View* (NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, 2014).

The Framework (Department of Health, 2013a) emphasised medical and technical approaches for prevention. These included new methods of contraception or increasing uptake of Long Acting Reversible Contraception (LARC) to prevent unintended pregnancy (Great Britain Department of Health, 2013a) and immediate testing and treatment of STIs to preserve health and reduce onward transmission via rapid access to open access services (Department of Health, 2013b). Local authority regulations issued from the Department of Health (2013b) did not include requirements to fulfil wider preventative interventions such as information provision or education, marketing and advertising, or outreach, youth services and condom distribution schemes. These regulations did however stress that such activities are crucial to develop

the knowledge and skills to prevent poor sexual health and therefore reduce demand for services. The Local Government Association (2015) provided some examples of how this might be met, for example, through collaborative commissioning of wider preventative initiatives across a number of local authorities.

The Framework and *MiW* advocated a targeted prevention approach to concentrate resources 'where they are most needed': *the prevention of HIV and STIs should be targetted at those populations most at risk of infection* (Department of Health, 2013a, p. 22), although these were broadly defined categories which included *'young people'.* More recently, however, Public Health England (2015) had begun to introduce notions of *universal proportionalism* in their policy for improving young people's overall health and wellbeing. This was illustrated through suggestions that support should be offered at different levels; 'universal' (mainstream/generic services, open to all (p.25)), 'targeted' (for especially vulnerable groups, for example care leavers or asylum seekers (p.14)) and 'specialist' (for those with specific needs, 'such as substance misuse or services for lesbian, gay and transgender youth' (p.23)).

The Framework recognised the importance of tackling stigma to improve sexual health and wellbeing as it was referenced in multiple places in the document (Department of Health, 2013a). Certain groups, such as young people, at risk of poor sexual health, were recognised as more likely to face stigma related to sexual health (Department of Health, 2013a). One response, well established in England, was to ensure services are 'open access' meaning that people can self-refer to the service of their choice regardless of location (Public Health England, 2014). This arguably does not tackle the underlying stigma but rather designs services on the basis that it exists.

According to *The Framework* one 'positive' approach to tackle stigma was to:

> *"Identify the assets that those resilient young people have and to try and help at-risk young people to develop them. In this way, significantly improve their resilience - their ability to 'enjoy life, survive challenges, and maintain positive wellbeing and self-esteem'. This also helps young people to challenge and change the taboos that are sometimes*

associated with sex and sexual health." (Department of Health, 2013a, p. 19)

The Framework further suggested that one way to tackle stigma was to open up communication about 'risky activities' and advocated an approach to *changing behaviour by promoting and prompting conversation about health issues using a range of digital and mass-media channels.*

MiW (Public Health England, 2014) went beyond this by recognising that other wider determinants of sexual and reproductive health include social, infrastructural and cultural contextual factors. Brook, (2016), similarly advocated approaches that acknowledge the need to tackle stigma and argued for a cultural shift towards greater openness, challenging negative or discriminating social attitudes towards sexual health. This was in order to support young people to "*fulfill their potential free from prejudice and harm."* The majority of the literature did not address how cultural, social and community values should be challenged. One case is presented, however, that explained how programmes, networks and relationships have been built with communities to ensure they address specific community needs (Local Goverment Association & MEDFASH, 2015).

In summary, sexual wellbeing has been introduced in many of the key policy documents but not in guidance related to specific aspects of sexual health. There were few examples of how to support sexual wellbeing. In addition, mandates emanating from the documents referred primarily to reducing negative sexual health outcomes. The term holistic was used for different purposes - to refer to a comprehensive commissioning package, or to refer to an approach which looks at the whole person. Prevention was a priority for policy but medical and technical solutions were emphasised and there was no weight behind multi-modal approaches. Stigma associated with sexual health which may deter young people from accessing services was recognised, but there were few clear examples of what to do to combat it in society. Examples of best practice did, however, often exemplify positive principles and characteristics.

Principle three: to be person-centred

The final principle elicited from the review of academic literature was to be person-centred with three further sub-principles: to respect diversity and changing needs over the life-course, to include users in the design and evaluation of services and integrated provision. These ideas were present in some of the policy documents as illustrated below.

Respecting diversity

Most of the policy and guidance documents were clear that services ought to be tailored to meet individual needs. This included clinical guidance (NICE, 2014a, 2014b), policy ((Department of Health, 2013a; Health, 2014; Public Health England, 2015) and statements from advocacy groups (Brook, 2016; FPA, 2011). *The Framework* clearly acknowledged differing needs of young people with its ambition that "*that all young people's sexual-health needs - whatever their sexuality - are comprehensively met*" (Department of Health, 2013a, p. 17). *MiW* recommended that the specific needs of 'high risk and vulnerable' groups such as gay, bisexual and transgender people should be understood and articulated in any needs assessment (Public Health England, 2014). The Department of Health's *Health visiting and school nurse programme implementation guidance* (Health, 2014) referred to supporting diversity and the guidance, aimed at young people's health and wellbeing, addressed the need to cater to different age bands (Public Health England & Association for Young People's Health, 2015). Brook's 'Sex:Positive' campaign was explicit about inclusivity not just in terms of age, gender expression or sexual orientation but also relationship status or sexual experience:

> *"Sex positive is open to all young people regardless of their gender or sexuality. You don't have to be in a relationship or having sex to join either" (Brook, 2016 (online)).*

These documents did not provide any particular guidance or examples of how services may adapt to cater for young people's different and changing needs. Brook's Traffic Light Tool which was designed to educate practitioners about healthy sexual development stated:

"Knowing how to take a positive view and recognise healthy sexual behaviour in children and young people helps to support the development of health sexuality and protect children and young people from harm or abuse…Many expressions of sexual behaviour are part of healthy development" (Brook, 2015).

Brook (2015) recognised that children and young people do need support to alleviate their vulnerability, but that first, this should be part of a full appreciation of young people's emerging sexuality and second, that rather than shutting down their lines of inquiry, support should be given to help young people recognise risk and learn strategies to mitigate it.

As illustrated above, a life course approach, from a wellbeing perspective, can mean paying attention to the emerging sexuality and evolving capacities of young people and the specific needs these bring. However, as noted previously *The Framework* set out a life course perspective, but positions the transitions as 'challenges', presumably to be overcome (Department of Health, 2013a). Public Health England also suggested that 'life-course' was related to the risks associated with each stage of life and the ways in which these accumulate over time. This document placed a focus on education and early intervention which *"should achieve the greatest improvements in sexual health and reductions in health inequalities"* (Public Health England, 2015). It could be inferred that sexual health services were not intended to play a great role in supporting wellbeing.

In short, whilst the rhetoric suggested the breadth of needs should be catered for, the directives and mandates emanating from these documents were not specific about this.

Integrated provision

The FSRH vision statement which was published after *The Framework*, explicitly acknowledged that current service models may be orientated around professional disciplines which may not be in a user's best interest (Faculty of Sexual & Reproductive Healthcare, 2015). The Health Visiting School Nurse Programme implementation document and FSRH vision both stressed the need for seamless support across and within organisational boundaries. They

recommended a partnership pathway - with co-ordinated and collaborative efforts across agencies - and based this pathway around the needs of the young person or individual (Faculty of Sexual & Reproductive Healthcare, 2015; Health, 2014).

MiW presented a 'patient pathway model', although here, as illustrated by the following extract, it may have meant the need to integrate medical pathways to reduce risks associated with ill-health, rather than maximise wellbeing.

> *"…following provision of emergency contraception, access to advice and provision of the full range of ongoing contraceptive methods, including LARC, is important. Poorly connected care increases the **risk of service users falling out of the system** which can reduce their treatment adherence and worsen subsequent health outcomes. Disjointed pathways also result in **missed opportunities** to address people's wider needs, whether they relate to alcohol or drug use, domestic violence or building self-esteem". (Public Health England, 2014 my emboldening)*

There has recently been a strategic push towards integration of contraception and GUM services. These combined services have been described as 'one-stop shops', for comprehensive sexual health needs (Department of Health, 2013a). This model provides some opportunities for supporting sexual wellbeing by reducing the number of appointments one might need. However, the extent to which they genuinely do support a broader range of young people's sexual health is not made clear.

The Framework (Department of Health, 2013a, p. 44) and service standards (BASHH & MEDFASH, 2014) proposed the ongoing development of sexual health managed networks which may be *empowered to lead transformational change across organisational boundaries.* The rationale they gave was that users' needs are beyond the scope of individual agencies, which must link to a clinically broad network which is holistic in focus (BASHH & MEDFASH, 2014). This document went on to place the responsibility for developing effective partnerships on the local commissioners. There were no further mentions of how and through what mechanisms collaborations might be founded.

Fully involving users in the design and evaluation of services

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (2015) urged commitment to engaging young people and including the user voice in both the service design and evaluation phases. Brook (2016) concurred, stressing that young people have a right to be involved in decisions that affect them. User feedback was also considered important to support designers' understanding of practical considerations, such as accessibility (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015).

The Framework suggested that *"public and patient feedback is used to ensure that services are meeting the needs of the local population"* (Department of Health, 2013a, p. 49). This was echoed in *MiW* and other implementation guidance which also stressed the need to include professionals on the ground (Public Health England, 2014) in consultation. Formalised organisations such as Healthwatch and Clinical Senates were encouraged (Public Health England, 2014). What was not stressed, however, was the frequency and level of influence or priority the view of users should have in the ultimate decision making.

3.4.8 Section conclusion and limitations

The results indicate that there has been a trend, albeit inconsistently observed, towards positive principles in policy over time. This was reflected in overarching ambitions and ministerial forwards but rarely translated into practice characteristics services should be aiming for. Some suggestions for how to meet these principles were present in the most recent policy, guidance from advocacy bodies and case studies of best practice.

Some of the policy and guidance documents used terminology associated with a positive approach but used them for different purposes, which may reflect risk-based, medical approaches. My review also illuminated inconsistencies within the documents, where positive ambitions, set out in the initial pages, may not be translated into actionable directives. This review of policy has supported my refinement of the provisional definition of positive services as described below.

3.5 Synthesis of key principles and characteristics of positive youth sexual health services

The purpose of this chapter was to identify aspects of service which might signify a positive approach to youth sexual health. This section draws together the principles and characteristics and refines their definitions in light of the two reviews. I combined data and ideas from the various sources into a 'synthesising argument' (Dixon-Woods et al., 2006; Entwistle et al., 2012) that is, a coherent, albeit provisional, theory of the principles and characteristics of a positive approach. In short, three interrelated foundational principles may reflect a positive approach in service. These are:

- First, there would be an acknowledgement of young people's sexuality and rights associated with this. This would be demonstrated in the affirmative language and framing of the programmes and policies, a welcoming environment and friendly and genuinely non-judgemental staff.
- Second, there would be an ambition to support young people to achieve sexual wellbeing. This would include prevention of sexual ill-health and promotion of positive sexuality, in line with emerging capacities. This would recognise sexual wellbeing is influenced by individual, interpersonal and societal factors. Sexual wellbeing would be supported by a holistic, by which I mean, 'whole person' approach and catered for by a comprehensive package of services. Preventative work would be multi-modal and work to reduce inequalities would include universal, targeted and specialised approaches. In addition, appropriately broad strategies to support individuals and contribute to reducing societal barriers would be implemented.
- Third, there would be a commitment to place young people's needs, as opposed to political, professional or societal needs, at the centre of decision making. This would be reflected in sufficient time and appropriate personnel to provide holistic care, prioritisation of users'

views in design and delivery of services and integrated, collaborative working across and within agencies.

These principles for positive services should be seen as complementary to, and an extension of, those advocated by the World Health Organization for 'safe', 'equitable', 'acceptable', 'accessible', 'effective' and 'appropriate' services (World Health Organization, 2015) .

3.6   Chapter Conclusion

This chapter has presented a critical synthesis of the literature culminating in a provisional definition of a positive approach to youth sexual health services. This definition suggests three overarching principles and a broadened range of characteristics which potentially distinguish a positive approach from other models of care. I acknowledge its provisional nature and the 'authorial voice' which produced it (Dixon-Woods et al., 2006). This was mitigated in part by an earlier version which was reviewed by a group of sexual health practitioners.

In exploring how positive approaches to youth sexual health services can be conceptualised and the attributes which define it, I uncovered and sought to explain inconsistencies and contradictions across current English policy and guidance as outlined above. This finding alerted me to the fact that interpretations of what a positive approach is, in the field, may differ. Following a logical argument I supposed that positive youth sexual health services would not be delivered if there was no local agreement about what it was. This had two main implications for my research design:

Firstly, rather than looking at final outcomes (such as services demonstrating they consistently adhere to the three principles suggested or youth perceptions of autonomy and choice), it was more pertinent to look at local buy-in to positive approaches to interrogate what works, or works against, this important stage in local implementation. This became the focus of my evaluation phase, reported in chapters four to seven.

Secondly, by recognising that positive youth sexual health services may be interpreted differently, I was not able to impose this definition on the empirical work. Rather, I used it as a basis to identify synergies and disparities in the field. I also sought to understand why such differences in interpretation might exist. This analysis would necessarily include consideration of the alternative discourses, structural contexts, such as the policy agenda as well as a host of other organisational, interpersonal and individual demographic features. These theories are introduced in chapter four and further developed in chapters five to eight.

Chapter 4. Initial rough programme theories for buy-in to positive approaches

4.1 Chapter outline

This chapter outlines a set of initial rough programme theories of what works to deliver positive youth sexual health approaches, under what circumstances and why. The focus of these initial rough programme theories is on what works to achieve local buy-in to positive approaches; this is the point at which local health service and relevant networks share a broad ambition to deliver services that uphold positive principles and reflect positive characteristics.

The chapter begins with a presentation of the method used for developing the initial rough programme theories. This describes the use of a broad conceptual framework of theories which were used as a scaffold to build initial rough programme theories. Concepts, relevant to my research question, were extracted from these theories and mapped against the data from the literature sources described in chapter three. These concepts and data were used together with the *theoretical model of social action*, introduced in chapter two, to inspire the creation of theory propositions. The initial rough theories are introduced within this chapter and include postulated contexts and mechanisms sufficient to bring about change in services towards a positive approach.

4.2 Methodology and methods

4.2.1 Overarching approach for building initial rough programme theories

In my review of positive approaches, described in chapter three, I identified an absence of programme theory which would enable me to meet my study's aims to understand what works to gain local buy-in to positive services, for whom, under what circumstances and why. Cycle one, of the research study, therefore also included building initial rough programme theories (IRPT) (Pawson, 2013;

Wong et al., 2017). For the purposes of this study, programme theories are the specific ideas about how a programme leads to a goal (Davidoff, Dixon-Woods, Leviton, & Michie, 2015; Funnell & Rogers, 2011). The IRPTs are nascent versions of these programme theories that were refined over research cycles two, three and four (Pawson, 2013; Pawson & Tilley, 1997; Wong et al., 2016, 2017) (see Figure 7 p.47).

Figure 11 illustrates the processes involved in developing the programme theory. The *theoretical model of social action,* introduced in chapter two (See Figure 6 p.44), outlined how, in general, prior conditions (structural, agential and cultural) may affect but not determine individual's choices, whose subsequent actions may reproduce or transform the conditions in which they are situated. As described, this is an explanatory framework, which guided the theory building but didn't explain anything itself. This chapter now describes how existing substantive theories were selected, with reference to the *theoretical model of social action,* to form a *conceptual framework of middle range theories.* The *conceptual framework* contained concepts pertaining to different levels of social strata (Westhorp, 2012) and common phenomena and interactions (guided by the *theoretical model of social action*) which condensed some knowledge about what was likely to influence change (Salter & Kothari, 2014). In other words, the *conceptual framework of middle range theories* comprised an initial set of concepts and relationships that I thought should be examined in order to explain what works to sustain local buy-in to positive services. The *conceptual framework of middle range theories* itself didn't specify the critical hypotheses of change (Kitson et al., 2008). The concepts and relationships from this framework were mapped against the data from the literature and policy review to develop IRPTs. These theories were denser and provided propositional explanations for what worked where and why.

I have previously articulated the advantages of this approach for large, complex and messy interventions, over building IRPTs from data alone (Shearn et al., 2017). In short, using the *conceptual framework of middle range theories* helped to contain the generation of initial ideas which could easily have become overwhelming and not feasible to test in this programme of study (Pawson, 2013). It provided a scaffold to support theory building. I suggest that this approach is also in keeping with realist methodology which posit that the job of

the evaluator is to make the ideas about how the world works ever more refined by building on previous theory (Pawson, 2013; Sayer, 2000). Similar approaches have been described to develop IRPTs based on existing theory (e.g. Herepath et al., 2015; Rycroft-Malone et al., 2012; Vareilles, Pommier, Kane, Pictet, & Marchal, 2015; Westhorp, 2013; Wilson et al., 2015). This study explicitly incorporates theories at different levels of social strata and suggests some initial criteria for selecting suitable theories.

The execution of the methods, described below, happened concurrently with the review described in chapter three. The same source material was used, but different data was extracted from it, as will be explained. The analysis was orientated towards developing initial causal explanations which could then be tested in the case study research reported in chapters 5-7.
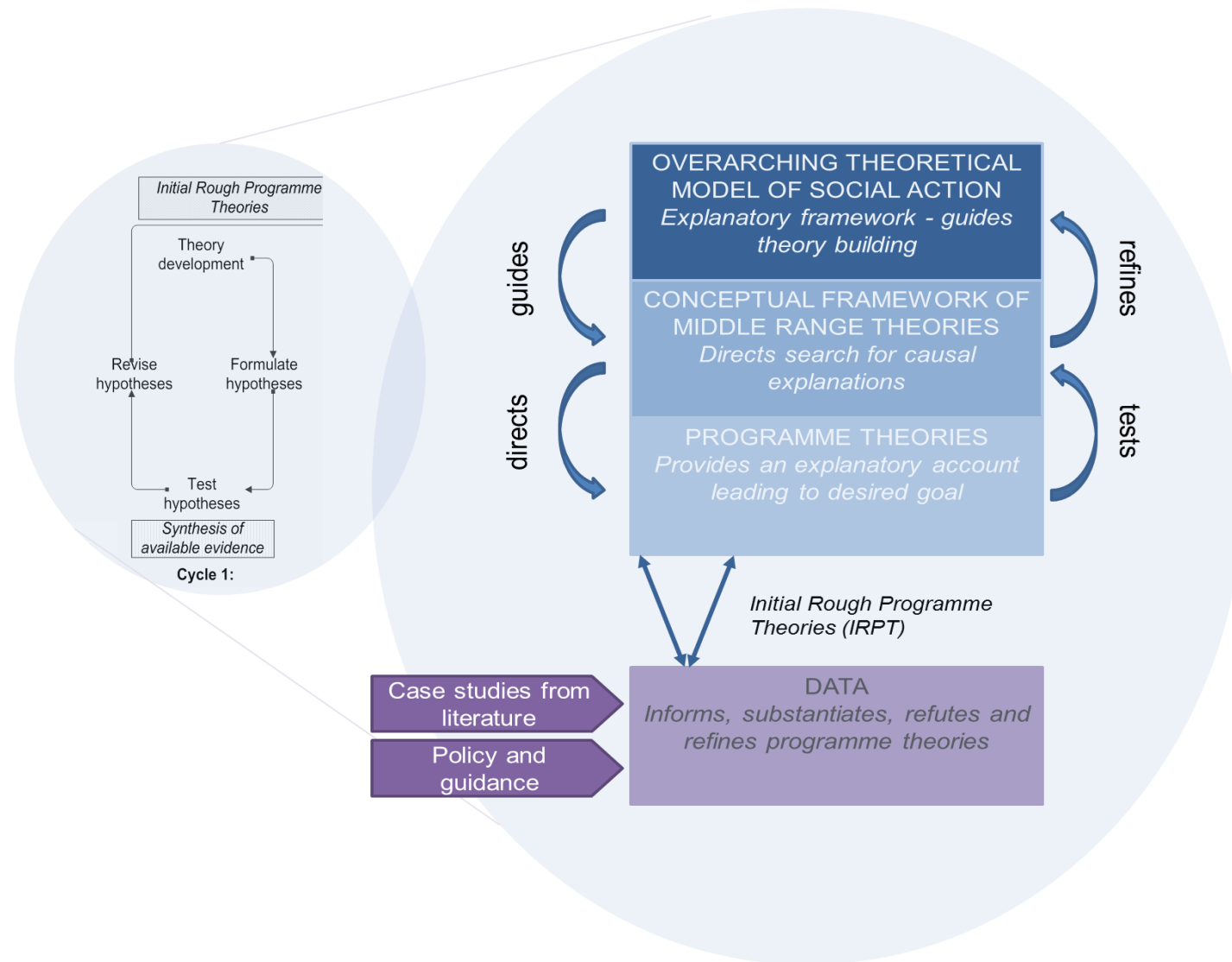
Figure 11. Building initial rough programme theories (Adapted from Walker and Avant (2005) and Shearn et al (2017)).

4.2.2 Identifying suitable theories for the conceptual framework of theories

An immediate task was to find abstract theories which would be suitable for the purposes described. Other practitioners of realist approaches have outlined the challenges associated with this, including the difficulty in choosing between the potentially large number of possible theories (Jagosh et al., 2014). I considered that these challenges could be great in this investigation as the 'intervention' was large and complex, with multiple components, layers and emergent phenomena which interact (Westhorp, 2012, 2013). To mitigate for this I worked at a more abstract level in the first instance. This facilitated the inclusion of broader constructs, complexity and detail without becoming overwhelmed.

At an abstract level the intervention could be described as an example of 'the adoption of a new, potentially controversial model of service, at a systems level'. I conducted a purposive search for abstract theories which might help to explain this general organisational change. I intended that my initial programme theories would correspond to multiple layers of social structure and so ensured the selected theories corresponded to or included concepts relating to macro, meso and micro level changes (Westhorp, 2012).

My search strategy for suitable theories was three fold:

- I reviewed the work of key scholars in sexual health service delivery to identify any middle range theories that they utilise.
- I identified scholars of realist accounts of similar service transformation efforts in health services. I reviewed their accounts for theories used to inform theory construction or validation. These accounts were identified via a systematic search of Scopus using search terms "realist evaluation", "realist synthesis" and "realist review". Results were then screened according to their relevance to health service transformation and their reference to any middle range theories.
- I asked colleagues in psychological and sociological fields for any suggestions of theories which might be useful.

This search resulted in the identification of a short list of 15 separate theories and frameworks (see Appendix 2).

As far as I was aware there is no realist guidance for selecting the most suitable theories from my short list, to help inspire my theory building. I therefore established four criteria on which to judge the theories to use to build the framework (Shearn et al., 2017) these are illustrated in Table 5.

Table 5 Criteria for selecting abstract substantiated theories to support initial theory building (Shearn et al., 2017).

Criteria	Explanation	Scoring
Social strata	The layer within the social system that the theory relates to. That is, the extent to which the theory offers guidance for explaining phenomena at or between micro, meso or macro levels	0 = unstructured 1 = layer identified 2 = one or more layer identified and relations between them explained
Fit	The theory's potential fit with the general programme aims. That is, the extent to which the theory offers guidance for explaining the likely phenomena observed when looking at the transformation of services	0 = no fit 1 = likely partial fit 2 = likely full fit
Utility	The theory's simplicity. That is the extent to which the theory could be readily utilised as an inspirational tool for data collection / analysis.	0 = highly complex, hard to understand and apply 1 = complex but easy to understand and apply 2 = simple concepts easy to understand and apply
Compat-ibility	The theory's compatibility with realist notions of causation. That is, the extent to which they offer guidance for articulating underlying causal processes.	0 = limited or no compatibility with key tenets 1 = compatibility with key tenets but not explicitly realist 2 = compatible and explicitly realist

I applied each of the criterion to the short listed substantive, formal theories and three were selected which were the highest scoring (the full list of theories and judgements against the criteria can be found in Appendix 2). Between the three theories, all relevant layers of social structure were included. The three theories were the Morphogenetic Approach (Archer, 1995), Normalisation Process Theory (NPT), (May & Finch, 2009) and the COM-B model of behaviour change (Michie, van Stralen, & West, 2011).

Archers' *Morphogenetic Approach* offers a range of ideas pertaining to social phenomena, at primarily macro and meso layers of society (1995). This theory arranges concepts related to social change or social stagnation in a chronological sequence which supported my theorising in relation to time. Concepts initially extracted to inform the *conceptual model* were:

- in the cultural domain: *'pluralism of ideas'* that is the availability of different ideas to decision makers.
- in the structural domain: *'crystallisation or marginalisation of opposition'*, *'superimposition of elites'* and '*stability or instability of structures'*. These refer to conditions in which new ideas can be assimilated into practice, (or otherwise).
- in the agential domain: *'strong or weak corporate agency'* and *'vested interests and opportunity costs'*. These refer to internal conversations and influence decision makers may have (or not), which may be necessary to bring about change.

In addition, *situational logics*, which refer to the possible relationships between different ideas and processes / practices, were compared to the events reported in the case studies. These will be introduced in the relevant chapters (see four, eight and nine).

May & Finch's (2009) *Normalisation Process Theory* (NPT) describes how organisations change to adopt new practices via social processes relating to implementation, embedding and integration. This is primarily a meso level theory operating at the level of how the work gets done to implement and

sustain new practices. According to this theory, a new approach can become routinely embedded in sexual health services via four broad 'mechanisms'[14]: coherence, cognitive participation, collective action and reflective monitoring (May & Finch, 2009). These broad mechanisms are comprised of conceptual processes. I extracted the concepts most relevant to the specific area of theory I was attempting to build, that is, what works to gain initial and sustained local buy-in to positive services. The extracted concepts were:

- *'differentiation'*: referring to how the new practice is defined by its differences.
- *'individual specification'*: referring to how people personally made sense of it.
- *'communal specification'* referring to the extent to which this conceptualisation (of the differences) is shared.
- *'contextual integration' (*within the 'collective action' construct) which relates to how the new practice links to other existing structures and procedures.

These specific ideas contributed to the conceptual framework of theories, but they were still interpreted and applied with reference to the whole of Normalisation Process Theory in recognition that they do not stand isolated from the other processes critical for embedding new practices.

The Behaviour Change Wheel is a tool devised by Michie and colleagues (2011) to distill individual behaviour change theories into a manageable framework for intervention design and evaluation. The central layer of the wheel, the hub, suggests that behaviour or action is the interaction of capability, opportunity and motivation (*COM-B*).

Concepts extracted from the behaviour change wheel related to sustaining local buy-in to positive services were:

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[14] May and Finch (2009) use the term 'mechanism' to refer to what people do and how they work, this differs from a realist definition (s) of mechanism which is the process by which the underlying powers of phenomena are actualised (Sayer, 2000) or individuals reasoning in response to the resources offered by the intervention (Pawson & Tilley, 1997).

- learning processes as a result of physical capability and / or opportunity via training of exposure to different models of care.
- psychological capability and automatic motivation to engage with the new material.

These theories suggest concepts which relate to different aspects of social action. Key conceptual areas on which the theories elaborate are highlighted below in Figure 12.
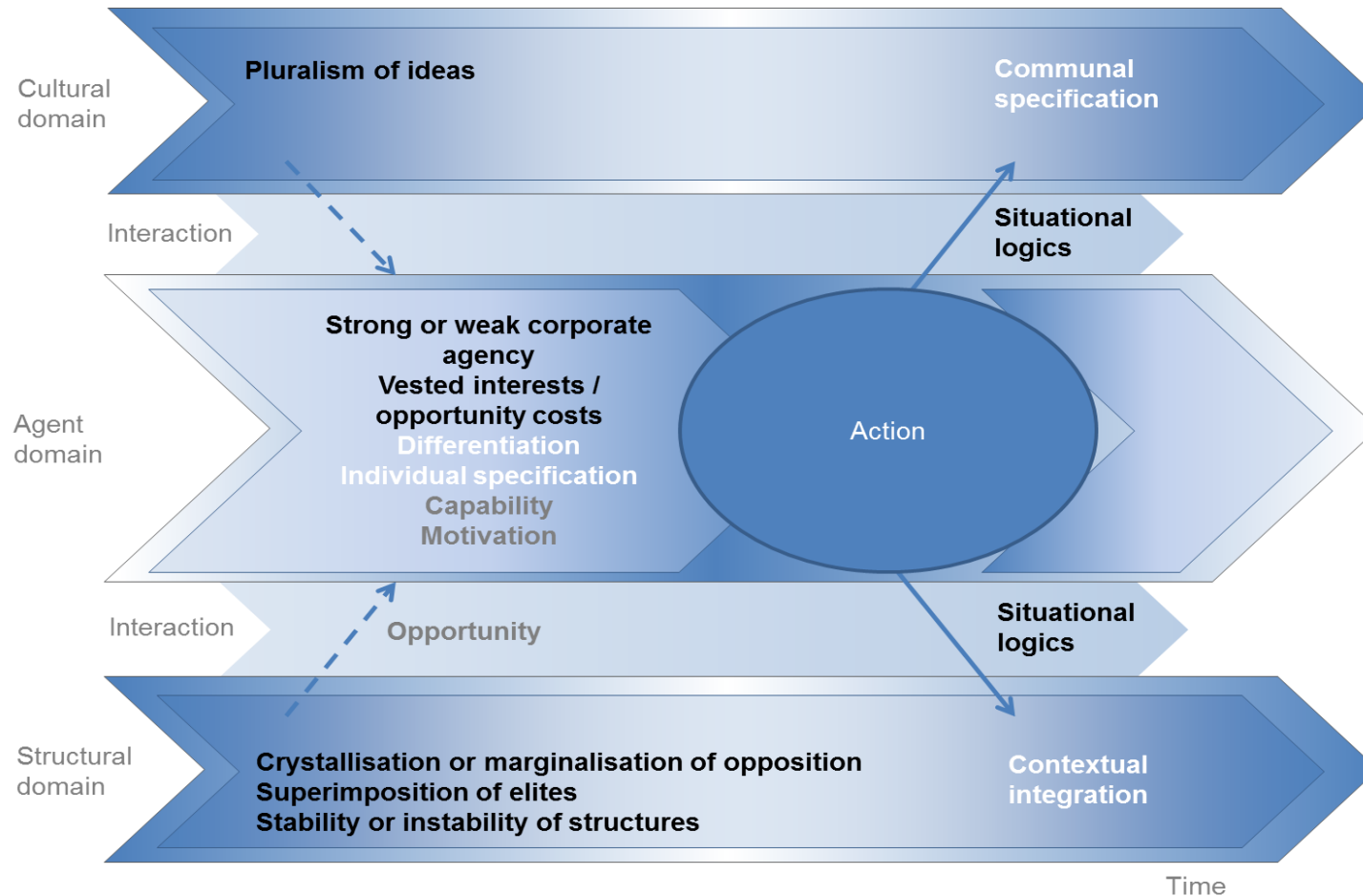
*Figure 12 Concepts from the conceptual framework mapped to the overarching theoretical model of social action. Text in **black** relates to concepts from the Morphogenetic Approach (Archer, 1995), text in white relates to concepts from Normalisation Process Theory (May & Finch, 2009). Text in grey relates to concepts from COM-B (Michie et al., 2011).*

4.2.3 Initial rough programme theory development

With the developed conceptual framework, the next stage was to analyse the academic and policy literature that had been selected using the process described in chapter three. I extracted data relevant to concepts concerning local buy-in to positive approaches; this was done using a loose deductive coding framework based on the conceptual model of theories and principles and characteristics from the defining stage (see Appendix 3 for the coding framework). This framework was flexible and codes were added iteratively where data did not fit.

Theory propositions were then developed as follows. Where data from the literature supported the theoretical constructs I developed statements which related to how, when and why positive approaches became differentiated from other models of care, actors and agents developed conviction in the approach, and through what possible mechanisms the approach could be integrated into the social context. Explanations were derived by iteratively hypothesising how local buy-in could be achieved based on a theoretical understanding of what mechanisms and conditions are favourable (retroduction) and by identifying and interpreting causal features in the literature (abduction).

I then connected the theory propositions together, with reference to the overarching theoretical model of social action to provide an explanation of local buy-in to positive services. More propositions were developed than could have been tested in the empirical stage so I focussed on individual decision making (primarily) because this would be possible to refine in the participant interviews. The other propositions have been summarised and are provided in Appendix 4.

4.3 Results

4.3.1 Introducing the theory themes

Three theory themes collectively captured the initial ideas about the underlying processes leading to local buy-in to positive services. They were: 1) *Clarity*, the participants have a clear idea of the notion of positive sexual health 2)

Conviction, the participants have a commitment to that notion and 3) *Coherence,* this notion and commitment cohere with cultural and structural aspects of the social context.

4.3.2 Theory theme one - Clarity

Proposition development based on the conceptual model and data from the literature reviews - clarity

This section is the first in the set that relate to the theory theme of clarity. This section, informed by the *conceptual model of middle range theories* concerns the extent to which a positive approach is *differentiated* from other models of care. Furthermore this theory theme refers to how people *interpreted or made sense* of the approach. This theory theme relates largely to interactions of social entities proceeding from the cultural and structural realm to the agential realm and the internal conversations that ensued.

Differentiation

Concepts from the broad conceptual framework relating to differentiation

Normalisation Process Theory suggests that 'Differentiation' relates to distinctive features which distinguish it from other 'established' practice and that holds together well enough to be operationalised (May & Finch 2009).

Archer describes the phenomenon of 'ideation opposition' within the cultural realm, that is, ideas which diverge from the hegemony. There must also be 'crystallisation of opposition' in the structural realm - that differentiated groups have enough power to introduce and then sustain specialised ideas (Archer, 1995, p. 315).

COM-B and the Behaviour Change Wheel explain how meaning can become established through 'learning processes' (Michie et al., 2011). Broadly, this understanding may be as a result of physical capability and opportunity via training or exposure to different models of care and, psychological capability and automatic motivation to engage with the new material (Michie et al., 2011).

Both strategic and evaluative sources from each of the case studies, Oregon, Lothian and London, identified within the literature review, contained data relevant to differentiation. This theory development is also supported with data from professional and advocacy bodies' policy and guidance documentation.

Nystrom and colleagues (2013), who were embedded in the work of the Oregon Youth Sexual Health Plan, reflected that there was a *shift* from 'risk-focussed' to a 'youth development' framework. The language that was used in strategy documents reinforced this change, for example, approaches were 'broadened' from single issue policies to comprehensive care (Oregon Department of Human Services, 2009b). There was also an emphasis on changing attitudes from seeing young people as part of the problem to seeing them as people who can meaningfully contribute to society (Oregon Department of Human Services, 2009b). This process, being led by public health commissioners in local government, may indicate that there was 'crystallised opposition', in Oregon to sex-negative approaches, that was a clear group with enough power to introduce other means of working.

In Lothian, both the organisers (Healthy Respect, 2005) and the evaluator (Elliott et al., 2010) suggested that the intention of the health demonstration project was to be 'innovative'. The strategic aims of the programme included the need to create an environment that would lead to long term improvements through explicitly linking education, information and services (Healthy Respect, 2005). The vision for the service highlighted a new strategy: t*o "help young people in Lothian develop a positive attitude to their own sexuality and that of others, and a healthy respect for their partners"* but, arguably, did not clearly distinguish it from alternative models, particularly as the aims still reflected narrow and clinical outcomes *of reducing unplanned teenage pregnancies and sexually transmitted infections* (Healthy Respect, 2004).

The reports of the service outlined some of the ways in which Healthy Respect did attempt to realise this positive vision. The Healthy Respect Two proposal (Healthy Respect, 2005) proposed to provide new forms of working, including partnership models and networking opportunities, it also described the need to meet the youth-determined 'All I want' standards (Healthy Respect, 2005).

These standards suggested a range of things that *would make services better* including: looking at the whole person, have special young people's services, help young people not to be ashamed about using services, know more about who uses services, improve access with more clinics and accessible facilities, tell more people about specialist services, give better information and listen to young people (Healthy Respect, 2004). None of the documents provided an overarching set of principles that could have helped practitioners specifically distinguish it from other models of care.

Evaluators of the London Case Study outlined that the Modernisation Initiative, which financially supported the transformation, set some specific aims about their expectations. It was intended to make a 'big difference' represented by novel services and cultural change which would be reflected in the balance of power between organisations, staff and users (Greenhalgh et al., 2008). What this should look like was not made explicit as the intention was for local stakeholders to determine its development.

Current English and International policy were also not specific about how positive approaches might differ from other models of care. This led to the development of the first theory to be tested in the empirical study relating to the importance of clarifying how positive services might differ from other models of care.

This data was condensed into an initial proposition relating to processes of differentiation as illustrated below.

IRPT 1a: Differentiation

Where principles and characteristics of positive approaches are made explicit, via training or illustrations of other models of care, commissioners, managers and practitioners will be able to distinguish this approach from other models of care.

Concepts from the broad conceptual framework relating to sense-making

Normalisation Process Theory suggests that individuals may distinguish the new approach from existing approaches in work related to *individual specification*. This means individuals understanding how it might affect their day to day roles and responsibilities (May & Finch, 2009).

The three case studies differed according to the extent to which local 'sense-making' was directed.

In Oregon, policy was non-prescriptive in how individual agencies (and by extension, practitioners) should make sense of these principles in the context of their day to day practice (Nystrom 2013). The strategy suggests that stakeholders across the state, who led different agencies working with young people, should self-reflect and adjust 'thinking, language, programs, policy and measurement' accordingly (Oregon Department of Human Services, 2009a).

Similarly in London, evaluators reported that how the Modernisation Initiative should be operationalised was to be locally defined (Greenhalgh et al., 2009). The evaluation further detailed that an extensive consultation was conducted with a range of stakeholders. This highlighted that existing services were experienced as, variably,

> *"inaccessible, inconsistent, staff-centred, designed around a medical model of disease, culturally naïve, disjointed, hierarchical and inefficient" (Greenhalgh et al., 2008)*

The vision for transformation was therefore set out as services to be:

> *"more accessible, evidence-based, patient-centred, designed around a holistic model of illness and risk, culturally congruent, integrated, collaborative and efficient" (Greenhalgh et al., 2008)*

This may illustrate that project leaders had clearly outlined the desired differences between the new and old model, although it is not clear how this vision was communicated, nor whether this vision was suitably clear for individual practitioners to understand how it might change their roles. Indeed, the evaluators subsequently make clear that divergent views persisted and some clinical practitioners failed to see an alternative to the model in which they currently operated (Greenhalgh et al., 2008; Macfarlane et al., 2011).

In Lothian, the final evaluation report (Elliott et al., 2010) highlighted that a more 'top-down' approach was introduced whereby the Healthy Respect team were assigned leadership amongst a multi-agency, multidisciplinary team. This meant that dissemination of the approach was potentially more consistent. However, this same evaluation questions the extent to which partners, less closely connected to the NHS roots of Healthy Respect, bought into the idea and made sense of it themselves (Elliott et al., 2010). This suggests that where the idea comes from or who the 'messenger' is may play a role in stakeholders' buy-in.

These results informed an IRPT regarding individual specification and how it might be brought about. The results from the academic case studies suggested that there will be contexts in which some do and some don't specify a positive approach in terms of how it affects their practice. This was therefore one avenue of exploration in the empirical study.

IRPT1b: Individual specification

When directed to do so, commissioners, managers and practitioners will be able to make sense of the principles and characteristics of a positive approach and understand how it might affect their day to day roles and responsibilities

These initial theories are depicted below in figure 13, transposed to the overarching theoretical model of social action.
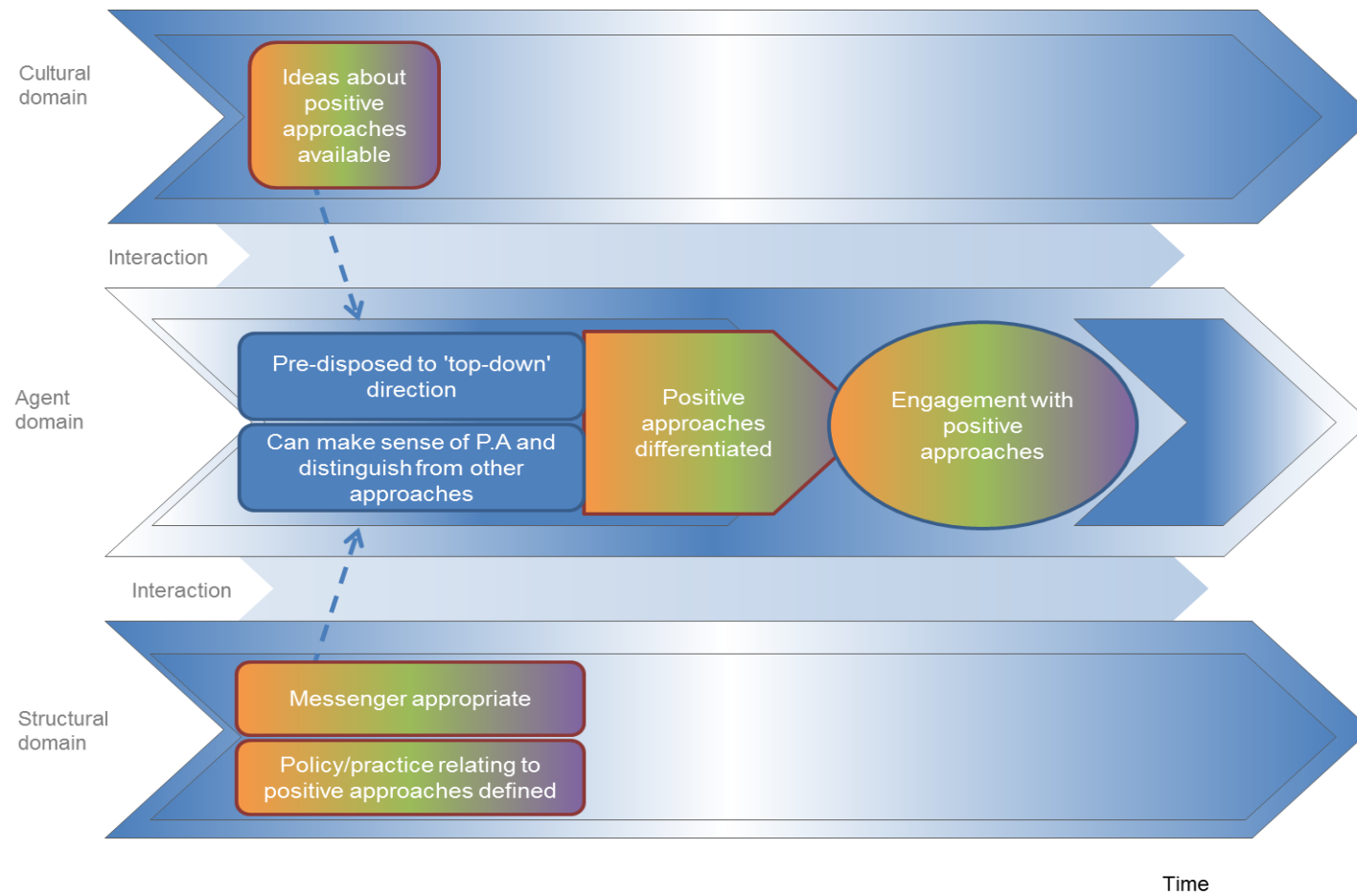
Figure 13. Propositions relating to clarity and engagement with positive approaches

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4.3.3   Theory theme two - Conviction

Proposition development based on the conceptual model and data from the literature reviews - conviction

This next set of theories concern the extent to which individuals come to value a positive approach and/or have conviction in its utility to meet the outcomes they are most interested in. This theme primarily refers to reasoning and reflexive processes that operate within an individual actor.

Concepts from the broad conceptual framework relating to conviction

Theoretically there is agreement that decision making is not a strictly linear or rational process.

Michie and colleagues (2011) COM-B model define habitual processes, emotional responding and analytical decision-making within their motivation construct. The Behaviour Change Wheel references two processes 1) 'reflective motivation' towards a course of action "may be achieved through increasing knowledge and understanding and eliciting positive (or negative) feelings about behavioural target" and/or 2) 'automatic motivation' towards a course of action can be achieved through associative learning that elicit positive (or negative) feelings, impulses and counter-impulses relating to the behavioural target, imitative learning, habit formation (Michie et al., 2011)

This tallies with concepts in the overarching theoretical model based on Archer's Realist Social Theory relating to internal conversations (reflective motivation) and 'habitus' (automatic motivation).

Data from the literature review appeared to offer some support that conviction in positive approaches is important for gaining and sustaining local buy-in to positive services. It did not offer strong evidence, however, because the papers were not designed to detail the psychological processes underpinning people's decision making. Two processes suggested by the concepts from the

conceptual framework were supported. Conviction may be brought about by 1) a belief that a positive approach can meet their own objectives (reflective motivation) and/or 2) a favourable match between the values implied in the approach and the actors' values and/or those of the organisation in which it is being implemented (automatic motivation). These will be explored in more detail below.

Synergy with objectives (reflective motivation)

The WHO's *Framework for Sexual Health Programming* (2010a) highlighted the "growing consensus that sexual health cannot be achieved and maintained without respect for and protection of, certain human rights". These rights reflect the principles and characteristics suggested as indicative of a positive approach. It can therefore be implied that this document suggests that a rights-based approach is the only successful approach that should be considered to improve sexual health and wellbeing. In support of this claim WHO (2010a) outlined evidence that, for example, enabling young people to take an active role in the development of programmes which concern them can increase its effectiveness by ensuring their suitability.

In Oregon, the strategy document and appendix of the Youth Sexual Health Plan made the claim that a positive and holistic approach '*is necessary'* to improve sexual wellbeing (Oregon Department of Human Services, 2009b). It gave the example that experiencing discrimination in everyday life may make it difficult for some young people to gain knowledge and skills and access services for fear of being judged (Oregon Department of Human Services, 2009a). It also linked to other policy areas with the aim of reducing gender inequities, poverty and discrimination because it recognised that sexual wellbeing may be affected by more than just health services. It can therefore be inferred that those who developed the plan wanted to improve young people's sexual wellbeing and believed that a positive and holistic approach *was the best way* to achieve this, hence writing it into the strategic plan.

In London, the evaluators reported that the objectives for the Modernisation Initiative were agreed at the outset. This included improving on measures relating to organisational processes, sexual ill-health as well as increasing opportunities for building knowledge and self-management (Greenhalgh et al.,

2008). According to MacFarlane (2013) who published a report focussing on sustaining institutional change, those that argued for a community-focussed pathway did so in the belief that a wide variety of sexual health problems are manifestations of common upstream causes, for example, coercive relationships or low health literacy and disadvantage. They favoured a social model of health, characterised by a one-stop shop with and focus on holistic sexual health education to prevent the same or other sexual health problems from occurring in the future (Macfarlane et al., 2013). In this case, it can be inferred that those who developed the approach wanted to reduce the incidence of young people's sexual ill-health as well as build their sexual wellbeing and believed that a holistic, early intervention approach may meet that end. Conversely, Macfarlane reported those in London who did not favour the community-focussed pathway had conviction in a high quality medical model, with each speciality keeping its designated area to meet the service objectives (Macfarlane et al., 2013).

In Lothian, the second Healthy Respect (2005) proposal outlined the belief that improving the environment, cultural attitudes and increasing access to sexual health services through the Healthy Respect project would improve sexual health outcomes but does not provide any detail about why this should be the case. The strategy document that preceded it, from the Scottish Executive (2005), indicated that 'teenage' conceptions and STI rates would be managed through building self-respect, respect for others and strong relationships.

This data informed the development of the next IRPT which stated that:

IRPT 2a

When practitioners engage with a positive approach, they will judge the extent to which it will help them meet their ends. These may be personal or organisational objectives. They will only have the intention to embed its principles and features in their own work if they believe it meets their ends or those of others.

Compatibility with values (automatic motivation)

An alternative explanation for the development of conviction was also developed relating to compatibility with values.

In Lothian, the second evaluation of Healthy Respect (Elliott et al., 2010) highlighted that cultural values were seen as highly important to its successes and contributed to some of its challenges. The evaluation report identified that the Healthy Respect brand was seen as supporting liberal values which were broadly recognised and welcomed by those in the NHS (Elliott et al., 2010). However, these same values apparently contrasted with one of Healthy Respect's projects, which was based in the Catholic Church, where the liberal values were not accepted. As a result this particular project was difficult to implement. Similarly, the evaluation report claims that those who were dealing with vulnerable young people, prioritised safeguarding and disagreed that a positive universal approach was suited to all (Elliott et al., 2010). The evaluators of Healthy Respect Two recognised that where there is a clash in values this may be hard to overcome. They highlighted that cultural values were often reinforced by community norms which, in turn, were deeply ingrained within communities (Elliott et al., 2010).

The Oregon Youth Sexual Health Plan appeared to specifically set out to challenge practitioner assumptions about young people and youth sexuality. As noted above, this meant recognising that young people themselves were not inherently part of the problem and that it should be an adult's role and responsibility to support and empower them (Oregon Department of Human Services, 2009a). Further to this the strategy outlined the need to train staff to address unconscious bias, judgemental attitudes and to support youth development philosophy. This implies that they expected a clash in values between the approach and some quarters of the delivery staff which they felt the need to address in the implementation of the plan (Oregon Department of Human Services, 2009a).

These data, together with concepts from the conceptual model informed the following initial rough theory proposition.

IRPT 2b: Compatible with values

When practitioners engage with a positive approach, they will begin to judge it against their values and only have the intention to embed its principles and characteristics in their own work if they deem the values on which it is based to be compatible.

The development of IRPT2a and IRPT2b raised the possibility of whether or not people were supporting a positive approach primarily because they thought it would 'work' to improve sexual health (that is as a strategy to reduce incidence of sexual ill-health), or because they thought it was the 'right' thing to do to uphold the human and sexual rights of young people. The final theory in this theme related to a combination of the two which, it was hypothesised may result in an increase in strength of opinion, or 'conviction', in the approach.

IRPT2c

When practitioners engage with a positive approach and judge it as an appropriate way to meet their objectives and as compatible with their values they will develop a strongly held conviction in its promise. This will strengthen the intention to embed the principles and features in their work.

This could not be established via the sources from the literature review alone and the lack of attention to the judgements and ethical decision making of service designers and those who deliver such services warranted further investigation as will be seen in chapter seven.

The concepts in this theory theme are illustrated below demonstrating how they relate to each other and the different levels of social structure.
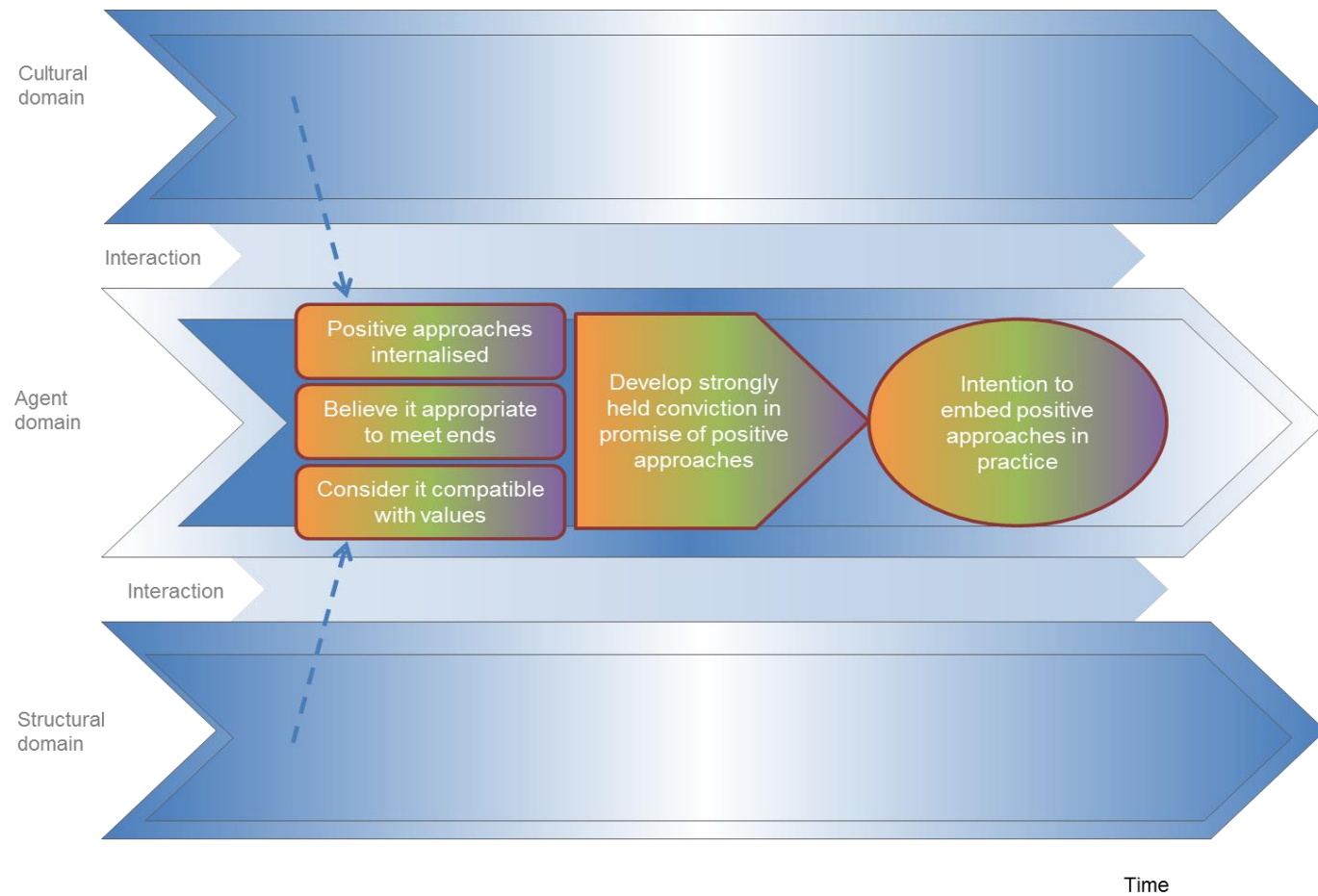
Figure 14. Propositions relating to conviction in positive approaches.

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4.3.4 Theory theme three - Coherence

This set of theories concerns how a positive approach might be integrated into a social context. This theory theme is about the interaction of individual and social level phenomena which make it possible for individually held conviction to be shared with others and the characteristics of a positive approach to be incorporated at an organisational level. There are two aspects of this theory theme: *cultural coherence*, relating to shared ideas and understanding and; *structural coherence*, relating to contextual integration.

Concepts from the broad conceptual framework related to cultural coherence

Normalisation Process Theory suggests that for local buy-in to be achieved, the approach must be *understandable to* and *shared by* the people whose work might concern it, for example, commissioners, managers and practitioners of a local service. May and Finch describe this as *'communal specification'* (May & Finch, 2009). Following on from this, is the way in which actors understand the actions of people around them, described as *'relational integration'*.

Archer also provides concepts which are relevant to this theme.

First, Archer outlines that different agents have access to different resources as a result of their different *bargaining power* (Archer, 1995, p. 298). This may be important to changing to a positive approach because buy-in may depend on the relative *agency* of those in the advocacy group compared to other groups.

The second relates to situational logics (Archer, 1995, p. 216), that is, the relationships between ideas in which there is tension or coherence. She proposes that where there is a logical and necessary link between ideas in a specific cultural system, there are two situational logics:

1) Cultural beliefs and ideas that are compatible may be *concomitant complementarities* (Archer, 1995, p. 234). In these cases there will be ongoing

processes of clarification and strengthening. Everybody has something to lose from disrupting the cultural status quo which gives rise to a defensive mode of interaction and situational logic which 'protects' the ideas (Archer, 1995, p. 219). In these cases one can expect morphostasis i.e. lack of change in the cultural realm.

2) Cultural beliefs that are in conflict with each other are '*constraining contradictions*'. (Archer, 1995, p. 230). This is where there is poor integration of ideas. The tension, in an orderly social system, is ultimately resolved by 'corrective' interactions that is, 'correcting' one or both of the ideas so that they are compatible with each other.

Where there is disorder at the socio-cultural level there are two further situational logics

3) Cultural ideas that are compatible but do not rely on the same underlying structures give rise to *contingent complementarity*. This gives rise to 'opportunistic' modes of interaction

4) Where the new idea is logically inconsistent with the existing idea such that the actor is forced to choose between them a *competitive contradiction* would arise (Archer, 1995, p. 244). This gives rise to a situational logic of 'elimination'. This is where greatest gains on either side give rise to maximum injury on the other (Archer, 1995, p. 225).

Proposition development based on the conceptual model and data from the literature reviews - cultural coherence

I was alerted, through an email exchange with a long standing public health officer that, over a number of years, practitioners went on study trips to places in Europe with better rates of sexual health. These trips were apparently

sponsored by an external charity *Advocates for Youth*[15]. The trips were apparently designed to support practitioners to learn about the so called positive, holistic approaches to sexual health education, support and services in these countries which, it was claimed, these rates could be attributed to. The public health officer explained that this meant that successive waves of practitioners in the region received relatively standardised exposure to positive approaches. These practitioners apparently became a network for each other, all sharing similar beliefs and values about positive approaches. As teams initiated positive approaches and began to value them, they became advocates for it enrolling others. This broad, shared agreement served as a bedrock for the development of the Oregon Youth Development plan. It could be inferred therefore that a process of reciprocal *communal specification* led to shared values and understanding of positive services.

In Lothian, the Healthy Respect final evaluation (Elliott et al., 2010) suggested that the project was much more successful in embedding the values and work of a positive approach in the local NHS organisations, which they themselves were part of, than with other organisations. Evaluators of the programme (Elliott et al., 2010) related this to the broadly shared liberal values within the NHS. This may be an example of '*concomitant complementarities'* where, at some level, both the existing NHS staff and Healthy Respect work to protect the liberal ideals of the NHS.

Evaluators of the London Modernisation Initiative (Greenhalgh et al., 2012; Macfarlane et al., 2013) commented that conflict arose during implementation given that modernisation 'meant' different things to different stakeholder groups. As previously outlined, MacFarlane (2011) and Greenhalgh (2008) and colleagues reported that the consultant team was in favour of retaining the traditional medical model but renovating the premises in which they operated. The community clinicians and health promotion staff had favoured a flatter structure and ensuring that socio-relational aspects of sexual health had equal priority with medical aspects of sexual health. This incompatible set of ideas led to conflict. In addition, the new ideas challenged previously held assumptions

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[15] There is an account of the benefits and learning derived from these trips (Berne & Hubermann, 2000). This account was not included in the review because it does not specifically detail the development of the Oregon Sexual Health Plan.

that everyone had agreed with the existing structure which created further interpersonal tension (Greenhalgh et al., 2008). The consultant team may have felt threatened by the proposed change as this would have meant them losing status compared to other colleagues. Macfarlane and colleagues (2013) reported that one GUM consultant had begun to develop conviction in a flatter structure, as advocated by the community clinicians and health promotion staff. However, other GUM consultants considered that she had 'sided' with the community clinicians, and were hostile towards her. Eventually, this led to her being removed from management structures (which were dominated by GUM consultants) and she left the Trust soon after. MacFarlane (2013, p. 15) reported one community clinician's comments:

> *"men in grey suits, or whatever, went to her and said this is crazy, you're going out saying we don't need microscopes, we don't need the hospital, who do you think you are?"*

This anecdote illustrates the possibility of competitive contradiction which can give rise to 'elimination'. Ultimately, however, the community clinicians were successful in implementing a flatter structure. Macfarlane (2013) suggested that this may be because *'wider national policy initiative to replace traditional hierarchical, secondary care led genito-urinary medicine services with inter-professional sexual health networks'* were prevalent at the time. In Lambeth, one area that was covered by the initiative, the evaluation highlighted that clarity around the vision shared across the team for an approach where 'people will be enabled to effectively manage their own sexual health by easy access to information, resources and excellent services' was seen as a key driver for success (Miles, 2010).

MacFarlane (2013) suggested several causal processes operating in this example which I have reinterpreted in line with the Morphogenetic Approach. They propose that deeply held professional identities, and structural hierarchies, which may preclude changes in the structural realm may be partially overcome by an additional resource stream which supports an alternative structure as was seen by the injection of money from the Modernisation Initiative. This may be an example of *contingent compatibilities* allowing for 'opportunism'. However, Macfarlane (2013) continued, this was still unstable as key actors, the hospital

consultants, did not find the new structure legitimate. This may be an example of *necessary incompatibilities* leading to 'compromise'. Macfarlane (2013) contends that in this particular time context, wider policy, that is the move toward collaboration and patient centred care, eventually supported the service transformation. This may be an example of *contingent compatibilities* giving rise to 'opportunism'.

These concepts and ideas were configured into initial rough programme theories, as summarised below and depicted at Figure 15.

Cultural coherence

IRPT 3a

When commissioners, managers and practitioners, who intend to embed a positive approach in their work share an understanding with other local decision makers and pursue the same goals, they will be motivated to work together as this will enhance their chances of success

IRPT 3b

When there is a clash between the existing cultural and the new idea and the advocacy group have high corporate agency, by virtue of their own role and status, ideas and processes relating to the more traditional approach may be 'eliminated' and a positive approach imposed.
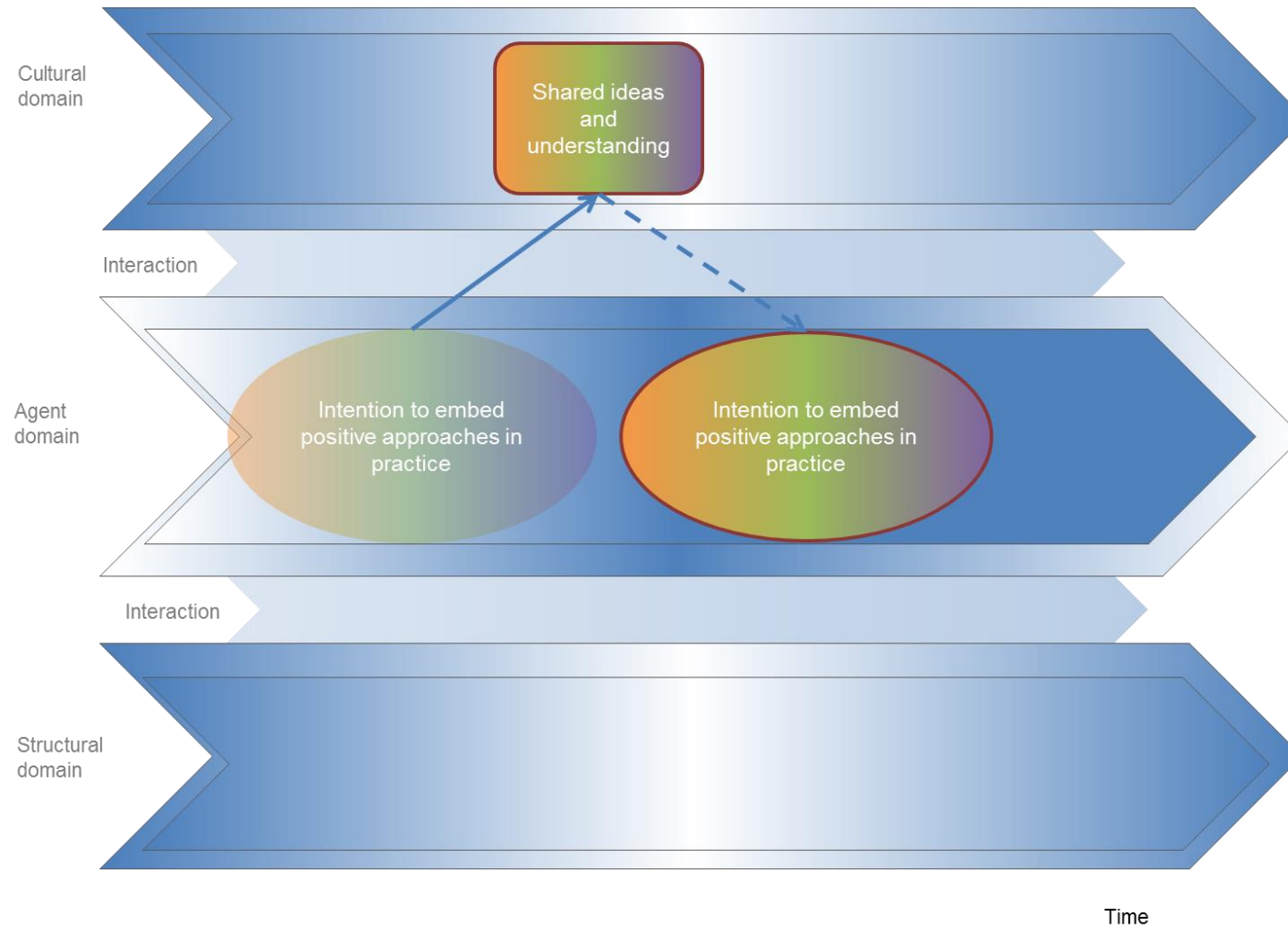
Figure 15. Propositions related to cultural coherence

Proposition development based on the conceptual model and data from the literature reviews - structural coherence

Concepts relating to structural coherence are now outlined.

Concepts from the broad conceptual framework related to structural coherence

Two concepts were extracted from Normalisation Process Theory which related to how a positive approach might be operationalised. Firstly how it will affect the 'normal' pattern of work, that is, its *interactional workability* and how it might be integrated with the existing social context - *"contextual integration"*.

Archer proposes four illustrative situational logics, which mirror the cultural concepts described above, which may explain compatibility or tension in the structural realm

1) Where a positive approach is seen as mutually reinforcing the existing structure (Archer, 1995, p. 219) there will be a *necessary complementarity.* In these cases a positive approach would reinforce the existing system and would give rise to a situational logic of 'protection'.

2) Where the new approach is necessarily and internally linked to the existing structure on which they both depend there can be '*constraining contradiction*'. (Archer, 1995, p. 230). This would be where the new approach is seen as necessarily and internally linked to the existing structure, but that there is incompatibility, in that not all groups' vested interests can be promoted by the interaction of the new and old approaches (Archer, 1995, p. 222). This gives rise to a situational logic of 'compromise' because overhauling the structure would be prohibitively risky for all agents involved.

3) Where the new approach is not necessarily and internally linked to the existing structure and where it has divergent interests there is a *contingent incompatibility*. This gives rise to a situational logic of 'elimination'.

> 4) Where the new approach is not necessarily and internally linked to the existing structure but where it has compatible interests there is a *contingent compatibility* and a situational logic of 'opportunism'. This is where the new approach may be supported alongside the existing structures assuming the resources are sufficient to maintain both (Archer, 1995, p. 226).

Proposition development based on the conceptual model and data from the literature reviews - structural coherence

Several elements of the pre-existing context (or first order emergent properties of previous morphogenetic cycles, as Archer would put it), were frequently cited as important conditions effecting buy-in to positive approaches. These were prioritised, with reference to the literature review, and following input from the local sexual health network, although it should be noted that this is not an exhaustive list of all contextual factors. The aspects of social structure elaborated here are 1) the nature of evidence and accountability, 2) a precedent for multi-disciplinary, collaborative team working and 3) user involvement.

Evidence and accountability

The Lambeth evaluation of the Modernisation Initiative (Miles, 2010) describes one of the key objectives was *to establish a network that enables services to work together to consistent evidence based standards of service provision*. Developing a robust, credible evidence base was positioned as a key desirable outcome in the realist evaluation of the Modernisation Initiative.

However, what counted as 'evidence' was varied. According to the realist evaluation (Greenhalgh et al., 2008), published evidence was rarely sought by those implementing the service modernisation which was attributed to the fact that individuals were not skilled at reviewing the evidence, initial searches were fruitless or there was not sufficient time to do it well. In addition, baseline metrics that were 'important, practicable and valid' were considered by the implementers and evaluators to be hard to attain and interpret (Greenhalgh et

al., 2008)[16]. The evaluation team suggested that a staff survey, whilst methodologically flawed, increased perceptions amongst the staff that their views were important. This appeared to encourage them to buy-in to the service model (Greenhalgh et al., 2008). Qualitative methods were employed to understand the experience of users. In addition service developers had the opportunity to visit systems elsewhere to gain insight and learn about alternative models (Greenhalgh et al., 2009). It can be inferred therefore that whilst the broader structure demands evidence based practice, the nature of the change in question (that is, whole system transformation), the complexity of the topic, (that is, sexual health) and the potential skills and capacity of practitioners involved in collecting it made this a hard objective to meet.

In Oregon, London and Lothian, the new approaches were intended to be measured against existing outcomes indicators relating to youth sexual health, such as rates of under-18 conceptions (Macfarlane et al., 2013; Oregon Public Health Division, 2014; Tucker et al., 2007). This meant that the approach had to be integrated with existing forms of data gathering and accounting. Two issues arising from the use of measures such as hard outcome data such as under-18 conceptions reported by the various evaluators are that they do not adequately encapsulate the breadth of sexual health issues (Greenhalgh et al., 2009; Tucker et al., 2007) and that they can direct attention to activity whose purpose is to alter the indicator not to improve sexual health more broadly (Elliott et al., 2010; Paterson, 2007). It can be inferred therefore that accountability focussed on these measures, as opposed to other measures such as access, satisfaction and socio-relational outcomes, may have affected commitment to the positive approach. The relationship between the new approach and the existing monitoring system may be seen therefore as a *necessary incompatibility*.

My analysis of the current policy also supports this theory. There was no requirement for local authorities or health services to act on the positive aspects of the English policy and meet the diverse needs of all young people

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[16] Several difficulties in measuring sexual health outcomes are detailed. For example, rises in STI positivity rates at any one clinic could be down to: an increase in prevalence, an increase in clients due to improvements in the service environments, better diagnostic services, more acceptable modes of testing, changes in NHS capacity for testing (Greenhalgh et al., 2008).

(Department of Health, 2013a; Public Health England & Association for Young People's Health, 2015). There was also little justification to collect data or account for activity in this area. Logic suggests that without broadening the data collected, there will always be a limited evidence base to support positive, inclusive approaches. Conversely, data was required to satisfy the Public Health Outcomes Framework indicator set (Department of Health, 2013a; Public Health England, 2015). These indicators were used to benchmark local authorities (Department of Health, 2013d) which means they may effectively become targets influencing the prioritisation of service activity.

Teams in Lothian and Oregon attempted to compromise by introducing new measures such as those relating to self-efficacy and gender equality (Healthy Respect, 2005; Oregon Public Health Division, 2014). However, in London, the full evaluation report highlighted that it is difficult and sometimes impossible to identify valid metrics because of shifting denominators (Greenhalgh et al., 2009). For example, what constitutes positive sexual health for one person may be different for another.

The ideas relating to evidence and accountability can be summarised in the following theories.

Structural coherence - evidence and accountability

IRPT 3c

Where evidence based practice is strongly recommended, positive approaches may not be deemed acceptable, as they may not have a suitably strong evidence base. In these cases, practitioners are compelled to develop a credible, alternative or additional evidence base to substantiate its wider claims.

IRPT 3d

When commissioners, managers and practitioners believe that a positive approach is the best way to meet the pre-existing organisational objectives such as reducing teenage conceptions and STI transmission rates (theory 2b), work will be orientated towards and evaluated against measures related to these outcomes. If outcomes do not improve, this may pose a threat to a positive approach because organisations are orientated towards demonstrable successes.

Integrated provision

All of the case studies stressed the need for integrated collaborative team working, something which they considered inherent in a positive approach.

Collaboration resulted in relational tensions, as described by the evaluators in London (Greenhalgh et al., 2008), or was highly beneficial with shared learning and alternative ways of looking at things (Elliott et al., 2010). The evaluation of the Modernisation Initiative accepted that given that the dominant model of care was based around a medical model of health, which naturally places doctors in positions of power, adopting true multi-disciplinary and collaborative team working required substantial work (Greenhalgh et al., 2008) .

The second evaluation of Healthy Respect provided some insight as to how the Healthy Respect team engaged with providers (Elliott et al., 2010). Many of the services that they targeted were funded separately. The Healthy Respect team provided training, support and advice to engage and develop shared understanding of the approach. Its leadership role was recognised and they were viewed as championing and raising the profile of sexual health locally (Elliott et al., 2010). As noted, those who benefited from the training and support most were from the NHS. Elliot et al (2010) attributed this success to ease of building natural alliances where structure and goals were shared. Elliot and colleagues (2010) further reported that The Healthy Respect team were also successful in building relationships with other organisations whose core business was providing sexual health services and who occupied key positions

in the local networks already. This suggests that where core goals overlap, collaborative working is more easily achieved. Elliot et al (2010) indicated that another important aspect of success in this area appears to be time. This may be because collaborative team working is based on interpersonal relations as well as structural compatibility, which take time to develop.

In London, evaluators highlighted 'integrating services across providers' as one of their key mechanisms for giving a seamless and consistent patient experience (Greenhalgh et al., 2008). They highlighted a number of features that may support this. These were, interpersonal trust, a history of collaboration and compatibility of values, approaches that are imaginative, locally responsive solutions, the ability to 'unbundle' funding, negotiable and technology supported, boundary spanning roles, gathering of diverse opinion, providing a space for networking, shared guidance and protocols, external incentives that reward collaboration, using 'soft' and 'hard' approaches, and approaches that are negotiated and owned by all stakeholders and not imposed by one party (Greenhalgh et al., 2008).

The case study literature does not highlight which of these supportive features, outlined above, affects collaborative working, under which circumstances and how they may influence in the change process. This will therefore be subject to full investigation in the empirical case studies. Theories representing these concepts are outlined below.

Structural coherence - integrated provision

IRPT 3e

When all individuals, with a role in the delivery of youth sexual health services, have a shared, broad understanding and conviction in positive services (theory 3a and b), they will intend to work to integrate provision with other stakeholders in the network.

This may be influenced by a range of prior circumstances (interpersonal trust, history of collaboration, compatibility of values), resources (supportive technology, space for networking, boundary spanning roles, shared guidance, external incentives) and skills (imaginative solutions, ability to unbundle funding).

User involvement

As discussed in chapter three, user-involvement may be seen as one of the key characteristics of a positive approach. Sources from each of the case studies also highlighted that user-involvement is pivotal in gaining buy-in to a positive approach (Greenhalgh et al., 2008; Healthy Respect, 2004; Institute for Community Research, 2014).

The Oregon strategy document suggested that user involvement was logical, in that young people are best placed to advise on their lives and the services they need (Oregon Department of Human Services, 2009a) . Similarly in Lothian it was seen as critical to legitimising the new approach as services that young people want and need (Healthy Respect, 2004). From this information it may be inferred that young people's input may fulfil their democratic rights and/or young people's input will improve the service design.

The evaluators of the Modernisation Initiative in London, Greenhalgh et al (2009), suggested that in addition to these benefits, user involvement served to provide inspiration, energy and momentum to the change process. These evaluators proposed a number of conditions which may influence the extent to which users are involved. These were drawn from the full project which included modernisation of stroke and kidney services as well as sexual health services. They suggest that user involvement will lead to successful innovation where:

> *"there is a strong tradition of user activism, users' identity and motivation are high (i.e., service users identify positively with, and want to help, other users), the condition is chronic, the staff value, and try to*

implement, the user voices, potential users are readily identified, recruited, and managed and the infrastructural support for users' involvement is strong, enabling, and adequately resourced" (Greenhalgh et al., 2009, p. 408).

Structural coherence - user involvement

Theory 3f

When all individuals, with a role in the delivery of youth sexual health services, have a shared, broad understanding and conviction in positive services, they will work to include users in the design and evaluation of their service because: it is right to consult people on services that affect them, and/or this may provide insight to improve service design and/or this may provide evidence to support the service transformation.

If achieved, this can prove to be a catalyst for change, improving the practical aspects of the approach and strengthening resolve for it, particularly where practitioners are concerned with promoting the rights of young people (theory 2b).
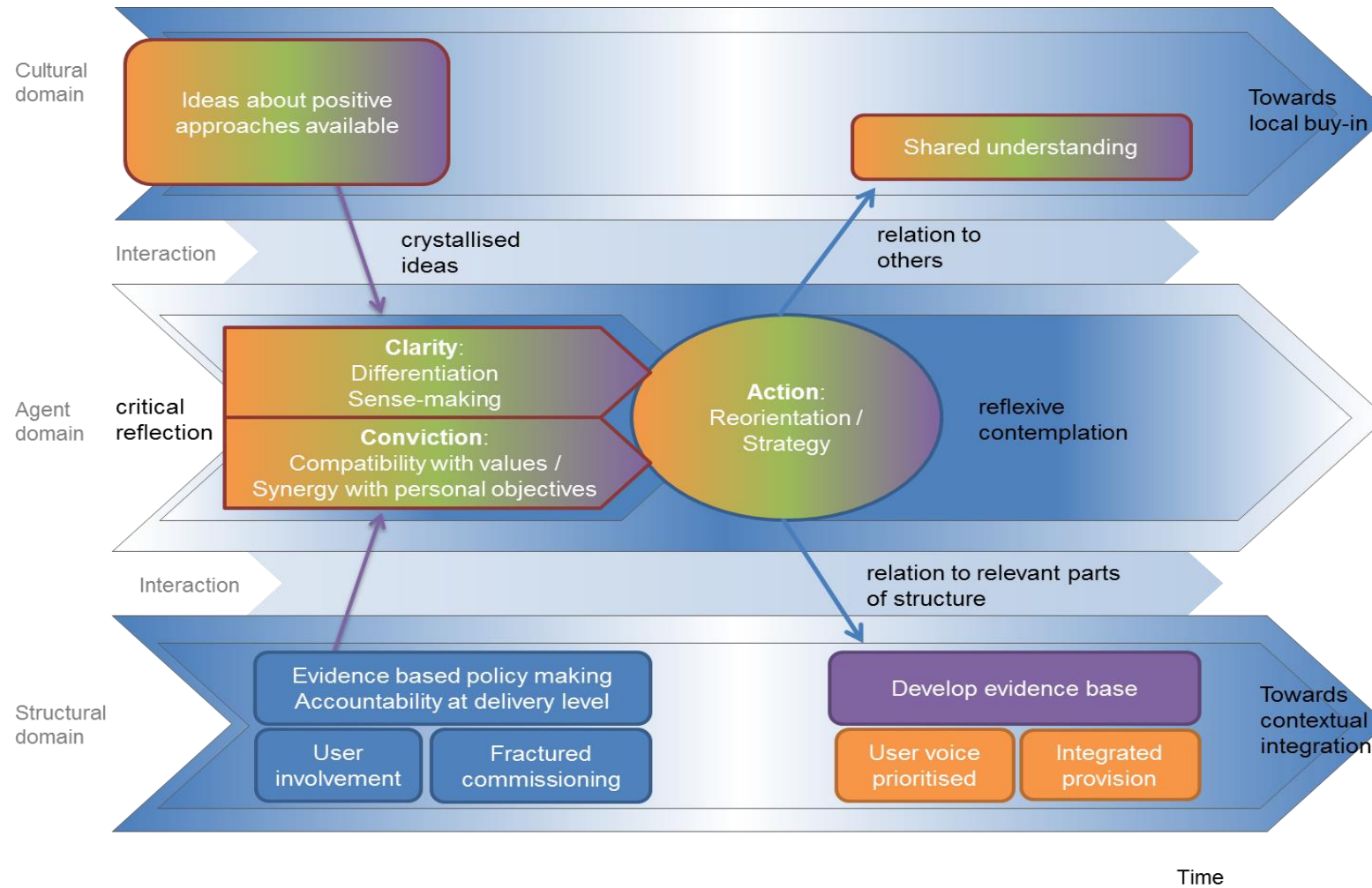
Figure 16. Propositions related to structural coherence.

4.4 Chapter conclusion

This chapter has illustrated the method used to analyse and build initial rough programme theories. Twelve propositional theories have been introduced. These related to three theory themes: *clarity*, where individuals differentiate positive services from other models of care; *conviction*, where individuals value positive services over other models of care for delivering against their personal objectives and; *coherence* where organisations view positive services as compatible with other social processes in the same context.

These theories are corroborated by existing formal abstract theory and data from the literature review. This provided a robust starting point for further interrogation in the empirical cycles where I aimed to refute, substantiate or refine the theories, adjudicate between them and/ or add new ideas.

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Delivering positive youth sexual health services:

A realist evaluation

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Chapter 5. Overview of the empirical case studies: methods and characteristics

5.1 Chapter outline

This chapter describes the process and methods used to examine the initial rough programme theories via three empirical case studies of sexual health services, over two research cycles (cycles 2 and 3 of the overall programme).

The methods section explains how services were selected through purposive sampling (Emmel, 2013). It then outlines the data collection and analysis techniques used in each realist cycle. Cycle 2 comprised semi-structured realist interviews with a purposive sample of decision makers (Manzano, 2016). It also included documentary analysis. Cycle 3 comprised workshops in which theories were presented to a broader range of stakeholders from the services, for scrutiny and refinement.

The chapter then provides an overview of the case studies' characteristics. This is followed by a brief descriptive history of each of the case studies for a particular timeframe, highlighting key events pertinent to the theory testing. This chapter sets the scene for the following chapters (six-eight) which comprise cross-case analysis of specific aspects of programme theories.

5.2 Methods

5.2.1 Two realist cycles using a case study design

This section reports the precise data collection and methods of analysis used in cycles two and three of the realist approach highlighted in Figure 17 within the yellow dotted lines.
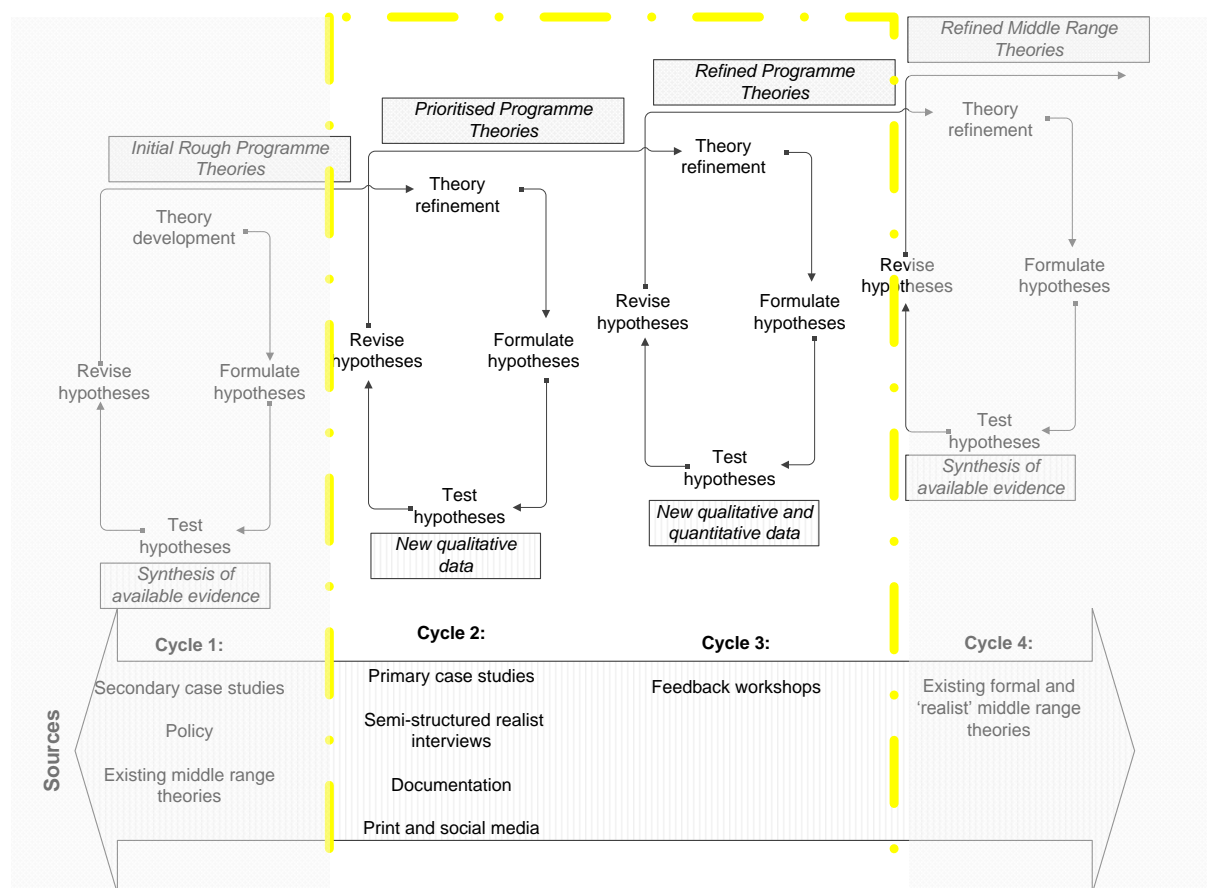
Figure 17. Research approach for theory refinement and testing

As explained in Chapter two, a case study approach was used to refine the initial rough programme theories (IRPTs) because this method allows the researcher to explore the structures and mechanisms operating in social systems, as required in realist research (Baškarada, 2014; Emmel, 2013; Koenig, 2009; Sobh & Perry, 2006).

Three different case studies were compared to discern what, if any, structures and underlying mechanisms and conditions seemed to be necessary, in all cases, for successful local buy-in, (and perhaps, which conditions prevented buy-in), as against features that might have made a difference in a particular case but which would not be required in all cases (Danermark et al., 2002, p. 105).

Two research cycles were completed with each of three case studies in order to refine the IRPTs with a purposive sample in cycle two and then a broader

research sample in cycle three. The methods used to accomplish this will be described in section 5.2.3 and 5.2.4 respectively, following a description of the process of selecting the case studies.

5.2.2 Selection and recruitment of case studies

The inclusion criteria for the cases were: NHS sexual health services which described their service as a positive (or equivalent) model and catered for young people. Cases were at different points in their proposed trajectory towards, or away from positive, holistic services; this enabled the project to consider the development of a positive approach over time as well as under different circumstances. The NHS services incorporated a number of agencies involved in supporting young people's sexual health including: Genitourinary Medicine (GUM), contraceptive services, outreach and health promotion. Cases were only included where it was possible to speak to people in both the Local Authority[17] and the local health services. This was to ensure representation of the commissioning, management and delivery aspects of the NHS service, when refining the theories. This was important to understand the power dynamics within this commissioning system.

Three case studies which had attempted implementation of a positive approach to youth sexual health services were selected. I identified two of the cases through networks that I developed as part of my doctoral programme, supported by my supervisors. A further one was found from best practice case studies reported in the policy literature. I established that these cases claimed a positive or holistic service model through descriptions of the services in publically available literature and marketing documentation which were compatible with the principles and characteristics described in chapter three. Local contacts confirmed this during the recruitment process.

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[17] At the time of the fieldwork the local authority was mainly responsible for commissioning NHS services. Some services which support sexual health and wellbeing are also commissioned centrally, through NHS England and the Clinical Commissioning Group (Public Health England, 2014). These were not included in the sample because it was not feasible to broaden the sample further, and not necessary to answer the research question.

5.2.3 Cycle two methods

Data collection

Cycle two was an intensive, largely qualitative phase to help develop the IRPTs and enhance their explanatory power (Sayer, 2000, p. 21). A number of different sources were sought to build a rounded picture of the case and corroborate or contest different aspects of the IRPTs. Data was collected using semi-structured realist interviews (Manzano, 2016), field notes from network meetings and analysis of literature related to the cases. This literature comprised: service specific documentation, print and social media and in one case, academic outputs. These specific data collection methods are now detailed below.

Semi-Structured Realist Interviews: A purposive sample of participants from each case study was recruited (Emmel, 2013). This sampling approach was used to capture the breadth of roles and responsibilities involved in delivering sexual health services. This approach supported the collection of data about local system buy-in to a positive approach, as well as any differences in viewpoints or incompatible behaviours which might frustrate change, as suggested by the theories in cycle one. The sample consisted of: those involved in commissioning services, scrutiny and oversight (local authority commissioners, advisors and elected council members), those responsible for designing and managing services (local NHS service managers and past decision makers) and those involved in delivering services (sexual health practitioners including GUM consultants and nurses, nurses with a background in contraception and non-clinically trained health promotion specialists). Best efforts were made to include those in similar positions across each case study, where possible and relevant, to support within and across case comparisons.

Individuals from the local authority were recruited directly by email. Individuals from within the health system were recruited via a local contact already working in the NHS. A person specification was developed outlining the characteristics I wished participants to have. The local contact then invited people within their organisation, who met the specification, to opt in to the research and provide me with their contact details directly, so that I could recruit them to the study. The interview was conducted at a time and place of the participant's choosing.

The majority of the interviews were completed face to face in a private room within the participant's place of work. Some interviews were completed in a neutral space to further safeguard the participant's anonymity. A minority of interviews were completed over the telephone. All interviews were audio recorded with the participant's permission. Half were transcribed by me and half by a transcription service. All transcripts were checked for quality before the audio recording was deleted. In three of the interviews, additional information was shared 'off the record'. This information has not been used directly but I sought alternative sources of data to try to back up or reject the claims made.

The theories from cycle one were incorporated into the interview schedule (Manzano, 2016). The interview began with an introduction to the topic and a general discussion capturing the participant's views on what a positive service was and how it might be delivered. The theories were then introduced, as themes on stimulus cards or specific prompts, for discussion. Not all theories were relevant to all positions and all people and the interview schedule was adjusted accordingly. Attention was given to individual, interpersonal, institutional and infrastructural conditions influencing or hindering the change processes (Pawson, 2006). Answers were fully explored, frequently probing with 'why?' to reach perceptions of underlying causal processes (Wong, 2015). I also used juxtaposition techniques by introducing ideas about how things have worked in other areas for the participant to reflect on (Manzano, 2016). For example, when highlighting the catalytic role user involvement had in one setting compared to another.

As the fieldwork progressed the interview schedule was revised and focussed in line with ongoing analysis and prioritisation of theories. Appendix 5 summarises the interview schedule, how it changed and why.

Field notes from network meetings: I attended six sexual health network meetings across two of the case studies. The commissioners of services, in each location, confirmed that these were the most appropriate meetings for me to attend to understand the depth and breadth of agency activity across the area they were responsible for. These meetings, which occurred quarterly, were attended by various representatives of agencies working to a greater or

lesser extent in sexual health services for young people in the local area. During the meetings I made notes regarding the main topics of discussion and the language used when young people's sexual health was raised. I also made observations about the way in which the various organisations interacted or appeared to work together and the priorities for action. I was unable to attend network meetings at the third case study site because they had been suspended by the local authority at the time of the fieldwork.

Literature concerning the case studies: I gathered a range of literature sources which were related to the case studies. This evidence was used to substantiate participants' accounts and different aspects of theories, in particular, to provide textual evidence of local buy-in to positive approaches. The sources cannot be named and cited because of anonymity, however they included:

- Service specifications, needs assessments and consultation documentation from the services themselves.
- Print media, derived from a Nexis search looking for "sexual health" and the location of each of the case studies.
- Social media, derived from a Google search for blogs relating to the local services.
- Academic outputs including published conference proceedings and journal articles.

Data analysis

All sources were then converted to text and uploaded to NVivo. This was so that data could be indexed from each of the different sources and compared within a common coding framework. In this way, the software package was used primarily to support the organisation and cross-referencing of data. Social media and academic video sources (from YouTube) were also transcribed and uploaded. In addition, documentation which was not already in a Word or PDF format was converted or scanned and then uploaded. Sources were categorised according to the case study they related to. For interview transcripts categories were added relating to the role or position each interviewee performed. These categories supported cross and within case analysis later in the process.

I adapted a framework method to organise and analyse my data (Pope, Ziebland, & Mays, 2000; Ritchie & Spencer, 1994). A coding framework, based on key aspects of the initial rough theories was developed a priori to data analysis (Fletcher, 2016). Propositions related to the theory themes were incorporated in the framework as codes. These formed a series of 'parent' codes and 'child' codes for each theory theme. Separate broad codes were also created referring to 'structure', 'culture' and 'agency'. These meta-theoretical concepts were used to capture and organise (Fletcher, 2016) broad contextual conditions apparent in the case studies. The coding framework was transferred to an NVivo project file.

Excerpts from the sources were then allocated to the codes. Due to the complexity of the theories and data, chunks of text were often coded to multiple theory propositions. Large chunks of text were often coded together ensuring that contextual data were kept together with information about supposed mechanisms and outcomes, where applicable. Where the data did not fit the theory proposition directly, but was relevant to the overall research question, the theory proposition was tentatively elaborated (by adding more detail to this specific aspect of the theory, which could be tested in subsequent interviews,) or new codes were added (Fletcher, 2016). Some data, for example viewpoints or written text were interpreted along with other contextual factors such as participants' knowledge, demography, politics and culture (Befani & Mayne, 2014). These were recorded in annotations within the project file. This helped me to interpret the data about how individuals made sense of positive approaches, their conviction and subsequent action. Throughout the coding process, explanatory ideas that occurred to me were recorded in annotations within the programme.

Analysis was orientated towards identifying and then explaining evidence that substantiated or refined the IRPTs, that is the ideas about what worked to gain local buy-in to positive approaches (Pawson & Tilley, 1997). I adopted a method of analytical induction (Bloor, 1978) to support this process. The data within each of the codes, corresponding to different theory propositions, were scrutinized in order to produce a tentative list of common features which supported the explanation. Confirming data (meaning that the causal mechanism postulated could be considered more likely) was seen as

strengthening the theories and disconfirming data (meaning that the causal mechanism postulated could be considered less likely) presented the opportunity to develop alternate explanations (Befani & Mayne, 2014; Wong et al., 2013).

I used a variety of conceptual modelling techniques to help make sense of the data and propose underlying mechanisms which, when triggered under certain circumstances, lead to the desired outcomes. These included writing out theories in prose, compiling tables relating to configurations of contexts, mechanisms and outcomes (Pawson, 2013), re-describing the results using concepts from the theoretical scaffold and other middle range theories (de Souza, 2015) and by constructing models explicitly highlighting the linkages and interrelationships between the social entities under scrutiny (see Appendix 6 for examples which illustrated some of the modelling techniques). These various techniques incrementally supported me in distilling the data, and my interpretations of it, to the core components of the refined theories.

5.2.4 Cycle three methods

Data collection

Cycle three involved a further round of data collection with each of the cases. The purpose of this round of data collection was to examine the prominent theories, developed in cycle two, with a broader range of participants.

Feedback workshops were organised with each site. An opportunistic sampling strategy (Suri, 2011) was used which consisted of integrating these feedback sessions into regular organisation's meetings. This allowed me to reach a wide range of practitioners who may not otherwise have engaged directly with the research. I worked with a local contact to agree the time and location for the feedback session.

Sessions ranged from 1 hour to 90 minutes. My results to date (emerging) and initial theories were translated into a brief presentation and presented by myself using PowerPoint. Hand-outs, which included opportunities to provide individual feedback, were used to get a sense of the nature of the feedback and provide a space for hand written responses and explanations (See Appendix 7).

The format of the event was designed to facilitate some discussion. Breaks were built in after each new theory proposition was presented and participants were encouraged to challenge this theory or provide evidence to support the theory. These discussions were audio recorded and subsequently transcribed, in two of the sites (for details see 5.3 and 5.4). In the other, due to the higher number of attendees, verbatim quotes were manually recorded (for details see 5.5.3 and 5.5.4). Permission was obtained from the participants for my supervisors, PhD colleagues and myself to capture verbatim from the small group discussions.

Data analysis

The data from the completed hand-outs were entered into Google Sheets. The group discussions and verbatim quotes were uploaded to NVivo. These were coded against the developed theories from cycle two. Data which supported the theory propositions were added to these codes; refinements, such as additional contextual circumstances were added.

Data analysis was undertaken with the intention of identifying demi-regularities (Fletcher, 2016) in the outcome patterns and increasing confidence in the theories. Outcome patterns were identified by tracing the individual circumstances to their responses and/or agreement with the theory propositions. For example, GUM nurses working in single disciplinary teams tended to have different viewpoints to those working in multi-disciplinary teams.

The new data also contributed confirmatory or disconfirming evidence. This tentative stance is appropriate given the acknowledgement that all theories are partial and fallible (Befani & Mayne, 2014; Wong et al., 2013).

This analysis allowed me to further refine the theories which are presented as Refined Programme Theories at the end of chapter six pertaining to 'clarity', and the two subsequent chapters pertaining to 'conviction' and 'coherence' respectively.

5.2.5 Ethics and governance

Ethics approval was obtained from Sheffield Hallam University to carry out the interviews and documentary analysis in cycle two and the feedback sessions in cycle three. Initially ethics approval was granted for two case study sites, this was amended when I identified the third case study site. Access permissions were granted for each of the three case study sites and a research passport was obtained. Original ethics and site approvals included the possibility of providing feedback sessions conducted in cycle three. See Appendix 8 for copies of documentation associated with these approvals.

5.3   Data collected for each case study

5.3.1 Characteristics of the case studies

Three services were included in the empirical work. To safeguard anonymity they have been given pseudonyms: Ponston, Stadford and Rissfield.

The three services differed from each other in a number of ways which were relevant to the theory development. For example, the service approach that was claimed, how long the service had claimed such an approach, the extent and nature of service integration, the size of the service, its leadership and whether or not a youth clinic was separate from the adult clinic.

Table 6: Characteristics of the three NHS services for each of the case studies

Feature	Ponston	Stadford	Rissfield
Service approach stated in marketing collateral	Positive	Positive	Holistic
Approach heritage	Long established in community outreach and contraception.	Recently established (4 years at the time of research)	Newly established (2 years at the time of the research)

Extent of integration	Fully integrated contraception and GUM	Partially integrated contraception and GUM	Integrated contraception, Level 1[18] and 2 GUM and other lifestyle factors
Leadership	Consultant-led	Consultant-led	Nurse-led
Size	50+ employees	30+ employees	Fewer than 15 employees
Separate youth clinic	Yes	No Some youth centred provision at Level 0 and 1 only.	Yes

5.3.2 Data collected in cycle two

Twenty four interviews lasting between 45 minutes and 2 hours were conducted across the three case studies in cycle two. These were completed with individuals with roles across the commissioning, design and delivery of the sexual health services over the last five years.

In both Ponston and Stadford one interview was conducted with individuals who were no longer in post, but who had previously been instrumental in the direction the services took. Table 7 provides a breakdown of the interviews completed.

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[18] Levels in sexual health provision refer to Level 0: self-management, Level 1: sexual health and risk assessment, STI testing, HIV testing and counselling, pregnancy testing and referral, contraceptive information and services, Level 2: LARC fitting, testing and treating STIs, vasectomy, partner notification and Level 3: complex/specialist testing and treatment, outreach prevention (Department of Health, 2001)

Table 7: Interview sample

Type	Ponston	Stadford	Rissfield
Past decision makers	1 (Community Manager)	1 (Project Manager)	0
Local authority councillors	1	0	1
Local authority commissioners	1	2	2
Local authority adviser	0	1	0
NHS managers	2	1	1
Sexual Health Consultant	1	1	1
Nurse	1	2	1
Outreach / health promotion officers	1	1	1
TOTAL	8	9	7[19]

Literature collected varied according to availability across the case studies. A greater range of sources were available for Stadford. This was due to the media and social media activity associated with the launch of the web resource and academic outputs generated through collaboration with a local university. Table 8 details the sources obtained for each of the case studies.

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[19] The smaller number of interviews achieved in Rissfield reflects the smaller size of this service.

Table 8. Sources obtained for each case study

Type	Ponston	Stadford	Rissfield
Grey literature published by agencies responsible for commissioning and delivering sexual health services for young people	• Needs assessment • Annual reporting template • Consultation documents on service restructuring • Local evaluation report	• Board of Directors Report • Integrated Performance Board Report • Children and Young People Annual Report • Invitation to Tender Documents	• Teenage Pregnancy Update • Councillor recommendations for signposting for Young People/Partnership Working • Consultation report on young persons' service redesign • Service specification • Sexual Health Partnership meeting minutes • Terms of Reference: Sexual Health Partnership group • Terms of Reference: RSE group
Print media derived from	• Local newspaper articles	• Local newspaper articles • National news articles	• Local newspaper articles

Nexis search			
Social media derived from google search		• Blog authored by the local authority advisor x 5 entries	
Academic outputs		• Published conference proceedings x 1 • Journal article x 1 • Recorded conference presentation on you tube x 1	
Trend data	• Office for National Statistics Teenage Conceptions data • PHOF indicators and wider determinants of health from Public Health England		
Field notes	• x 4 meetings	•	• x 2 meetings

5.3.3 Data collected in cycle three

In Ponston and Rissfield, the feedback sessions were attended by the whole service delivery team, with the exception of a small number of those delivering clinics which had overrun or who were absent[20]. This meant that feedback was obtained from a range of practitioners with varying backgrounds and experience as well as the reception and admin staff. In Stadford the feedback session only involved the executive team who consisted of senior managers and senior clinical staff because they did not want the emerging findings to be shared with the wider team at that point. Table 9 provides the number of participants in each of the case studies.

Table 9 Number of participants in each of the case studies in cycle 3

Case study	Ponston	Stadford	Rissfield
Number of participants	48	6	9

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[20] The discrepancy in total participants in Ponston compared to Rissfield reflects the size of the service, and size of the population they serve.

5.4 Descriptive history of the case studies

The following sections set out a brief description of the key events occurring in each of the case studies. This information has been drawn from data collected throughout the study. For example, events, described by participants as important occasions, that affected local buy-in to positive services. In addition, some events were observed during meetings or identified through documentary analysis.

It should be noted that the following sections are intended to set the scene for the following three chapters; these will offer more specific analysis and explanation and cases will be compared and contrasted according to their historical contexts (Herepath et al., 2015). Each case study will be presented in turn and then illustrated with a timeline (figure 18, 19 and 20) which situates the events alongside key policy events (described in chapter one).

5.4.1 Stadford

Stadford refers to a service which was, at the time of writing, transitioning to an integrated service model. It provides sexual health care for a county in the south west of England.

At the end of the Teenage Pregnancy Strategy in 2010, Stadford, unlike a number of areas across England, retained their Teenage Pregnancy Coordinator, a role which was jointly funded by the local authority and local NHS organisation. This role was converted to a project manager role for an existing campaign to improve young people's sexual health.

Together with the newly appointed local commissioner, the project manager secured funding from the European Union to visit the Netherlands to see first-hand how the approach to youth sexual health differed from England. This study trip was attended by twenty practitioners, from community, education and social work in the county. The group did not include sexual health clinicians. During the trip the practitioners attended lectures, discussions and observation sessions about positive approaches for youth sexual health.

Following the trip, a number of developments took place. First the local authority commissioner and project manager arranged a 'partnership conference' to disseminate the learning from their study visit. It was attended by a wide range of stakeholders including community workers, clinicians and senior decision makers in the council. Second, an extensive programme of training was developed and provided for other frontline practitioners working in the community and schools. Third, the project manager and commissioner re-developed a web based resource for young people along positive principles. They worked with young people and an advisor expert in engaging with this age group to develop the content, look and feel of the web resource. These young people were also involved in a mystery shopping exercise which evaluated the young person friendliness of the local sexual health services.

The local authority commissioner and project manager also created new ways of measuring the activity generated by the campaign to provide evidence of its value and effectiveness.

Following the Health and Social Care Act 2012 (Department of Health, 2012a), which came into force in April 2013, the clinical services came under the commissioning responsibility of the local authority. In 2015 the CASH (Contraceptive and sexual health) and GUM (Genitourinary Medicine) services, which had previously been run by three different Trusts, were tendered and one NHS Trust won the contract to deliver an integrated service for the county. The local authority commissioner amended the service specification, as part of this process, to reflect the positive principles and characteristics adopted in the development of the wider sexual health campaign. Key Performance Indicators did not reflect these principles which will be discussed in full in chapter eight.

At the time of the fieldwork three hubs, in three different hospitals, provided clinical care at Levels 1-3 (see glossary). The overall service was consultant-led. Integration of GUM and contraceptive services was underway but not complete at the time of the fieldwork. Initial priorities for the integrated service were to secure effective IT facilities and suitable premises. These clinics provided care which young people could use alongside older adults. There were a number of other outreach locations which provided Level 1 support for young people only.

The website was maintained over this time period although funding reductions meant the commissioner scaled back the training programme and wider campaign marketing activities. One outreach community clinic for young people in an area with historically high levels of under-18 conceptions was due to lose their local authority funding in March 2017.

At the time of the fieldwork, the project manager had moved on to a different role in a different company, the commissioner had taken a broader role and a new commissioner was managing the website. The new commissioner also interpreted positive approaches in line with the principles described in chapter three.
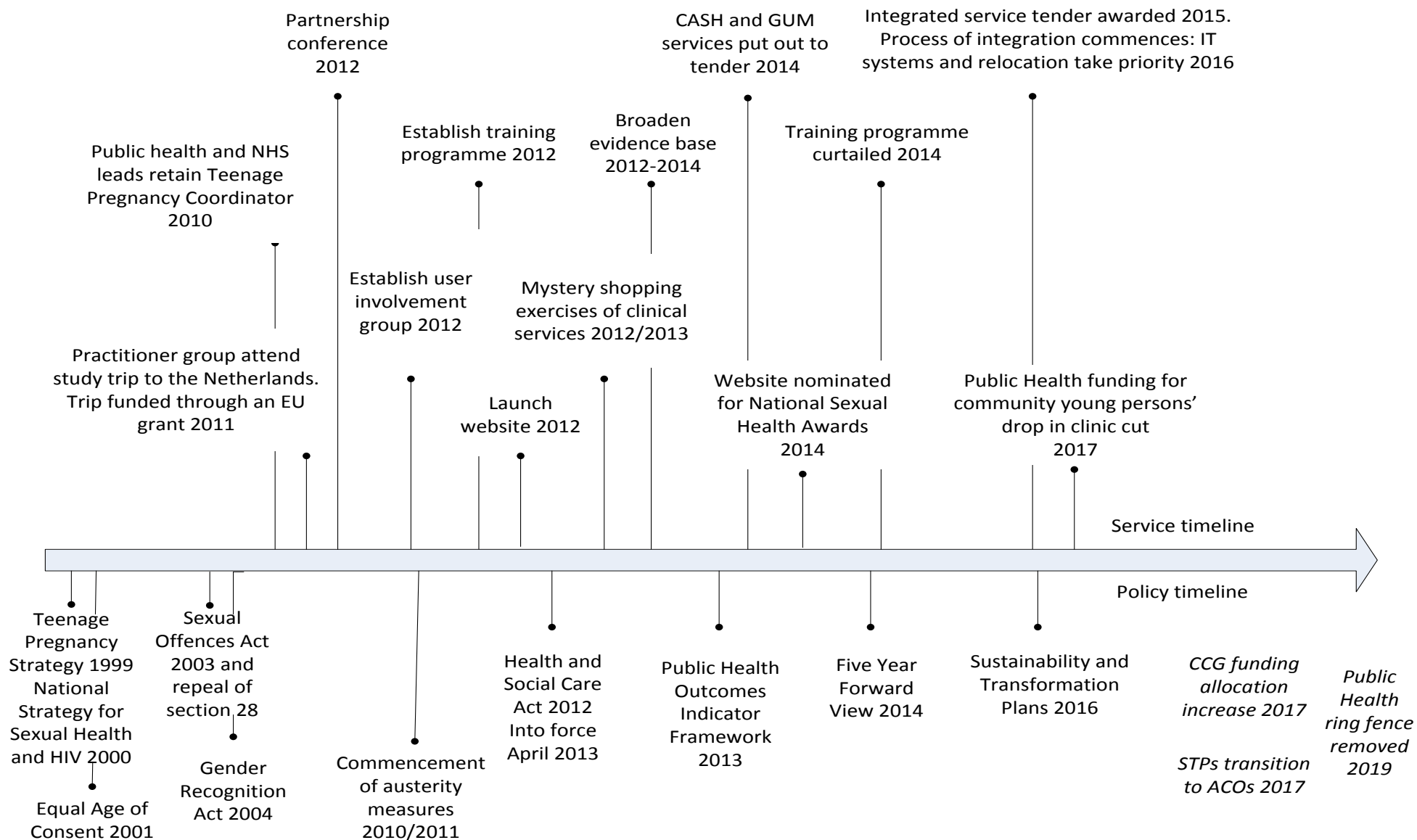
Figure 18. Key events relating to local buy-in to positive services in Stadford 2010-2017

5.4.2 Rissfield

Rissfield refers to a small, holistic youth service in a large town in the north of England. The town has a history of poor sexual health. It was identified at the time of the Teenage Pregnancy Strategy as a 'Hotspot', meaning that it had higher than average percentage of under 18 conceptions (Social Exclusion Unit, 1999). It has also been highlighted as an area with high rates of STIs compared to statistical neighbours in 2013.

Prior to 2013, sexual health services for young people and adults were divided into CASH and GUM services located within different parts of the town. Separate services for smoking cessation and drug and alcohol abuse were commissioned by the local authority.

In 2013, the local authority commissioners and senior management consulted on a new service model for young people. This model proposed to consolidate services for sexual health, smoking cessation, drug and alcohol abuse in a youth specific setting. Initially, it was planned that the service would include Child and Adolescent Mental Health Services (CAMHS) although this was never actualised.

The 'holistic' service consisted of a small, nurse-led, centralised team including around one third non-clinical and two thirds clinical practitioners. Practitioners were dual trained to deliver sexual health as well as brief interventions for smoking, and/or alcohol and drug abuse. The restructuring of this service meant that young people, under-19, were only seen at the universal sexual health care service for specialist treatment. At its inception, the holistic youth service was not explicitly sex positive.

A year after the service was established, the commissioner began to introduce ideas about sex positive approaches, which they had researched. Three simultaneous activities were apparent, which intended to support the development of positive approaches. First, the service manager attempted to build the youth teams' understanding and application of sex positivity. This was undertaken in team meetings, through presentations and discussion. Second, the commissioner had introduced the idea of positive approaches to the wider Sexual Health Partnership Group (a network which comprised of

representatives from a range of agencies whose activities related to youth sexual health work including clinical services, youth work, SARC, organisations for LGBT communities and school nursing) and included actions related to this on the networks' shared work plan. Third, on recognition that some young people in the town could not access relationships and sex education or sexual health self-management support, the commissioner invested in the sex-positive web resource (developed in Stadford) which could be tailored to their town's activities.

The service manager and commissioner, at the time of the fieldwork, were unable to develop the youth service, with dedicated staff and outreach clinics, as they would like to due to funding restrictions.

Considered a teenage
pregnancy 'hotspot'
2001-2010

High rates of STIs compared
to statistical neighbours
2013

CASH and GUM
adult services put
out to tender
2014

Integrated, comprehensive
sexual health services
commence
2015

Sexual health network
meetings include sex positive
2016

Launch website
2016

Consultation on
holistic youth
service model
2013

Holistic youth
service model
developed
2014

Funding for youth
service threatened
2016/2017

Service timeline

Policy timeline

Teenage
Pregnancy
Strategy 1999
National
Strategy for
Sexual Health
and HIV 2000

Sexual
Offences Act
2003 and
repeal of
section 28

Gender
Recognition
Act 2004

Health and
Social Care
Act 2012
Into force
April 2013

Public Health
Outcomes
Indicator
Framework
2013

Five Year
Forward
View 2014

Sustainability and
Transformation
Plans 2016

*CCG funding
allocation
increase 2017*

*Public
Health
ring fence
removed
2019*

Equal Age of
Consent 2001

Commencement
of austerity
measures
2010/2011

*STPs transition
to ACOs 2017*

Figure 19. Key events relating to local buy-in to positive services in Rissfield 2010-2017

5.4.3 Ponston

Ponston, at the time of writing, was an integrated sexual health service serving a city in the North of England. The city's diverse population had a slightly higher than average deprivation with distinct health inequalities across the city.

Up until 2014, GUM and health promotion and contraception clinics operated separate clinics. The health promotion and contraception clinic claimed a long heritage of delivering a positive model of care, in line with positive principles and characteristics described in chapter three, through the 1990s and 2000s. This service had also been seen, by others in the country (for example in Rissfield and Stadford), as pioneering in approaches they had advocated. It also celebrated a long history of dedicated youth services. The importance of sexual health had been recognised within the local council who had, in the past, appointed local councillors as 'Sexual Health Champions'.

Around the time of integration (2013-2014), both the Sexual Health Strategy for the city, (to which the local sexual health network including the NHS services contributed and subscribed to), and the outward marketing of the integrated service described many of the principles and characteristics of a positive approach. Nevertheless, health promotion activities were not updated in the sexual health needs assessment for the city and the actions contained within the Strategy related primarily to activities which may impact on the Public Health Outcome Indicators (see chapter one and three for details).

During 2014 the community and contraceptive services were integrated with the GUM services as a response to the Health and Social Care Act 2012 and wider policy which was driving towards an integrated model of care. This process was undertaken without the local authority re-tendering the service. Two integrated hubs were established.

In 2016 the service was further reconfigured, in response to a reduction of funding available from the local authority and concerns about the facilities in one location. One of the integrated hubs, which had previously been the community outreach and contraception service, was closed. This hub had had a well-established youth drop-in clinic on several weekdays and Saturday mornings. The staff were relocated to the other hub which had previously been

the GUM department. The remaining service was consultant-led and included a far greater number of clinical compared to non-clinical staff. A weekly youth-specific sexual health drop-in was set up in a local youth support service to provide a central clinic site for young people.

The remaining services had significantly reduced health promotion, outreach and training capacity. The leadership associated with this aspect of the service had resigned and management posts for the contraceptive aspects of the service had been given to GUM specialists.

Sexual Health
Champion within
local council up to
2016

Health promotion, CASH
and GUM services asked to
integrate without
retendering 2014

City centre
clinic
closed.
2016

Health promotion
and CASH operate
independently from
GUM
up to 2014

SRH drop-in
opened in
holistic youth
service 2016

Community
manager
resigns 2015

Health promotion and
contraception clinic pioneers
of positive approaches
from 1990s onwards

City wide sexual
health strategy
launched 2013

Peer educators
programme wins
National Sexual
Health Awards
2014

Community outreach team
reduced five fold in size
2017

Service timeline

Policy timeline

Teenage
Pregnancy
Strategy 1999
National
Strategy for
Sexual Health
and HIV 2000

Sexual
Offences Act
2003 and
repeal of
section 28

Gender
Recognition
Act 2004

Health and
Social Care
Act 2012
Into force
April 2013

Public Health
Outcomes
Indicator
Framework
2013

Five Year
Forward
View 2014

Sustainability and
Transformation
Plans 2016

*CCG funding
allocation
increase 2017*

*Public
Health
ring fence
removed
2019*

Equal Age of
Consent 2001

Commencement
of austerity
measures
2010/2011

*STPs transition
to ACOs 2017*

Figure 20. Key events relating to local buy-in to positive services in Ponston >2010-2017

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5.5 Chapter conclusion

This chapter has introduced the case studies; how they were selected, what methods were used to collect and analyse the data, their key characteristics and descriptive history relevant to the theory testing.

The three cases differed from each other in several important ways including their geographic location, population served, service model, trajectory (that is the point in their evolution towards adoption of, or sustaining, positive approaches), and the extent to which they had integrated GUM and contraceptive services. These differences will allow me to illuminate more aspects of the theory than one case study alone as will be seen in the following chapters.

The theory themes developed in chapter four will now be examined in light of evidence from these case studies. Cross-case comparisons allow for the identification of common and diverse features which provide an explanation of local buy-in to positive services. Chapter six investigates the theories relating to the theme 'clarity', chapter seven explores the theories relating to 'conviction' and chapter eight considers the theories relating to 'coherence'.

Chapter 6. Results relating to the theory theme of clarity

6.1 Chapter outline

This chapter relates to *'clarity'*, one of the theory themes developed in cycle one (reported in chapter four). It reports the results of the empirical research, (introduced in chapter five), and how the theory was refined in light of these results.

The initial theories relating to differentiation of positive services and how they were made sense of were subject to refinement in the empirical research cycles (cycle two and three).

The data showed that individuals, across the delivery chain, learn to distinguish positive approaches via different routes. The results also illuminated a diversity of interpretations held by those differentiating positive approaches. The results supported substantial revision to the initial rough programme theories relating to '*clarity'*. This chapter concludes with revised theories based on the results presented.

6.2 Initial rough programme theories from cycle one

Initial rough programme theories developed over the course of cycle one relating to *'clarity'* were:

IRPT 1a Where principles and characteristics of positive approaches are made explicit, via training or illustrations of other models of care, commissioners, managers and practitioners will be able to distinguish this approach from other models of care.

IRPT 1b When directed to do so, commissioners, managers and practitioners will be able to make sense of the principles and characteristics of a positive approach and understand how it might affect their day to day roles and responsibilities

6.3 Results

6.3.1 Theory 1a: Differentiating positive approaches from other models of care

The first set of results concerns IRPT 1a which relates to whether or not, how and why commissioners, managers and practitioners come to distinguish a positive approach from other models of care. The theory derived from cycle one stated that: *Where principles and characteristics of positive approaches are made explicit, via training or illustrations of other models of care, commissioners, managers and practitioners will be able to distinguish this approach from other models of care.*

The data supported this theory to an extent. Some of the participants did learn to distinguish positive approaches through training and illustrations of other models of care. However, others developed this understanding through their experience working with young people. Others still had been exposed to positive principles and characteristics but did not appear to have internalised this sufficiently to distinguish it from other models of care, notably medical models or risk reduction models. The results pertaining to these three outcome patterns are presented in turn below.

Differentiating positive approaches: transformative learning
Councillors and commissioners in Stadford and Rissfield and managers in Ponsford and Rissfield described actively seeking an alternative to their existing

ways of working. They explained that this was because they were dissatisfied with current practice and considered outcomes, such as under-18 conceptions to be unreasonably high (despite these rates falling in recent years).

"in terms of their national targets…we're way off…things like under-18s conception and some of the screening rates". (Local Councillor, Rissfield)

Commissioners and managers had sought out practical ideas, through a range of activities, which they could translate to their own work. Activities included attendance at conferences, networking and desk research into case studies or opinion pieces presented in the academic and professional literature. Thus, ideas about positive approaches came from external, and what they perceived to be, reputable sources of information. They explained that these sources demonstrated positive approaches in operation in other locations.

"around the world, the countries that do better around teenage pregnancy, reducing teenage pregnancy, lower STIs, lower rape figures, generally, and I do say generally, are societies where the attitudes towards sex are much more positive towards sex" (Ex-community manager, Ponston).

The ideas were presented in a way which was easily digestible where it was presented 'live', often accompanied with discussion. This allowed the participants to begin to make sense of how the idea might be delivered in their own context.

"[I liked] the business model…Well it was more like a conference than training, and [advisor] was there doing a talk". (Commissioner, Rissfield)

Data from the realist interviews, press and social media in the Stadford case study showed that decision makers in the Local Authority (commissioner, project manager and local authority adviser) had not been satisfied with the county's performance on clinical outcome measures and sought an alternative approach. One participant explained that:

"the figures in the UK weren't particularly impressive around teenage pregnancy and things like STI rates were increasing and I think that we knew it needed something different" (Ex Project Manager, Stadford)

As described in chapter five, the project manager and local authority commissioner secured funding to visit the Netherlands together with twenty practitioners. This trip allowed them the time and opportunity to see first-hand how a positive approach differed from other models of care, inspired them to consider how it might work in their own settings and raised the profile and the importance of learning about positive services for all involved. As a result their concept of a positive approach was clearly differentiated from other models by those who attended the trip.

The 'partnership conference' and further frontline practitioner training organised on their return, (described in chapter five), provided the ideas, time, and opportunity for a wider range of people to gain clarity about positive approaches.

Accordingly, for these participants, exposure to illustrations and credible sources describing positive approaches allowed them to develop an understanding of the principles and characteristics to compare against their existing practice.

Differentiating positive approaches: experiential learning

Exposure to illustrations and sources was not the only way in which participants came to distinguish a positive approach from other models. The majority of health promotion staff, who took part in the research, across both cycles two and three, explained that their understanding of positive approaches had come from working with young people themselves.

> "…from the views that I may have picked up from young people over my time in this job and previous roles…" (Health Promotion Manager, Ponston)

These participants, often with social work backgrounds, explained that they had accrued their skills and knowledge over time, through reflecting on what had worked well or less well with the young people and adjusting their practice accordingly. They claimed that holistic, open and supportive practice was more effective than models based purely on medical interventions or risk reduction. This was because it allowed them to work with the young person's culture and

lifestyle and, where necessary, find solutions they were more likely to buy into. This approach also, occasionally had helped them to identify, and deal with, the root cause of any issues the young person was presenting with. In Stadford one outreach worker gave the following example about a conversation she had with a client after a pregnancy test:

> *"…we talked about her depression…it turned out that she was at risk of NEET[21] … so I spoke to her…put the referral in… she has now got a youth worker." (Outreach worker, Stadford)*

Around half of the nurses, across the two research cycles, also differentiated a positive approach from a medical model. These included the clinical staff in Rissfield who worked in a small, multidisciplinary team, based on holistic services for young people. It also included nurses with contraceptive backgrounds, particularly those who had offered clinics in the community, as opposed to within hospital settings.

Data also revealed that a small number of the nurses and health promotion officers distinguished positive sexual health from a more narrow view of conceptions and STIs as a result of their own sexuality development, and occasionally the experiences of their friends and family.

> *"…certainly for me to a large extent, it is about my personal experience about, I guess developing as a sexual being, throughout life and that influences how you think about it" (Manager, Rissfield)*

They extrapolated this to ideas about positive services, for example, that they should support sexual health and wellbeing for everyone including sexual minorities.

For most participants, multiple sources of information contributed to their ability to distinguish positive approaches from other models of care. Nurses and health promotion officers, particularly in Rissfield and Ponston, highlighted that alongside training, or personal experience, organisational culture and interaction with peers helped them strengthen their awareness and understanding of positive principles and characteristics. Other formal learning

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[21] Not in Education, Employment or Training

opportunities via appraisals and sharing of evidence and informal opportunities, such as becoming a parent or witnessing the limited impact of other forms of sexual health delivery had also reinforced these conceptualisations. This is summarised in the following quote.

> *"My experience has allowed me to build a knowledge base over several years. Training has added to my knowledge and evidence shows what works and what doesn't and best practice" (Manager, Ponston)*

Failure to differentiate a positive approach: lack of cut through

A handful of participants, mainly with GUM backgrounds, in Ponston and Stadford demonstrated little awareness of the term positive or sex-positive in relation to their service, despite the services being described as such in their statements of work and marketing collateral. They understood terms like 'holistic' and 'comprehensive' linguistically, but did not use them to describe their model of care or how such models might differ. This was particularly evident in cycle three data where comments received from these participants illustrated their confusion.

> *"We try to do positive approaches because we do asymptomatic sexual health screening… we are trying to encourage at the beginning of relationships, come down and have a test…" (GUM nurse, Stadford).*

Here, it might be inferred, positive is used as a synonym for 'preventative'. Certain key tenants of positive approaches, such as sexual pleasure[22], also appeared to confound a minority of participants. For example, some GUM nurses in Ponston, when asked if they ever considered discussing pleasure in a consultation replied 'never' as illustrated by this quote.

> *"never thought about pleasure…never heard other staff discuss this…never considered doing this" (GUM nurse, Ponston).*

In Stadford, data from interviews with participants from the clinical team, in particular from the GUM consultant and nurses, stood in stark contrast to the

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[22] For critique of the sexual pleasure discourse see chapter one.

local authority and community outreach participants described above. These participants didn't distinguish a positive approach from other models of care. For example, when pressed on positive principles and characteristics in the interviews, one nurse described what she thought was effective testing practice but seemed perplexed about broader principles as highlighted in the following quote.

> *"[on positive services] that we're offering a good service…that are safe, that are practical…offering the right tests to the right people, that the tests that we're offering are of a good standard." (GUM Nurse Manager, Stadford).*

When queried, in the interviews and cycle three feedback sessions, these participants explained that they had not been involved in the study trip to the Netherlands, nor had any representative from the clinical team, to their knowledge. They had little awareness of the outcomes of the trip and subsequent development of the sexual health strategy in the county. They were equally unaware that the Local Authority commissioners had included sex positive principles and characteristics in the clinical service specification when the service had been up for tender (the year prior to the research).

> *"[After prompting on the service specification] have the staff seen that?...well you'll be able to see that it means different things to different members of staff working for me, working here" (Nurse Manager, Stadford)*

In sum, these results highlight that simply describing the service in positive terms is not sufficient to ensure all staff are aware of the distinction.

Failure to differentiate a positive approach: focus elsewhere

Data suggested that another reason a small number of participants failed to actively distinguish a positive approach from other models of care was that they were simply focussed on delivering their 'core' business under increasing financial pressure and fragmented commissioning. That 'core' business does not automatically include positive approaches, for some, is further proof that

policy ambitions have not been translated into practice, as highlighted in chapter three. These points are explained in more detail below.

In Ponston, the commissioner explained that pressure to make efficiency savings (as outlined in chapter five) had led to individual agencies focussing inward. They believed that each agency was struggling to complete their own contractual obligations, with managers and individuals focussing on protecting their own roles. They explained that:

> *"It's the difference between being reactive and proactive. In an ideal world we would want all [the Clinical Commissioning Group, NHS England and Local Authority] to sit round together…but in reality it is the time when we are all having to be reactive to what we are facing"* *(Commissioner, Ponston)*

This account suggests that reduced budgets act as a barrier to innovation for some, not just directly in restricting training opportunities and networking, but also through reductions in time or 'breathing space' to critically reflect on service improvement.

The data demonstrated that the lack of priority given to positive approaches may also be attributable to the lack of coherence in national policy and guidelines as outlined in chapter three. Commissioners and managers interviewed reflected that such documents do not outline the type of service or quality expectations beyond the clinical pathway. All three of the case studies modelled their service specifications on that which is set out in national guidance (BASHH, 2010). This template is characterised by figures relating to throughput, such as the 48 hour appointment turnaround time. It has little which is directly related to the quality of the interaction between the practitioner and the young person. One commissioner reflecting on the BASHH guidelines commented:

> *"It's funny because they're called quality standards but most of them aren't measured qualitatively"* *(Commissioner, Rissfield)*

In Ponston, where arguably a positive approach has been established the longest (in the health promotion and community outreach clinic), it was noticeable that a perceived focus on STIs was dominating the views of the

clinical team, many of who were not aware of the legacy. This dilution of the positive vision is highlighted in the following quote:

> *"In recent years there has been an increasing focus on screening communities for STIs. This represents, to me, a shift away from a holistic model of sexual health" (Health Promotion Officer, Ponston)*

This highlights that a focus elsewhere can veil the existence of other approaches which clearly would prevent positive approaches from being differentiated by individuals working in the service.

6.3.2 Theory 1b: Making sense of positive approaches

The second set of results relate to how participants interpreted positive approaches. The initial rough programme theory derived from cycle one suggests that commissioners, managers and practitioners will be able to make sense of positive principles and characteristic if directed to do so.

IRPT 1b (Make sense of / interpret)

When directed to do so, commissioners, managers and practitioners will be able to make sense of the principles and characteristics of a positive approach and understand how it might affect their day-to-day roles and responsibilities

The data from these study cycles (that is, cycles two and three) suggest that across and within the three case studies, stakeholders, who distinguished a positive approach from other models of care, were able to make sense of it. However, their interpretations, and how such an approach might affect their day to day role, differed widely. Briefly, these interpretations of a positive approach were: (i) a strategy for reducing sexual ill health; (ii) a reorientation of sexual health services and/or; (iii) a standard of quality or an optional extra to a service. Whilst these interpretations will be explored separately below, it should be noted it is a simplification of reality. Some stakeholders' interpretations blended two or more of these meanings. Others held more than one definition

simultaneously, for example their own belief and that which represented the current model of delivery. There are also blurred edges between the definitions.

The fact that such disparate definitions exist, however, has ramifications for the implementation of the approach, as will be discussed in chapters seven, eight and nine. Analysis of these positions suggest that the interpretations (i) and (ii) both reflect the positive principles and characteristics outlined in chapter three, albeit to different extents. In the right context they have power to drive change towards local buy-in to positive approaches. By contrast, interpretation (iii) has no such power and is only a limited reflection of the principles and characteristics.

Interpreting positive approaches as a strategy to reduce sexual ill-health
The most commonly held interpretation, across the sample, was that an approach which improves young people's sexual wellbeing will, as a consequence, reduce incidence of infections and unwanted conceptions. There was no clear pattern, however, based on demographic, geographic or professional characteristics which determined who interpreted positive approaches. Those in strategic decision making roles tended to view positive approaches in this way.

Individuals who held this interpretation were all primarily interested in driving down incidence of sexual ill-health, child sexual exploitation and unwanted conceptions in young people. Their primary motivation for this differed across the sample. For example, one health promotion manager in Ponston felt that being a young mother was not good for the parent or the child. One contraceptive nurse in the same setting asserted that they felt that young women were 'lost' when it came to protecting themselves. Conversely, one commissioner, in Rissfield, reflected that their performance and that of the services they commission were judged against the PHOF indicators which, as described in chapter one and three, relate specifically to measures of sexual ill health. This suggests that efforts to reduce ill-health may be motivated by a belief that it benefits young people as well as being the targets that have been set. Despite the different motivations driving them, most described similar approaches which would exemplify a positive approach. These include,

'empowering' young people, providing a holistic service and engaging users in design of services and will be described below.

Those who interpreted positive approaches as a strategy, sought to adapt work practice and processes in order to 'empower' young people. They aimed to do this by giving them access to information, opportunities to ask questions, learn skills and access positive support to help develop their agentic potential. Their rationale was that young people who, for example, had greater self-esteem, had more equal relationships and were happier would make healthier choices. For example, one manager in Ponston explained that,

> *"…empowerment in relationships is really critical and that is a repetitive theme, especially among young women in particular. And without this aspect of it this will just be an ever revolving cycle that lots of people just can't get out of" (Clinical Director, Ponston)*

They further highlighted that simply improving access to services would not be enough if the service did not take steps to address the underlying causes for attendance. This had apparently been illustrated in Ponston where previously clinics had been geographically widespread, which increased access to contraception, STI testing and treatment but had not attempted anything else to support behaviour change. Participants, who shared this interpretation, perceived that a lack of a broader more holistic approach would ensure a perpetual cycle of sexual ill health for young people.

> *"to me it is more than opening a clinic door…so whether we take services out to young people…we use peer education…training partner stuff…build capacity, all of these methods can be used to achieve a particular goal" (Outreach worker, Ponston)*

In Rissfield, the commissioners and managers who developed the holistic youth service (described in chapter five) interpreted a positive approach as one which caters for a broader range of young people's needs. Rather than signposting to other services, the commissioners had worked with the management team to bring together a range of services relating to young peoples' 'exploratory behaviours'. They recognised that there may be common upstream causes of

multiple forms of ill health and that addressing them under one service stream better serves young people's needs.

Individuals who saw a positive approach as a strategy to reduce ill health also recognised the need for services to be user-centred and involve young people in decision making. This was mainly because they felt their input greatly improved the ultimate design of services. One example, cited by numerous interviewees in Stadford, was that the core team had conceived the web-based resource (described in chapter five) as a service finder app. Young people, who were involved in its development had rejected this idea, suggesting that it was unlikely it would be downloaded by their peers as they would not proactively be looking for it. The young people suggested that a more attractive idea would be an interactive, informative and amusing app with content that they might share with friends. This app could have the service locations embedded, should they wish to find them. This insight informed the design of the website and app which was subsequently highly accessed reinforcing the belief that user input improves service design.

Those that saw positive approaches as a strategy to reduce ill-health embraced the idea that collaborative working was essential. For example, at a strategic level, the commissioner in Stadford recognised the need to work together.

> *"and the deputy director of public health and the director of children's services in the local authority were all committed to working together to tackle our sexual health inequalities." (Commissioner, Stadford)*

These practitioners were conscious of giving out consistent messages and attending network meetings to share issues and experience.

Many individuals who interpreted a positive approach as a key strategy for reducing sexual ill-health had done so on grounds of logic: that working with young people's holistic needs and culture would be more successful in meeting the targets than working against them.

Some had been confronted with evidence which they felt was compelling enough to drive them to change their beliefs about the efficacy of a medical or risk-based model of care for substantially reducing incidence of young people's ill health. Some of those who had experienced this described it as a 'road to

Damascus' moment meaning that their eyes were dramatically opened to the new idea and that this knowledge caused them to accommodate their belief system accordingly. Examples grounded in real situations, where systems had changed and young people's sexual health had improved, were most compelling. For instance, Rutgers International had provided the team from Stadford with multiple case studies of where positive approaches had demonstrated such benefits. Access to reputable practical examples of positive approaches in practice appears, therefore, to be currently influential in interpretations of positive services as a strategy to reduce ill health.

Interpreting positive approaches as a reorientation of services to promote sexual wellbeing

A small number of participants, just one or two in each site in cycle two and a handful more across the sites in cycle three, had a more radical interpretation of what positive services are. This interpretation corresponds to their wider view that challenges the dominant power structures and cultural norms concerning young people's position in society. Participants with this view considered that young people are able to contribute to society in a meaningful way in much the same way as any other member of society. They interpreted a positive service as one which supports young people to achieve sexual wellbeing.

In Stadford, one participant who had been advising the local authority and was engaged in outreach work with young people, did not differentiate young people from adults except to acknowledge the emergence of their capacity to consent. This participant's position was that adults make mistakes just as young people do but that young people were the only ones stigmatised for it.

> *"You know, we [adult society] don't see young people being ready for sex as a good thing in any way shape or form" (Local Authority Adviser, Stadford)*

Their working ethos was around developing young people's sexual ethics, that is, that they respect one another, understand consent and seek to do no harm. Similarly, in Ponston, one participant recognised that there are a wide range of

sexual cultures and that, as long as there is legal consent and no harm is done, there is no inherently right or wrong way to express one's sexuality.

> *"So positive… It'll be things like promoting good sex, it would be pleasure. It'll be consensual sex. It'll be dealing with issues of relationships." (Ex Community Manager, Ponston)*

Individuals who thought a positive approach meant a reorientation of services reflected most closely the principles and characteristics described in chapter three. They refer to a need to change language, practices, processes, values and principles underlying the services. For example, one individual rejected the word service in favour of 'provision'. This was because 'service' had come to reflect the clinical medical model and they felt that 'provision' more accurately reflected the support would be flexible to the needs of young people.

> *"I can't talk about teenage pregnancy without talking about consent…contraception…how we feel in a relationship in relation to our body image " (Contraception nurse, Ponston).*

Aligned with this, others highlighted that in all circumstances, efforts should be made to reduce the social distance between the practitioner and the young person. This meant providing full information (for example on contraception side effects) and embedding shared decision making in practice. In some cases it meant creating a coaching culture around the young people rather than just being there to perform medical interventions.

> *"coaching culture…that's about facilitative…self-determination…self-actualisation. It's not about telling them what to do; it's about them realising what's best for them, what's possible." (Ex Community Manager, Ponston)*

Participants who described positive approaches as a reorientation of services advocated the promotion and prioritisation of the views of young people in service design and implementation. Particular attention was paid to how to get users involved and how to act on their viewpoints.

> *"The…campaign is committed to giving young people the power to confidently make positive informed decisions.... To ensure this happens*

we have to listen to what young people want and need and recognise that it's not always something we feel comfortable with but we just have to get on and do it." (Ex Campaign Manager taken from News Reporting Stadford)

This highlights one aspect of the reorientation interpretation, which differs from the strategy interpretation described above, in that practitioners would consider promoting young people's voices over and above that of their own because they consider them as individuals with rights to influence the services which affect them.

The other key difference between a reorientation and strategy interpretation was that people who interpret positive approaches as radical were more inclined than others to disregard sexual health indicators of ill health in favour of a suite of measures orientated towards sexual wellbeing. Participants with this view tended to be critical of the indicators. For example in Rissfield, the service manager was frustrated by what they considered to be blunt outcome measurements and was working with another academic team to develop outcome measurements which might better reflect the contribution the holistic service was making.

In describing how they had come to a reorientation interpretation, two of the participants were working on the basis of social justice. These practitioners, considered to be pioneering by other participants, appeared to have less reverence for or had circumnavigated existing social structures to establish a highly individual style of practice that appeared to promote the sexual wellbeing of young people in their immediate vicinity. When working with these pioneering practitioners, other participants claimed they had tried, to an extent, to model this behaviour.

Participants who interpreted positive approaches as a reorientation of sexual health provision were very familiar with international policy and practice in places famous for their pragmatic, positive stances such as the Netherlands. However, they acknowledged that these models were not easily transferable and felt themselves to be interpreting the positive principles and characteristics for themselves in the settings in which they were working.

All participants who interpreted positive approaches in this way had considered the issue of sexual wellbeing from a socio-relational and emotional wellbeing perspective first, before physical wellbeing.

> *"So the message lots of people get about relationships is that they're not always equal. So if you see that they're not always equal, you don't expect them to be equal" (Ex Community Manager, Ponston).*

Interpreting positive approaches as a quality marker: insufficient to lead to change

A small number of participants across the case studies in cycle two and cycle three interpreted positive approaches as a layer of quality topping a medical or risk reduction model of care. These participants were most likely although not exclusively from GUM clinical backgrounds working in hospital settings.

Participants who interpreted positive services as a standard of quality acknowledged young people's sexuality and recognised the necessity of being welcoming and non-judgemental. They felt this was important to ensure young people would not immediately be put off attending the services. For example, in Ponston, a consultant and the commissioner both said that if young people had a good experience, where they were treated with respect, this would mean that they would tell their friends not to be afraid to use the services and this, in and of itself, would reduce the stigma associated with attendance.

Following on from this, those that interpreted positive services as a marker of quality tended to view the interaction of the service with the young person as transactional. For example, clinical staff in Ponston and Stadford suggested that services are there to provide the young person with what they ask for and deliver this in a friendly and approachable way. If sexual history taking revealed other needs participants suggested they would try to signpost to other services or offer a brief intervention but this was not the aim of the consultation and may not be followed up due to time pressures or lack of connectivity with other agencies.

Some of those who interpreted positive approaches as a standard of quality were aware of other features of sexual health support, such as skill building.

However, they considered these features to be more relevant to education or social work than to their own practice. For example, one clinician when describing possible sexual health work suggested that,

> *"…promotion of sexual health is encouraging people to use condoms, encouraging people to use contraception, giving support for those with psychological issues or mental health issues that could put them at risk. You need to move it upstream really so that they don't end up coming into the Health Service" (Consultant, Ponston).*

This division in roles is arguably at odds with services/practitioners being responsive to the diverse and holistic needs of young people reflected in chapter three. These practitioners' perception of what they personally could contribute to young people's sexual wellbeing was limited to medical or technical interventions. Characteristics of positive approaches such as holistic care, and closer collaboration with contraceptive and non-medical teams were less familiar, less urgent and in their opinion, could risk de-skilling trained staff in the medical aspects of care.

In addition, when discussing patient consultations, practitioners highlighted that whilst patients are offered a choice, options are offered in a way that suggests there is a 'right' choice. For example, within a consultation, the contraception options were graphically presented ranked in relation to 'user failure', suggesting that LARCs are always the most appropriate choice for young people and a different choice is more risky (see Figure 21).
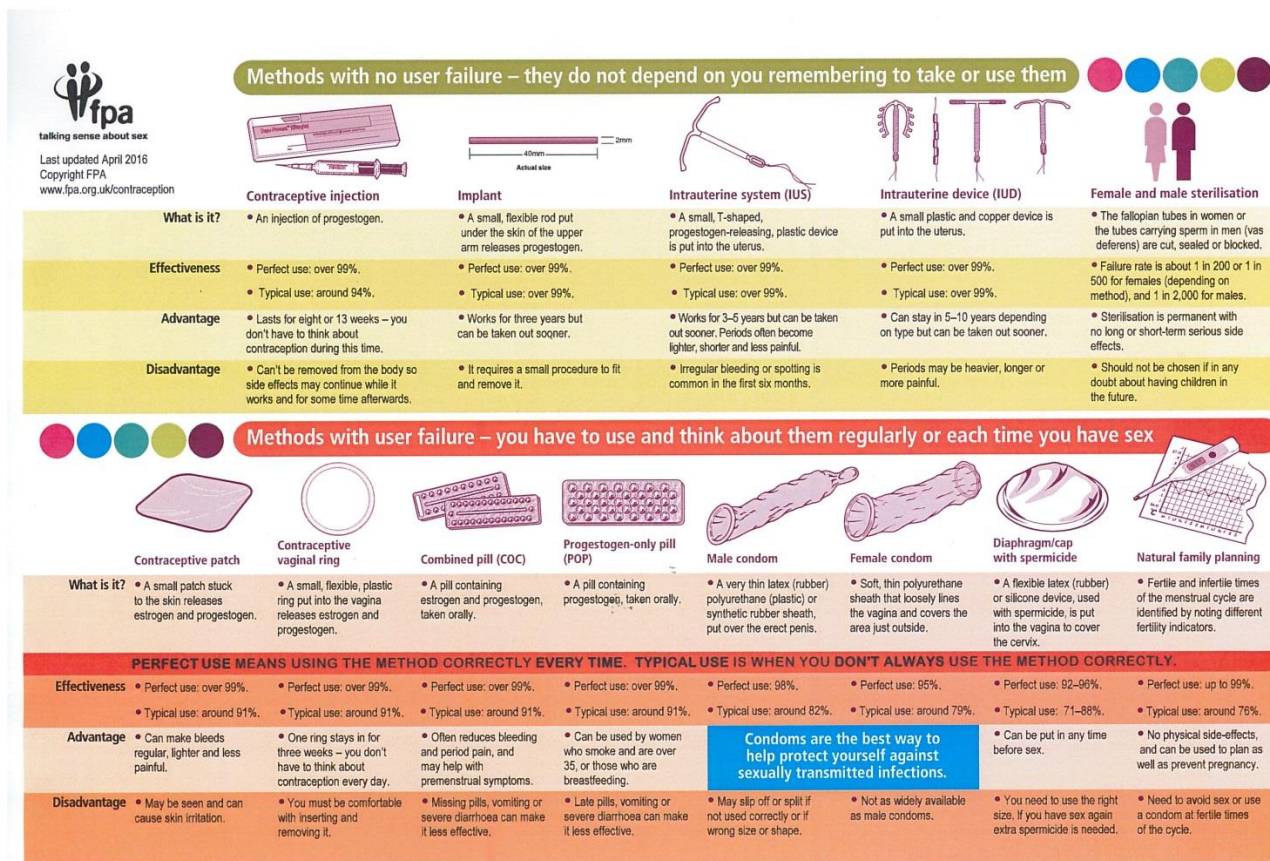
Figure 21. Chart displayed in NHS settings to support young people choose contraception (Source FPA)[23]

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[23] This chart has been updated (September 2017). The new chart does not use the term 'user failure'. Instead it reads 'Contraceptive methods that don't depend on you remembering to take or use them' and ' Contraceptive methods that you have to use and think about regularly or each time you have sex'.

These may be the right choice for some, but side effects associated with the low failure methods, such as irregular bleeding or hormonal imbalance may mean it is not the right choice for others.

In this interpretation of positive services, prioritising users' views in evaluation or design of services are also seen as an 'optional extra'. For example, they were not routinely included due to a lack of budget for such activities and difficulty in accessing young people. This, of course, reflects the stress on resources which were prominent during the fieldwork period but also the low priority of this activity compared to other processes.

A small number also did not feel it relevant to ask young people for their views. They suggested that young people could not contribute to service design as they were 'not experts'. This viewpoint was most commonly expressed in areas where services were delivered through a hierarchical medical model which situated consultants in positions of superiority, with nurses and then community practitioners below them.

Individuals who interpreted positive approaches as a quality marker did not cite any evidence which might support a more comprehensive or holistic approach. They were generally highly influenced by received curricula, top-down policy or guidance documentation and favoured experimental results when it came to evidence-based policy making and practice. These factors ensure that this interpretation is not sufficient to gain local buy-in to positive approaches, as described in chapter three over other models of care.

6.4 Refined programme theories

This subsection presents the refined theory based on the results of the empirical research cycles related to clarity. As noted, the empirical results were analysed with reference to the conceptual framework of theories. Additionally, I have used my own reflective and interpretive skills to make sense of the data. These theories are described in prose and are depicted graphically using the theoretical model of social action.

First, the theories related to how positive approaches are differentiated from other models of care are presented. These are followed by the theories of how different pre-existing contexts and reasoning produce different interpretations.

6.4.1 Refined Programme Theory 1a: Differentiating positive approaches from other models of care

Normalisation Process Theory (May & Finch, 2009) posits that differentiation is one process necessary for embedding new practices in organisation. The Morphogenetic Approach (Archer, 1995) and COM-B (Michie et al., 2013, 2011), as frameworks for understanding behaviour or social change, suggest that ideas need to be available and people need to be able and motivated to learn, but do not suggest the processes by which this occurs.

The data illustrated two main processes of learning to distinguish between positive models and other models of care were derived from the data. The entities related to differentiation described in Table 10 and 11. In realist terms, each of these packages could be described as a *'generative mechanism'*, in that it is the combined effects of multiple mechanisms which give rise to individual learning.

Common to both of these processes is the ability and opportunity to critically reflect on current practice and underlying assumptions. This seems to be a process of examining one's thinking and where necessary synthesising different perspectives to help make sense of an experience. Three of the conditions were also common to both learning processes. These were the perception that practice could be improved (either self-motivated, or directed by the organisation) and time for training and/or reflection and awareness of positive approaches. Awareness was however brought about by different routes as described below.

For those, in decision making roles, without recent frontline experience, '*transformative*' learning was brought about in the context of availability and access to new ideas.

Table 10 Transformative learning leading to clarity

Prior conditions	Availability of ideas about positive approaches to youth sexual health services
	Access to these ideas about positive approaches (for example through training, networking or conferences)
	Time to reflect
	Perception that practice could be improved
Habitus or internal conversations	Collectively triggers:
	Critical reflection of 'practice' compared to new material
Transformed or reproduced states	Leads to:
	Individual appreciation of positive approaches to youth sexual health services as different from other models of care

For those in frontline positions, particularly in non-clinical fields *'experiential'* learning was brought about through working with young people in situations in which they had a degree of autonomy in their practice and/or access to discussion with respected peers and/or exposure to situations in which heteronormativity is challenged.

Table 11 Experiential learning leading to clarity

Prior conditions	Exposure to working with young people (in settings outside clinical practice),
	AND/OR access to respected peers and information discussion
	AND/OR exposure to situations in which heteronormativity is challenged
	Time to reflect
	Perception that practice could be improved
Habitus or	Collectively triggers:

internal conversations	Critical reflection of 'practice'
Transformed or reproduced states	Leads to: Individual appreciation of positive approaches to youth sexual health services as different from other models of care

These processes are described separately. It is, of course, possible that one person could have developed learning via both transformative and experiential processes over time. In multiple accounts, various combinations of these contextual features co-occur. Largely this appears to reinforce learning. There were no examples in the fieldwork where experience working with young people and external training resources contradicted each other.

Certain conditions do not facilitate proactive learning about positive approaches. Immediate resource pressures reduce the time available to proactively consider alternative models of care as well as any direct costs associated with training or attendance at conference. Organisational priorities may direct budget and attention elsewhere, for example towards clinical advancements. Finally the lack of policy coherence around positive approaches leads to mixed and possibly conflicting messages in practice. These factors, alone, do not prevent learning because, as described, there are other means to acquire the knowledge.

6.4.2 Refined Programme Theory 1b: Making sense of positive approaches

May and Finch (2009) suggest that individuals must be able to interpret how an approach would affect their day to day responsibilities to embed a new practice in an organisation. The concepts from the Morphogenetic Approach and COM-B extracted to form the conceptual model did not elucidate this process further.

The results suggest that there are multiple interpretations of positive approaches and that sense-making is not static. Three main interpretations were described in the results. Theories concerning how these interpretations were formed are elaborated here below.

The first interpretation, *a strategy to reduce sexual ill health,* is refined with reference to the overarching context of a risk-reduction model of sexual health services which is dominant in England (described in chapter one) see Table 12. Those who attempted to implement positive approaches arguably interpreted the ideas (consciously or sub consciously) with reference to this background context and the dominant policy directives described in chapter three. This was particularly true of those who had strategic responsibility for sexual health commissioning and delivery. In these conditions, a positive approach was primarily interpreted as a strategy to reduce sexual-ill health.

Table 12 Interpretation of positive approaches strategy as to reduce ill health

Prior conditions	Dominant discourse about protection, ill-health and risk
	Policy reflecting narrow sexual health outcomes
	Strategic decision making role
	Differentiated positive approaches from other models of care
Habitus or internal conversations	Collectively triggers:
	Critical reflection of practice
	Influence of dominant discourse on sense-making
Transformed or reproduced states	Leads to:
	Individual interpretation of positive approaches as a *strategy to reduce ill health*

The second interpretation, *a reorientation of services,* is refined with reference to the overarching context of a risk-reduction model of sexual health services which is dominant in England *and* availability of other discourses relating to human flourishing and sexual wellbeing (described in chapter one) see Table 13.

Individuals, who were aware of a social model of health, and particularly where they have regular interaction with young people themselves, and/or a group of colleagues who champion positive approaches interpreted positive approaches as a new way to think about delivering services. In this interpretation, young

people's rights and wellbeing were of greater focus than impact on outcomes measures.

Table 13 Interpretation of positive approaches as a reorientation of services

Prior conditions	Aware of discourses about sexual wellbeing and human flourishing Not in strategic decision making roles Differentiated positive approaches from other models of care
Habitus or internal conversations	Collectively triggers: Critical reflection of practice Influence of flourishing discourse on sense-making
Transformed or reproduced states	Leads to: Individual interpretation of positive approaches as a *reorientation of services*

Both of these theories can be brought together with reference to the overarching model of social action. First, figure 22 depicts a refined theory of the generative mechanism to explain how positive approaches might be interpreted as a *strategy to reduce sexual ill-health*. Here, cultural and structural entities associated with risk based theories of sexual health, as well as ideas about positive approaches from external sources are considered by an agent with time to reflect and motivation and responsibility to improve performance. Second, figure 23 depicts a refined theory of the generative mechanism to explain how positive approaches might be interpreted as a *reorientation of services*. Here, cultural entities associated with both risk and flourishing based theories of sexual health, as well as ideas about positive approaches from informal sources are considered by an agent with experience of working with young people and/or exposure to challenges around heteronormativity and time to reflect and motivation to improve performance.
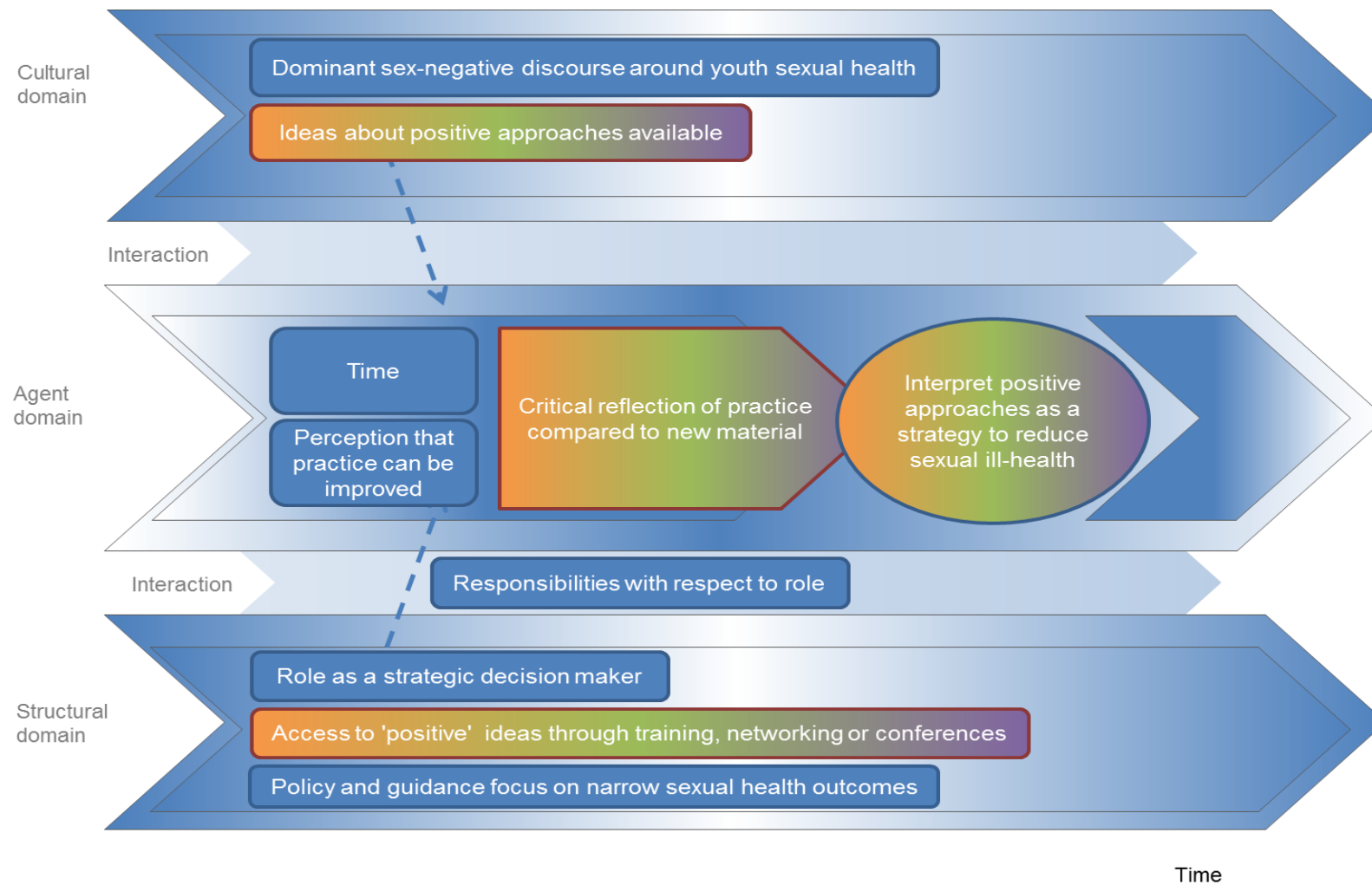
Figure 22 Refined theory of generative mechanism: interpreting positive approaches as a strategy to reduce sexual ill-health
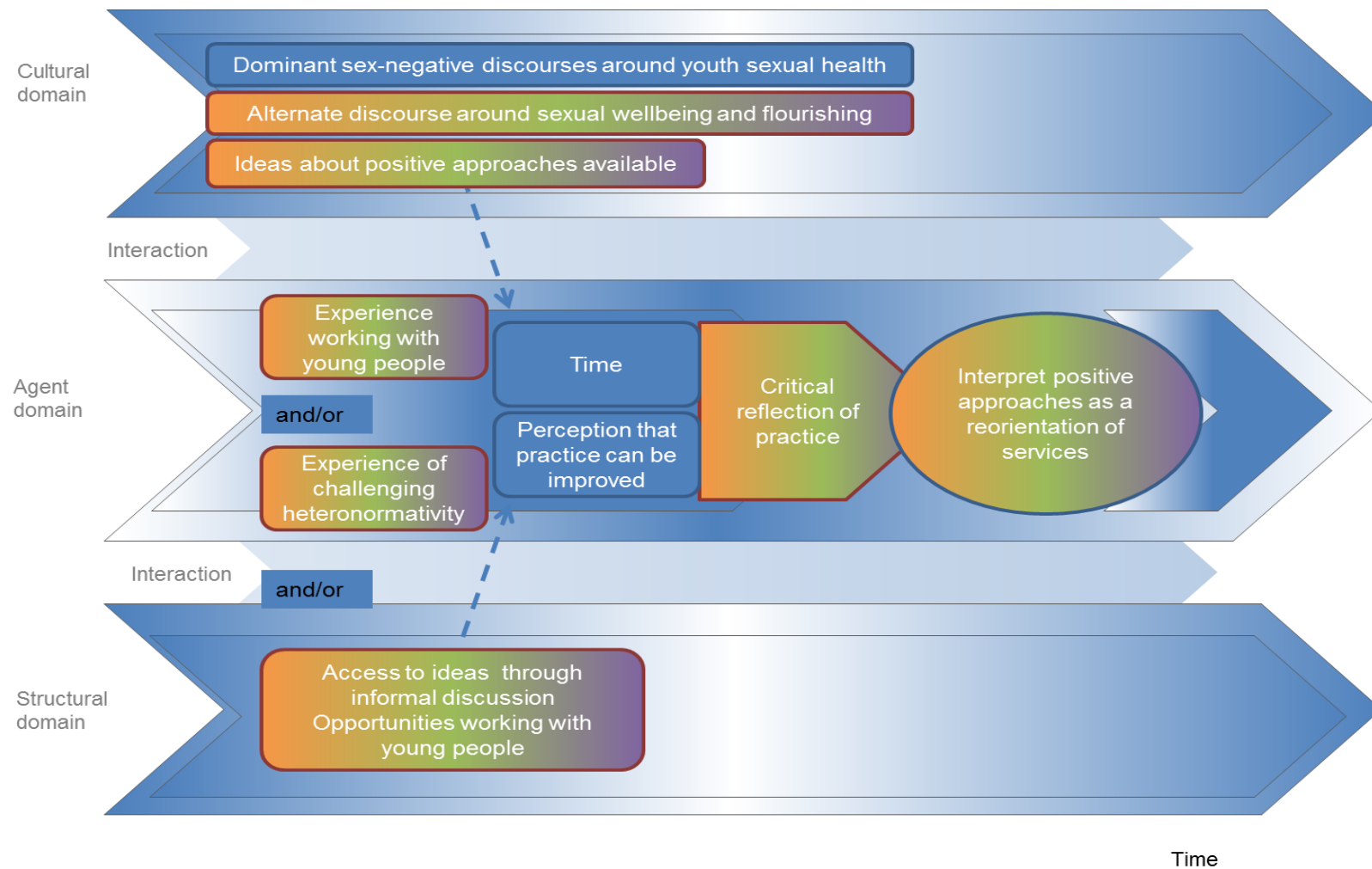
Figure 23 Refined theory of generative mechanism: interpreting positive approaches as a reorientation of services

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6.5 Chapter conclusion

This chapter has outlined the process of refining the initial theories derived from cycle one via two rounds of realist research.

The results have supported substantial revision of the initial theories. They have illustrated that participants learnt to differentiate positive services from other models of care by transformative or experiential learning processes. It is argued that critical reflection is the key means by which this learning occurs and that this is necessarily and internally related to a desire to improve, time to reflect and a source to reflect on.

It has also been demonstrated that differentiation from other models does not necessarily mean a common interpretation. The way that participants make sense of a positive approach is not static but ever-changing. Three interpretations were described that reflect the breadth of understanding. These include an interpretation that positive approaches mean a radical overhaul of services, a strategy to reduce ill-health or a quality marker. It is proposed that these interpretations are related to individuals' prior beliefs, particularly with regards to rights-based approaches compared to evidenced based approaches and the extent to which they subscribe to a medical model of health.

How individuals interpret positive services, compared to their frames of reference, has an impact on their conviction in a positive approach as the most appropriate model for youth sexual health services as will be seen in chapter six.

The diversity of views uncovered in services which claim a positive or holistic model of service is a key feature of local buy-in which will be fully explored in chapter seven.

Chapter 7. Results relating to the theory theme of conviction

7.1 Chapter outline

This chapter relates to *'conviction'*, one of the theory themes developed in cycle one (reported in chapter four) and an extension of the theory developed about *'clarity'* (described in chapter six). It reports the results of the empirical research, (introduced in chapter five), and how the theory was refined in light of these results.

This chapter reports data about the development of individual understanding and how and why individuals came to develop a confidence and conviction in positive approaches.

The three initial theories, developed in cycle one relating to: compatibility with values, efficacy in meeting objectives and the compounding effect of their combination, were subject to refinement during the empirical research (cycle two and three).

The data supported refinement of the initial theories in a way that would explain how conviction in a positive approach was developed. These refined theories also further explain how this conviction drove action towards a positive approach, even when there was uncertainty in the outcome.

7.2 Initial rough programme theories from cycle one

Initial rough programme theories from cycle one relating to Conviction were:

Theory 2a

When practitioners engage with a positive approach, they will judge it against their values and only have the intention to embed its principles and characteristics in their own work if they deem the values on which it is based to be compatible.

Theory 2b

When practitioners engage with a positive approach, they will judge the extent to which it will help them meet their ends. These may be personal or organisational objectives. They will only have the intention to embed its principles and features in their own work if they believe it meets their ends or those of others.

Theory 2c

When practitioners engage with a positive approach, judge it as compatible with their values and as an appropriate way to meet their objectives they will develop a strongly held conviction in its promise. This will strengthen the intention to embed the principles and features in their work.

7.3 Results

7.3.1 Theory 2a: Conviction based on compatibility of values

These results relate to the initial rough programme theory that people would only embed principles and characteristics of a positive approach if they found it to be compatible with their values. Data from cycle two and three of the research programme demonstrated that this was the case for some participants. However, the picture was more complex for others. This is in part because positive approaches are multifaceted and some principles and characteristics appear to be more acceptable than others. These results are now illustrated below.

Conviction in positive approaches as a 'reorientation of services' based on compatibility with values

Those who interpreted positive sexual health services as a 'reorientation of services' appeared to judge positive approaches favourably against their values. Indeed, it is also the case that these pre-existing values influenced their interpretation of positive approaches.

The common basis of these value systems seemed to relate to human flourishing and human rights, although very few referred directly to the formalised human or sexual rights described in chapter one. Most proponents of positive approaches as a 'reorientation of services' seemed to be self-aware and described their interest and beliefs in one or all of the following values: (i) young people's right to influence services that affect them, (ii) their belief that young people are entitled to sexual wellbeing and that it shouldn't be a taboo and iii) their disagreement with inherent unfairness in inequalities related to age, socio-economic status, sexual orientation and gender. These will now be illustrated with examples below.

(i) Values concerning youth participation. The local authority commissioning team in Stadford described one foundational principle of their approach to public services was being user-led. This, they related to an underlying belief that

young people should be able to influence the public services that concern them. For example, one of the decision makers instrumental in developing the web resource explained that,

> *"[in its previous incarnation, the website] was for young people and yet, no young people had been involved in the whole thing." (Ex-programme manager, Stadford).*

Four different participants, who had been involved in developing the web resource and produced an academic conference paper, reported that gathering young people's recommendations had been a priority and had strongly influenced the decisions they took. They suggested that these actions had been taken even when they or the service providers/senior stakeholders personally did not like the suggestions. For example, young people had argued for the inclusion of slang terminology for sexual practices and graphic pictures in the web resource as they believed it would draw their peers to the site[24]. The research participants explained that they had known this might attract negative attention from the community or news media. However, such was their purported commitment to being user-led that, instead of 'sanitising' the content, which they described might please other adults, they continued with these potentially contentious aspects. These participants had argued to colleagues that the service wasn't for them, but for the young people whose opinion was most relevant. They explained that they had adopted, between them, the mantra to *'feel the fear and do it anyway'*. This illustrates a deeply held conviction which was translated to action despite the possible consequences.

ii) Values concerning young people's right to sexual health and wellbeing. Most of the contraception nurses and some of the GUM nurses, as well as the majority of health promotion specialists working in Ponston and Rissfield suggested, during the cycle 3 feedback, that part of their role, within a positive

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[24] This type of content was illustrated in a similar web resource targeted at young people in the Netherlands. The theory underlying this content is that young people are naturally curious and will search for information about different parts of the body, methods of sexual stimulation and sexual terminology, they may have heard, using the Internet. As a response to this, a publically provided resource allows them to search in a safe place where the content is moderated. Any negative or offensive practices or terminology can be highlighted as needed. It is further argued that content which promotes positive aspects of sexuality is more interesting and appealing to young people, driving online 'traffic' to the website where resources about emotional literacy, relationship health, information about services and safe sex are also provided.

approach, was to help encourage young people to achieve wellbeing. In order to fulfil this role, they felt that they had to be responsive to the needs of the young person and adopt a flexible approach that would enable them to address those needs in a holistic way. For example, one outreach worker explained that they took into account broader cultural and structural factors that might impact on a young person.

> *"…that you understand the wider world, that you understand the place that politics and socioeconomic issues impact on somebody's ability to make a change" (Outreach worker, Ponston)*

For this participant, real support meant working with the young person over several meetings and facilitating them to access information, group work, reengage with education and in some cases to become peer educators themselves.

In Rissfield, the commissioners recognised that young people had holistic needs and believed that a service which was responsive to this would support them better. This meant changing the service design, to provide a young person specific clinic and incorporate more aspects of young people's lives in one setting. In addition, the emphasis of the consultation was changed from a single issue appointment to a more flexible conversation with an emphasis on building their capabilities. The intention was to build a different kind of relationship with young people as indicated by the following quote,

> *"it's important that young people can take responsibility for their own sexual health and it's not just about those services kind of nannying them" (Commissioner, Rissfield)*

Another way in which they had worked to respond, holistically, to young people in the Rissfield service was to ensure that they retained flexible appointment lengths which could last longer than twenty minutes which was the national standard. The manager explained, in cycle 2, that they had retained the option for a longer appointment times because they recognised that often young people give one reason for attending the clinic, for example for a pregnancy test, but that in reality they wished to talk about another aspect of their sexual health that they were more embarrassed about, for example a suspected STI or

a relationship issue. This can take time to work through in consultation and, when the root cause of any problems was identified, the appropriate intervention could be suggested. Some of the frontline practitioners in Rissfield were comfortable with a more conversation based consultation which they felt better drew out these hidden agendas. The manager suggested that, on occasions, some of the nurses worried about this open flexible consultation. They suggested concerns ranged from fear of not following a set protocol and/or worries about the number of people in the waiting room. The manager explained that they had personally deflected this concern saying *'we'll deal with it; you focus on the young person in front of you'*. The management team in Rissfield thought this approach was a better way to help young people to get control of their lives which was, they considered, ultimately a more sustainable way to operate. By the cycle 3 fieldwork, however, the service manager and staff had become worried that they may have to resort to twenty minute appointment times due to a reduction in funding for the service and increased demand from young people. These contextual conditions will be discussed in full in chapter eight.

Most participants who saw positive approaches as a *'reorientation of services'* also explained that they felt that sexuality *per se* should not be a taboo, that they considered it to be a normal part of life and that people, including young people, should be able to enjoy it, if possible. For example, in Stadford, the local authority advisor who worked with the team to facilitate the insight from the young people, and the sexual health commissioner expressed their own values regarding sex and human flourishing; one said,

> *"Sure sex can be a risky business but we must also be prepared to admit that it can be fun, enjoyable and a natural part of a healthy lifestyle"(Local authority advisor, Stadford)*

The team in Stadford suggested that young people should be given the support to embrace their sexuality and aspire to have satisfying sexual relationships when they feel ready for them. For example the lead commissioner reinforced their view that *"this is about emotional literacy"* highlighting that their aim was beyond just behaviour change such as using condoms.

This team appeared to reject approaches that aimed to frighten young people into abstinence by focussing only on the risks associated with sexual activity. For example, in their blog, the local authority advisor wrote,

> *"scaring kids might put them off for a while, but it does not arm them with the tools to make their own choices and not to follow the crowd."*
> *(Stadford, local authority advisor, from Blog.)*

Instead, they explained that they wished the sexual health campaign to be relatable, so that if and when the young person became sexually active they would engage with the content and services offered by the local authority. This also had pragmatic implications, motivated by their position as budget holders. Two of the participants recalled that the educators in the Netherlands had highlighted to them a costly campaign, which had not been seen as relevant to young people and as a result had completely failed.

The Stadford team also thought that the campaign should work to dispel stigma associated with youth sexuality, which they felt to be a root cause of some of the negative outcomes. The local authority team adopted the phrase *'enjoy the sex you have, without the consequences'* to reflect this positive perspective towards sexual health. This phrase was seen to sum up many different reflections of young people's sexual health for these individuals. They explained that it could be just to mean sex is something that can be enjoyed, that sexuality is a part of being a human being and that any risk associated with sexual activity could be avoided.

iii) Values concerning equality. A handful of those who saw positive services as a *'reorientation of services'* drew on the principle that young people's sexual health should be acknowledged and cultural and structural barriers to equality should be addressed. They said this was in line with their beliefs about the importance of eradicating inequalities, particularly concerning young women and vulnerable young men, for example, those who identified as gay, bisexual and/or transgender.

In Ponston, a local councillor, who had been appointed as the Sexual Health Champion in the local authority, discussed their engagement with positive

approaches in relation to the work they were doing with young women more generally. The following quote reflects the reason they gave for being in office:

> *"I am particularly interested in the issue of consent and the experiences of young women and I am involved in a lot of feminist campaigning" (Local councillor, Ponston)*

For this participant, a positive approach to sexual health appeared to be in line with their own values and was perceived to support practitioners in challenging gender stereotypes.

Participants who interpreted positive approaches as a *'reorientation of services'* appeared to be explicitly aware of their own values. Individuals with commissioning responsibilities in Stadford were most vocal, of the whole sample, in their recognition and articulation of values relating to the sexual health of young people. They most readily discussed young people's rights to information, support for emotional wellbeing, and involvement in service design. Notably, this small group had worked together over the previous four years on various projects related to young people's sexual health, including the study trip to the Netherlands. They had had a number of opportunities to articulate their ambitions for sexual health services with audiences both internal to their organisation and outside, which they did with gusto,

> *"not just timidly putting it out and hoping to get it past, but actually in advance doing a conference on why they want to do this [positive] approach." (Commissioner, Stadford.)*

At points the team in Stadford had been under pressure and attracted a high level of negative attention.

> *"We had a lot of hate mail, we had death threats and we had religious groups writing to us saying they were disgusted and that our computers ought to be seized by the police!" (Lead commissioner, Stadford).)*

However, they had rebuffed attempts to discredit the approach, by referring back to being user-led.

> *"…when the shit hits the fan and you're on the front page of the Daily Mail, we wouldn't have survived without the fact that the young people*

had driven it forward. We were absolutely annihilated but we came out smelling of roses because we had their involvement" (Ex-project manager, Stadford.)

This highlights that not only did they feel they had courage in their convictions; their actions had given them a powerful platform on which to implement the change they wanted. These results may indicate that greater awareness of core values and a deep understanding of positive approaches, particularly about why you are doing it, may strengthen conviction in the approach, as long as these values are compatible with their interpretation.

Cycle three highlighted that others developed a personal, almost intuitive sense of why positive approaches were important through working with young people, (a similar route to developing an understanding of what positive approaches are as discussed in chapter six). For example, one of the family planning nurses in Ponston recalled her experience as a school nurse,

> *"working with young people in the past as a school nurse - [I] realised part of a holistic approach to sexual health was the development of the young person" (Family Planning Nurse, Ponston (Cycle 3)).*

Health promotion specialists in Ponston suggested that their experience and previous ways of working, prior to integration, had given them confidence that a positive approach was the *'right thing to do'*. Additionally, their own personal experience influenced their conviction. For example, a GUM nurse who was relatively new to the job wrote in the cycle 3 feedback session that,

> *"Subculture or sexually liberal and genderqueer peers has made me think more holistically about comprehensive sexual health than the results driven by the nature of my work" (GUM nurse, Ponston (Cycle 3)).*

These examples highlight that conviction may not always be based on scientific evidence or logic per se, but on a form of anecdotal evidence, a sense of moral and ethical justification, based on personal values. Many of those who interpreted positive services as a *'reorientation'* described their commitment in emotive terms; that they had 'a vision', 'a passion', 'dedication' to this course of action. This is summed up by the local councillor in Ponston as,

> *"[talking about their role as sexual health champion] it could have been
> quite tokenistic, but because I feel really passionate about it I've worked
> on pushing this agenda forward…arguing to maintain a service which is
> focussed on community engagement and isn't all about the clinical
> aspect" (Councillor, Ponston).*

Such emotional attachment, where present, served to reinforce their belief in positive approaches and subsequently their commitment to taking action, despite the increasingly difficult structural and cultural circumstances in which they were working, which will be discussed in chapter eight.

Conviction is weakened when compatibility with values is variable

A handful of the participants who interpreted positive services as a *'reorientation of services'* highlighted that their values were different to some others they had worked with or which were held by some influential people in the community. One key tension they perceived and sometimes also struggled with was between a strategic approach which focussed on 'protecting' or 'shielding' young people from their sexuality and that of others, versus one which empowered young people to make their own choices. For example, the local authority advisor in Stadford recalled that professional partners often found it difficult to accept that young people may make an informed choice to engage in sexual activity, (such as condom-less sex, or sex with multiple partners), which is consensual, but might increase their risk of contracting STIs or becoming pregnant.

Challenging conversations were recounted with colleagues or parents who were extremely worried that discussing sex in positive terms would encourage sexual activity, a concern that some apparently retained even when contrary evidence was presented. For example, one participant in Stadford provided an anecdote in which they were introducing relationships and sex education to a group of parents when one Dad shouted out:

> *"I don't want my little girl to know that sex is something she should
> enjoy!'" (Local authority advisor, Stadford).*

This participant remarked how they felt this reflected a cultural taboo regarding young people's sexuality and that through their work they try to re-educate people who felt this way. Other commissioners and managers for example, those in Ponston and Rissfield, recognised that they, in contrast, would on occasion omit, 'dumb down' or reposition some of the more contentious aspects of positive services in order to make it palatable for people with differing views.

Discussing pleasure as part of a sexual health consultation appears to be one area which tests individuals' conviction in a positive approach. Some nurses and outreach workers across the three case studies suggested that they were personally comfortable with discussing sexual pleasure with young people indicating this was an important aspect of maintaining sexual wellbeing. They recognised that for many, pleasure was a key reason for engaging in sex and as a central part of explaining young people's behaviour could not be ignored when trying to influence behaviour. The practitioners claimed a discussion about sexual pleasure was also a conduit to a discussion about equality, relationship health and sexual function. For example, one dual-trained (contraception and STI) practitioner in Rissfield outlined some of the ways in which they introduced condoms to clinic attendees including the following,

> *"I'll say something like…'So is he a bit quick off the mark then, because we've got some condoms…called delay that'll help him last a bit longer…you telling him what you like matters.'" (Dual-trained nurse, Rissfield).*

The nurse explained that they were aiming to explicitly acknowledge that sexual pleasure is important for both partners and provide some advice to help the young person to achieve it. They aimed to do this in a light-hearted and humorous way (they also highlighted that 'glow' condoms might come in useful for the young woman if she were playing with 'his light-sabre' all night). A non-clinical outreach worker, who worked across drug, alcohol and sexual health services in Rissfield, included in the cycle three feedback group, reflected a more conservative approach. While they were aware of issues of pleasure, relationships and emotional wellbeing, they claimed that they didn't discuss this in practice because they *"assume they get pleasure"*. This reluctance to introduce pleasure, even as a side note in a consultation, highlights the different

attitudes and practices prevalent in the same service which ultimately influences what one practitioner may do that another may not.

One participant, who had previously led a campaign to raise the importance of sexual pleasure in relation to young people's sexual health promotion, had received a lot of negative press and social media attention. This had knocked their confidence. They still continued to promote *'good sex'* and believed it was important to young people to achieve sexual wellbeing, they were, however, now more wary about how it should be positioned, given the prevalent cultural values. For example, whereas they might previously have been unequivocal and unapologetic about the promotion of pleasure, in a video interview concerning the event they reflected that,

> *"I think we have to be really careful about how we do it and clever, imaginative and creative…don't talk about pleasure per se, we do it as part of a broader approach…openly and honestly…things like consent…good sex and positive sex and pleasure may just occur in that context." (Ex Community Manager, Ponston via YouTube).*

Even those who primarily espoused values relating to youth rights, empowerment and participation acknowledged that there are times, in clinic, or in outreach settings, broader preventative approaches had to be put to one side in favour of reacting directly to harmful, abusive or exploitative issues. One contraceptive nurse in Ponston, for example, reflected that many of the young women that she sees had engaged in sexual practices that they had not wanted to and others had severe mental health problems. Whilst this nurse recognised principles of positive approaches, and thought this was an appropriate model for commissioning, often their priority was safeguarding and to offer the young people a place of safety.

> *"quite a few young girls are having anal sex…there's a lot of exposure to porn…they just haven't got the confidence…we're mindful of sexual exploitation more than ever now…they don't always really know when they are being exploited…we see a lot of people with mental ill health, a lot of depression, self-harm, eating disorders, they're so alone...It's about providing a safe place I suppose." (Contraception nurse, Ponston).*

Similarly, participants from cycle three from each case study site, when asked to reflect on whether they interpreted positive services as primarily about safety or about empowerment[25] reflected that whilst empowerment might be their preferred strategy, safety would always be the first priority for those attending clinic.

For a small minority of participants, the approaches advocated by the organisation they worked for were more positive than their personal views about young peoples' sexual health. For example, two participants in Rissfield, who had been recently employed, explained that a holistic approach was the express policy within the service when they began employment. They reflected that the approach had been determined by the commissioners and management and as new employees they were directed to adopt this model, as illustrated by the following quote.

> *"My understanding was that it came from the top down…the theory was that if you brought everyone together…you then had a much better team." (Outreach worker Rissfield).*

When directly asked to determine which interpretation of positive approach reflected the position of their service and compare it to their own position, they indicated that they were less comfortable about a positive approach compared to others in the team and that their own personal views were more conservative that those of the organisation. One suggested that their view was influenced by the fact that they had recently become a parent and felt worried that their own child would be making similar choices at what they deemed *'such a young age'*. These participants spoke with less passion and conviction for the approach. One had *'put [their] own views to one side'* and made some adjustments to their previous practice, for example to explore the young person's sexual behaviour and reflections in more detail, address issues of consent and seek out root causes of young people's behaviour. They reflected that this was based on a sense of responsibility for the young person's safety,

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[25] in cycle 3 quotes were used to sum up interpretations of strategy and reorientation of services and were explained by the researcher during a PowerPoint presentation prior to seeking feedback from participants. See Appendix 7 for stimulus.

"It doesn't matter what they're doing, whether you agree with it or not, you've got to make sure they're safe". (Outreach worker Rissfield).

This suggests that organisational culture can impact on individual behaviour which is further developed in Chapter eight.

These examples highlight that variable compatibility between a person's core values and a positive approach can prevent individuals' full application of the principles and characteristics, in practice. In Stadford, one local commissioner felt that it was important to bring to the surface these deeply held beliefs and confront them if one was going to be able to understand a positive approach as described in chapter three. They reflected on the time spent in the Netherlands where they had been surprised to find that the educators had explained the Dutch could also be as conservative about youth sexuality as the British but that, for pragmatic reasons they had put these concerns to one side to support their young people.

"[Dutch practitioners] are not afraid to ask the important questions…regardless of whether it might make people blush…they deliver the work anyway because they know it is the right thing to do" (Commissioner, Stadford).

7.3.2 Theory 2b: Conviction based on synergy between a positive approach and personal objectives

The following results relate to the data used to refine or refute theories about the perceived efficacy of a positive approach to youth sexual health services in meeting personal objectives. This theory is supported, to a certain extent, by data collected at cycles 2 and 3. The specific objectives may be related to participants' values, but also specific organisational objectives, for example, to ensure the sexual health indicators were trending in the 'right' way or using budgets effectively. These became individual objectives as fulfilling their duties in relation to organisational performance would help them sustain employment. The perceived efficacy of positive approaches was particularly important to people who were in strategic decision making roles such as commissioners and

managers, who interpreted positive approaches as a *'strategy for reducing sexual ill health'*.

Perceived efficacy of a positive approach in meeting objectives

Many participants in management positions who interpreted positive services as a *'strategy to reduce sexual ill health'* acted on an evidence base, which they felt could be duplicated in the current situation. For example, in Rissfield, commissioners explained that part of the decision to integrate sexual health, drugs and alcohol services was based on evidence that poor outcomes arising from sex, drugs or alcohol related activity stem from underlying inequities. A consultation on merging the service reports that,

> *"There is gathering recognition of the integrated care model and the benefits of offering a holistic, patient-centred, team-based care and of generalism, as well as specialist knowledge (Ham et al 2012)… It was proposed that some services should be redesigned and integrated in order to improve health outcomes for young people in Rissfield." (Rissfield, Consultation with Young People Report).*

This report suggests that the commissioners agreed that outcomes would be improved by merging the service offer and pooling the expertise across the practitioner group. This might be best for supporting the young people as illustrated by this quote from the drugs outreach worker,

> *"a lot of the more complex ones…will tell you, 'I've seen a million professionals'…And if you can say, 'well, actually it's just going to be me'…they're more accepting of what you're doing." (Outreach worker Rissfield).*

Another consideration was potentially containing costs for the local council by reducing the number of organisations they commissioned. For example, within the consultation report, commissioner recommendations included:

> *"The service provider should consider new, potentially more efficient ways of working that are acceptable to young people" (Rissfield, Consultation with Young People Report).*

The lead commissioner in Stadford also pointed to the evidence base. They said:

> "You have to be clear about why you are doing it, you have to have an evidence base, and you have to be very brave" (Commissioner, Stadford).

This, and other participants, referred to the Netherlands model of sexual health services as their evidence base, stating that this was sufficient evidence for them to warrant attempting a more positive approach to their sexual health campaign.

One participant from Stadford, who had been the Teenage Pregnancy Coordinator when these roles had been established through the Teenage Pregnancy Strategy (1999), explained that they had been driven to act, initially, through a recognition that under 18 conceptions were still high compared to places in Europe and that STI rates were increasing. This participant was driven to find a 'better' approach, which implies that they believed the positive approach, they subsequently implemented, would positively impact on these rates. They explained this outcome was important for the pragmatic reason of securing continued funding.

> "Well for me it was less of a priority but our funding was very dependent on the figures going in the right direction, it was." Ex-Programme Manager, Stadford

This quote highlights that some participants acted to implement a positive approach to youth sexual health services because they thought it was the right thing to do, and because they also thought it was the best way to meet the organisations' objectives.

The community outreach and health promotion teams in Ponston who interpreted positive approaches as a 'reorientation of services' suggested that it was in line with the NHS prevention and health promotion agendas. They considered the principles and characteristics of positive approaches were designed to support young people avoid sexual ill-health in the first place. The local councillor also highlighted that sexual ill-health was, for them, entirely preventable and that "prevention is better than cure" for both the young people

and society in general. The ex-community manager cited national statistics that demonstrate the amount saved by effective health promotion and contraception programmes more than justified their costs. However, despite these assertions, other competing organisational objectives made things more complex, as will be illustrated below.

When projecting forward how this approach might play out, several of the participants, who proposed a positive approach, (resembling either interpretation,) recognised that it could pose a risk to their personal status. This risk was primarily associated with resistance and backlash from the community or the media, as opposed to risk associated with failure of the project. The commissioner and campaign manager in Stadford at the time referenced the need to 'be brave' and to think about young people's choices, for example.

> *"…this is about emotional intelligence and confidence around a range of things…if you want to create healthy young people who make those decisions you have to take those decisions yourself". (Commissioner, Stadford)*

Their actions included a number of strategies to mitigate or off-set this risk, for example, by reminding those who denounced the project that it was to serve the needs of young people, by getting a wide range of people across the region involved in the movement to ensure support and consistency of message and by collecting new forms of evidence to support their activities. This will be discussed in full in chapter eight.

Partial or little perceived efficacy of a positive approach in meeting objectives

Some participants reflected that a positive approach did not always meet their objectives. In some cases this was because their personal and organisational objectives were not in line. In others, this was because a positive approach was deemed appropriate in one setting, for one client and not another or for one decision and not another. The data relating to these scenarios is now outlined below.

A handful of participants across the sample expressed that their personal objectives were occasionally in conflict with other organisational objectives. For example, one contraceptive nurse, in Ponston, reflected that much of what they do in their consultations with young people is determined by the mandatory processes of the role, for example completing the sexual history taking protocols *'the dry side, if you like'*. Their own objectives were based on the belief that they can provide *'a safe place'* for young women who were unsupported and didn't know where else to turn. They personally thought that it would be challenging for positive approaches to satisfy all the organisational objectives. They highlighted a tension between the organisation wanting to account for every exchange within a consultation, and control things through templates and protocols, compared with the actual work they undertook, which they perceived to be much more open and multifaceted.

> *"…we're talking about contraception…prevent an STI…get them the right support for their mental health…keep them safe…doing lots of different things that [management] don't know what we're doing…" (Contraception nurse, Ponston).*

This participant believed it was difficult to measure exactly what they did and highlighted that their immediate boss, who had a GUM background was unaware of the particular way in which they conducted the consultation and did not appreciate the difference between this and a clinically based consultation. However they appreciated that people in decision making roles had different priorities,

> *"[positive approaches] are difficult to prove…the money has to go where we can see it's needed…targets are set for a [strategic] level…I'm not thinking of, because my passion is helping that young person…" (Contraception nurse, Ponston).*

In cycle three, when a possible discrepancy between individual and organisational objectives was prompted by myself, participants from a range of backgrounds highlighted a range of tensions that affected their personal viewpoints. For example: that the emphasis in clinic was only on safeguarding, STIs and unwanted conceptions, and/or that the services' efficiency objectives

were not conducive to longer appointment times that a positive approach might necessitate. These tensions are illustrated in more depth below.

Commissioners in Rissfield suggested that whilst they would love to drive towards a 'high quality service', by which they meant one which had a holistic focus and drove towards young people attaining sexual wellbeing, what they perceived the elected local council members and central government were only interested in was reducing under 18 conceptions and incidence of STIs. They explained that this was what they, as commissioners, would ultimately be measured against as highlighted by the following quote:

> *"it is our job to just make sure that the money is spent well. So we want to see those, increases in this, decreases in that…if we were going to go back and report, 'well you know we haven't seen a decrease in conceptions but young people are feeling really good about themselves and they can really negotiate condom use', or something like that I'm not sure that would have the same impact". (Commissioner, Rissfield).*

The commissioner implied that they were looking for interventions which they could be confident would impact on the indicators. This seemed important to commissioners and senior managers, who considered that they would be held accountable for the performance of the organisation, and as such had more to lose if it were to go wrong. In these cases, while they believed a positive approach might be able to have that impact, they could also see a range of challenges associated with implementation and recognised other medical or technical interventions might be more efficacious, in the short term, for impacting on the indicators. For example, they referenced their perceived difficulty in recruiting user groups, or that they thought the system did not support collaboration across agencies, or that they felt that the current economic climate and austerity measures meant that they could only be reactive to immediate need and not proactively innovate service commissioning. Some were also put off by the possible negative reactions from the community and press. In short, some of the commissioners and managers appeared to be inhibited by the possible challenges or negative eventualities that they could imagine. These people were unwilling to take the risk of developing positive services, believing that the uncertainty was too great or the challenge to hard.

Some clinicians, particularly those in Ponston, thought that a positive approach may be appropriate as an overall public health strategy for youth sexual health, but not for their service. They suggested that the strategy would ideally be wider than the sexual health services and join up with education and social justice policies, as highlighted by the following open ended response from cycle 3:

> "Readiness to express and enjoy sexuality is influenced by broader influences than sexual health, for example, self-confidence stemming from family/peers/school/leisure environment. These needs can also be met by other services." (Health Advisor, Ponston (cycle 3)).

They questioned the efficacy of positive approaches in their own service, however, for making a positive change in young people's lives, a position mirrored by a consultant in the same service.

> "I don't think it's necessarily messages that people get from the sexual health workers [that make a difference to their sexual wellbeing]." (Consultant, Ponston).

These participants also questioned whether young people would sufficiently engage with clinicians in clinic.

> "Young people expect us to treat them without interfering in their relationship." (Consultant, Ponston (Cycle 3)).

This particular participant rejected the introduction of positive, comprehensive, holistic care into their work, believing it better placed in other public services. This illustrates that where participants were unable to see how general principles and characteristics of a positive approach could help them deliver their objectives, they did not develop conviction in positive approaches and subsequently little or no action was taken, even if the local service claims such an approach.

7.3.3 Theory 2c: Compatibility with values and effectiveness in meeting objectives enhances conviction in a positive approach

In cycle 1, it was suggested that conviction in positive approaches would be enhanced where there was both compatibility with values and perceived efficacy in its ability to meet objectives. This theory was substantiated in part. However, high conviction is possible, even where there is a disjunction with meeting personal objectives. These conditions are explored below.

The data showed that those who thought that it was right to take a positive approach to young people's sexual health and believed that it would meet their own and organisational objectives had great commitment to it. This was observed most notably amongst the local authority commissioners, advisor and outreach workers in Stadford who believed that a positive approach was most efficacious to meet the counties' long term objectives but that also it was right for them to serve the young people and not be put off by detractors. They had worked together to deliver the positive sexual health campaign and website which had in the short term been successful as demonstrated by positive evaluation reports.

One commissioner in Stadford explained why they continued to pursue a positive approach as follows:

> *"I think that if you are passionate about what you are doing, which I am, and you are clear that you are here to improve the situation and well-being for the whole population, not to please people, and you feel you have the support to do that…and we have that here at every level of the local authority"* (Commissioner, Stadford).

These participants felt optimistic about taking a positive approach and were ready to commit to a long term effort to change the emphasis and organisational culture.

Despite this strong support for the theory that compatibility with values and belief in it helping to meet objectives enhances conviction, it is not sufficient to suggest that this is always the case. For example, in Ponston, outreach workers and the ex-community manager had a strong conviction in positive approaches, despite the fact that they perceived that, through the process of

integration, their service had retrenched back to a medical model of health. A positive approach was now seen as being out of favour and incongruent to meeting the narrow objectives of the new integrated organisation. Despite this, their conviction in positive approaches, as the most effective approach in the long term for supporting young people's sexual wellbeing, was not diminished. In one case this confliction had been instrumental in the resignation of a senior member of the team. This is one example of the challenges associated with implementing positive approaches into complex systems which will be explored in chapter eight.

7.4   Refined programme theories

This subsection presents the refined theories based on the results of the empirical research cycles related to Conviction. As explained in the methods section of chapter 5 the empirical results were analysed with reference to the *conceptual model of theories*. Again, I have used my own reflective and interpretive skills to make sense of the data. Once more, these theories are described in prose and are depicted graphically using the model of social action.

The results show that individuals who distinguish a positive approach from other models of care appear to judge the positive approach against both their personal values and/or their beliefs that it can help them meet their objectives. Analysis indicates that where individuals interpret positive approaches as a *'reorientation of services'*, their conviction is born out of compatibility with their values. Alternatively where individuals interpret positive approaches as a *'strategy to reduce sexual ill health'*, their conviction is based on a perceived efficacy in such an approach meeting their organisational, and role, objectives. Those in positions of authority, in particular, appear to need this reassurance to safeguard their position. The data illustrates that this appraisal may be based on evidence and/or logic which is sufficiently convincing for the individual.

However, the picture is muddied as:

- Some aspects of positive approaches are more compatible with people's core values than others.
- Individual's objectives are multiple and sometimes incommensurable.
- Some do act in line with some principles and characteristics of a positive approach, despite not having much conviction in it.

Rather than give every possible permutation relating to conviction, (which would not support the overall aim to increase understanding in what works to deliver positive services), the refined theory here combines initial rough theories 2a, 2b and 2c to outline two routes towards local buy-in to positive approaches. These theories do however distinguish the basis of conviction according to the interpretation of what positive approaches are. They are further advanced by proposing the underlying generative mechanisms operating at an individual level which can lead to action.

7.4.1 Refined theory 2a: Conviction based on interpretation of positive approaches as a reorientation of services and compatibility with values

The COM-B model of behaviour change (Michie et al., 2011) suggested concepts of automatic and reflexive motivation as a precursor to action. The data has highlighted that where people have conviction in positive approaches as a *reorientation of services* this is born out of compatibility with values, which may or may not be judged. The data highlights that intuitive and emotional responses also play a part in developing conviction in positive principles and characteristics.

Table 14 sets out a possible generative mechanism leading to conviction in positive services. This mechanism may be intertwined with the generative mechanism leading to Clarity. Where individuals have an understanding of and interpret positive approaches as a *'reorientation of services'*, self-awareness of personal values concerned with one or more aspect of 'human flourishing', a belief that they can play a role in supporting young people to achieve sexual wellbeing, they will judge that positive approaches are the 'right thing to do' to benefit young people. Where they believe there is no perceived conflict with organisational objectives, or that such conflicts can be mitigated, or that they do

not prioritise the organisational objectives the individual will develop conviction on which they may act. The action they take and impact this can have will differ according to their role and relative power within the system (this theme will be taken up in chapter eight).

Table 14 Conviction based on compatibility with values

Prior conditions	Critical reflection of practice in relation to youth sexual health AND self-awareness of personal values relating to human flourishing AND/OR exposure to ideas about positive approaches/sexual wellbeing Perceived lack of conflict with organisational objectives AND/OR conflicts can be mitigated AND/OR do not prioritise organisational objectives
Habitus or internal conversations	Collectively triggers: Internal conversation resulting in judgements of compatibility of a positive approach with personal values, that is, reflexive motivation (evaluative) Intuitive and emotional response that this is the 'right thing' to do, that is, automatic motivation (emotions and impulses)
Transformed or reproduced states	Leads to: Commitment to action towards reorientation of service (actions towards flourishing, pro-choice, non-prescriptive)

7.4.2 Refined theory 2b: Conviction based on interpretation of positive approaches as strategy to reduce sexual ill-health and synergy with objectives

In contrast to that described above, the data has highlighted that where people interpret positive approaches as a *strategy to reduce sexual ill-health* this is

related to an appraisal of the approaches' *synergy with objectives* and judged explicitly against evidence of logic.

Where individuals have an understanding of and interpret positive approaches as a 'strategy to reduce ill health' concerns for organisational objectives, perceived efficacy in positive approaches to meet organisational objectives, the individual will develop conviction on which they may act. The action they take and impact this can have will differ according to their role and relative power within the system (this theme will be taken up in Chapter 7).

Table 15 Conviction based on synergy with objectives

Prior conditions	Concerns for organisational objectives critical reflection of practice in relation to youth sexual health AND/OR exposure to ideas about positive approaches/sexual wellbeing
Habitus or internal conversations	Collectively triggers: Internal conversations resulting in judgement that positive approaches are the best way to reduce ill-health, that is, reflexive motivation (evaluative)
Transformed or reproduced states	Leads to: Commitment to actions towards strategy for reducing ill-health (broadening ambition for service delivery)
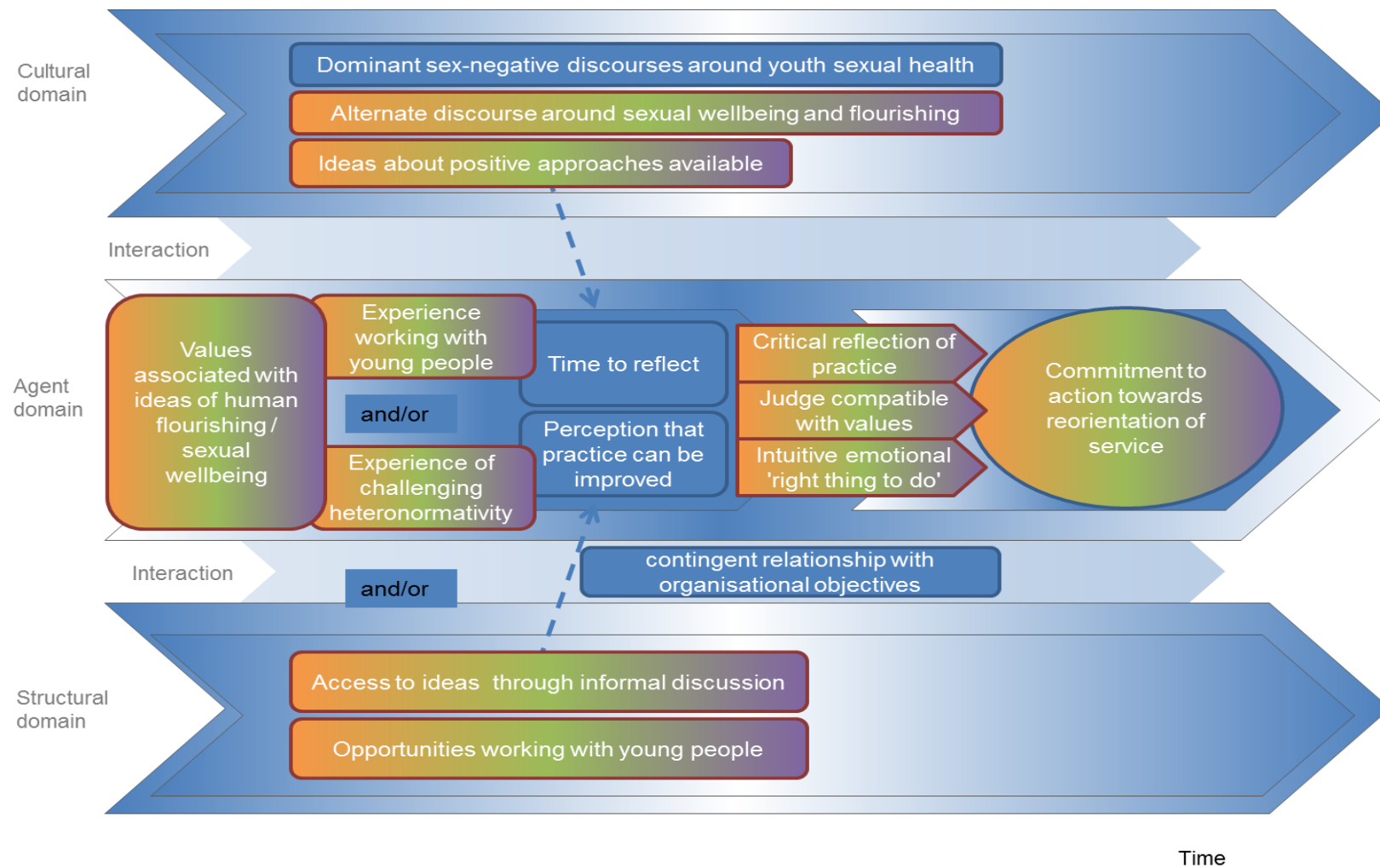
Figure 24. Refined theory 2a: Conviction in positive approaches being the best 'strategy to reduce sexual ill health' leading to action.

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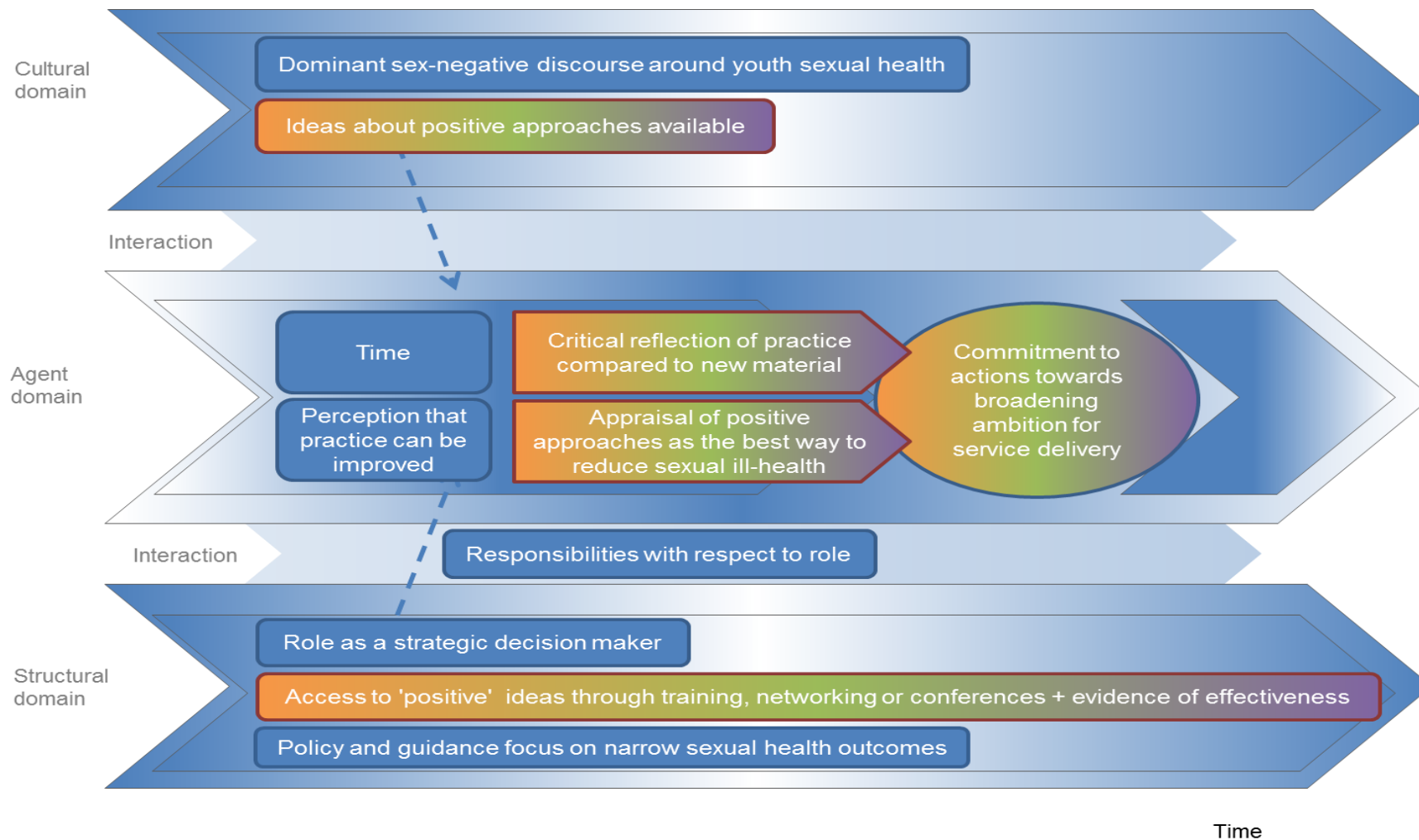
Figure 25. Refined theory 2b: Conviction based on synergy between a positive approach and personal objectives

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7.5 Chapter conclusion

This chapter has further refined the initial theories derived from cycle one. Once more, a substantial revision of the initial theories has been possible with insights relating to how and why participants judged positive approaches in the way that they did, and what process led them to take action.

The results have illustrated that participants' action or intention to act towards a positive approach may be based on perceived compatibility with their values, or perceived efficacy with their objectives, or both. They may take action on the basis of examples and ideas, even when these might not be considered as top 'quality' evidence. They may also take action, even when the possible risks, such as backlash from media or the community, are high. However people may also act in line with a positive approach based on the organisational direction.

Chapter eight will now explore how, if a positive approach is to be implemented, individual conviction must be converted to collective action within a service attempting to implement positive approaches to youth sexual health. It outlines proposed mechanisms to achieve local buy-in but also demonstrates that a range of contextual features create a challenging environment in which to affect change.

Chapter 8. Results relating to the theory theme of coherence

8.1 Chapter outline

This chapter presents the data relevant to the third theory theme, Coherence. It follows chapters Clarity, which primarily set out how people came to an understanding of positive approaches, and what this understanding was, and Conviction, which describes the circumstances in which individuals came to act in line with positive principles, based on their values, and / or beliefs that a positive approach was the best model to support young people's sexual wellbeing.

Theories related to the contextual integration of positive services, developed in chapter four, were tested over two realist cycles. These theories correspond broadly to cultural coherence - that is the synergy of ideas about the positive services between local stakeholders, and structural coherence - that is the fit between positive principles and characteristics and existing ways of working. These sub themes will be discussed in turn as they relate to elaboration of conditions in different 'realms'.

The individual, interpersonal, structural and cultural mechanisms which led to organisational and local network buy-in and the contexts in which these occurred are presented. This chapter also outlines the conditions in which local buy-in was not achieved, or maintained, and provides evidence and theory to explain these undesired outcomes.

As with the previous two chapters, this chapter ends with the refined theories, presented in both prose and diagrammatic form. These are elaborated from the theories presented in chapter four.

8.2 Initial rough programme theories from cycle one

IRPTs from cycle one relating to Cultural Coherence were:

Cultural coherence

IRPT 3a

When commissioners, managers and practitioners, who intend to embed a positive approach in their work share an understanding with other local decision makers and pursue the same goals, they will be motivated to work together as this will enhance their chances of success

IRPT 3b

When there is a clash between the existing cultural and the new idea and the advocacy group have high corporate agency, by virtue of their own role and status, ideas and processes relating to the more traditional approach may be 'eliminated' and a positive approach imposed.

IRPTs from cycle one relating to Structural Coherence were:

Structural coherence - evidence and accountability

Theory 3c

Where evidence based practice is strongly recommended, positive approaches may not be deemed acceptable, as it may not have a suitably strong evidence base. In these cases, practitioners are compelled to develop a credible, alternative or additional evidence base to substantiate its wider claims.

Theory 3d

When commissioners, managers and practitioners believe that a positive approach is the best way to meet the pre-existing organisational objectives such as reducing teenage conceptions and STI transmission rates (theory 2b), work will be orientated towards and evaluated against measures related to these outcomes. If outcomes do not improve, this may pose a threat to a positive approach because organisations are orientated towards demonstrable successes.

Structural coherence - collaborative, multi-disciplinary working

IRPT 3e

When all individuals, with a role in the delivery of youth sexual health services, have a shared, broad understanding and conviction in positive services (theory 3a and b), they will intend to work to develop a collaborative approach with other stakeholders in the network.

This may require additional resources of time or money which may only be available in times of strong economic performance or if other aspects of the service are deprioritised.

Structural coherence - user involvement

IRPT 3f

When all individuals, with a role in the delivery of youth sexual health services, have a shared, broad understanding and conviction in positive services (theory 2c), they will work to include users in the design and evaluation of their service because: it is right to consult people on services that affect them, and/or this may provide insight to improve service design and/or this may provide evidence to support the service transformation.

As highlighted in chapter five, the case studies, despite operating within a broadly similar national context, had differing levels of local buy-in to positive services. These results will be presented first with regards to how a shared understanding of positive services came about, and importantly, by whom it was shared. Second, results will detail how, and to what extent, those with a shared understanding were able to influence those around them.

8.3 Results

8.3.1 Theory 3a: Developing shared understanding, goals and a conviction that it can meet organisational objectives

The data illustrated that a shared understanding was developed among a core group of people in each case study. For the sake of clarity, this process will be illustrated for each case study

In Stadford, as described, a core team of decision-makers built a broadly shared understanding of and conviction in, positive approaches which they had developed through exposure to the Netherlands model on the study trip.

These participants' explanations show that their understanding and the basis of their conviction was not exactly the same. For example, the local authority advisor's interpretation appeared to be primarily values-based, and related to a *'reorientation of services'*, whereas the project manager and commissioner were also mindful of a need for reducing incidence of ill-health.

> *"[we should set] target rates as low as Holland" (Ex-project manager, Stadford).*

This may be because the project manager's and commissioner's role performance and continued service funding was also measured against these rates, whereas this was not as pertinent for the local advisor who was self-employed. That said, the project manager and commissioner both claimed that reducing ill-health was not their primary motivation, for example,

> *"Well for me [the outcomes indicators in the PHOF] were less of a priority but our funding was very dependent on the figures going in the right direction" (Ex-project manager, Stadford).*

Despite this slight disparity, the key principles of positive approaches, being about a broader conceptualisation of sexual health, acknowledging young people's sexuality and, in particular, ensuring users were influential in the design of the services appeared to have been shared amongst these three participants. This perceived compatibility, at the outset, between a values based interpretation and strategy based interpretation appeared to enhance their desire to work together. Indeed, their ultimate goals were shared, that is, to improve the sexual health and wellbeing of young people, even if these goals served slightly different purposes (in the case of the advisor, to satisfy young people's rights and in the case of the commissioners, also to meet the organisation's objectives).

This shared understanding was evidenced by a change in the language used and advocated by the core team. These participants refer to the conscious re-framing of language from words and phrases that denote a deficit model of sexual health such as 'risk', 'abusive', 'adolescents or teenagers', to a positive frame 'young people', 'value', 'healthy' and 'choice'.

In Rissfield, the original idea of developing a holistic model combining sexual health, drug, alcohol and smoking services for young people, came from the local authority. As noted in chapter five, this holistic model was not originally explicitly sex-positive. However, protagonists of positive approaches in Rissfield claimed this environment was a natural fit in at least three ways.

First, the service was designed in order to meet the needs of young people, by bringing services they might want and need together. This also enabled the service to argue for a longer appointment time, because in theory a number of issues would be covered. The service manager reflected that they felt their team was dedicated to this end,

> *"They are genuinely interested in young people, their wellbeing and ensuring that they do get a good service." (Service manager, Rissfield).*

Second, in the development of the holistic service, the service manager and commissioners were also beginning to realise that the language they used to describe the services was important.

> *"it was originally coined as 'risk taking behaviours' and I guess the consensus was that actually that is not a useful term and accepting that this is what young people do…it is a normal part of growing up…so they re-coined it 'exploratory behaviours"* *(Commissioner, Rissfield).*

This change reflects, to a degree, a shift in language from that which serves adults (that is by denoting risks that adults would wish young people to eliminate) to acknowledging the agency of young people (that is, by accepting that they should have autonomy in their decision making).

The third aspect that these participants claimed was important related to the management structure. The management, at the time of the fieldwork consisted of a nurse with a mental health background, and a non-clinical drugs and alcohol practitioner. The service manager argued that this was important because their training had focussed on the whole person, making holistic service provision more of a natural fit.

Thus, in Rissfield, although different participants had come to an understanding of sex-positive approaches through different means (as described in chapter six); there was a pre-existing platform on which they could build these nascent ideas.

Prominently, an awareness and appreciation of the potential of positive services was shared between the two service managers and one of the lead commissioners. This was in development over the course of the fieldwork. The service manager felt that they were in a privileged position and explained,

> *"I'm really fortunate to develop this service in partnership with commissioners…freedom to develop and change… "* *(Service manager, Rissfield).*

However, because the service manager and commissioner had come to an understanding of positive services through different means, the extent to which the principles of positive services were entirely shared was not clear. As a

result, despite promising beginnings, the extent to which these principles were embedded in the practice, at the time of the fieldwork, was also variable as highlighted in chapter seven.

In Ponston, a very different picture was apparent at the time of the fieldwork. There appeared to be little shared understanding amongst the key decision makers. Individuals with health promotion backgrounds appeared to have a very robust understanding of and conviction in positive principles and characteristics which reflected a *'reorientation of services'*. This shared understanding was potentially due to its fit with their role, that is, focussing on 'upstream' preventative support work, raising awareness of sexual health and working to dispel stigma. These participants also explained that it was part of the long term legacy from the community sexual health and HIV centre which had pioneered such approaches.

> *"There used to be a number of diverse leaders or champions promoting a holistic model. I think this has changed…services are fragmented and there is no collective approach to delivering a positive model of sexual health anymore" (Outreach worker, Ponston (cycle 3)).*

These participants felt that this understanding was not reflected across the service, attributing the variations to a lack of leadership which reflected their values. Notably, the leaders to which the health promotion staff members refer were clinical leaders with GUM backgrounds. These staff members, as identified in chapter six either recognised positive approaches but considered them to be outside the role of the NHS or prioritised the clinical services, and in particular, the GUM services over other aspects of holistic sexual health care.

In summary, there was a degree of shared understanding in each case study. This shared understanding was: robust within a core nucleus of decision makers and influencers in Stadford; tentative in Rissfield, but being developed by the local decision makers, and; disparate and in decline in Ponston, with strong conviction held only by ex-employees and employees who no longer held power.

8.3.2 Theory 3a-b: Gaining local buy-in to positive approaches

This section relates to how those with a shared understanding, and conviction in positives services attempted to encourage (or in the case of Ponston, sustain) local buy-in and indeed ownership of such approaches within their local organisation and stakeholder network.

Data from cycle three, in particular, highlights some of the disparities between individual interpretation across and within the settings demonstrating that these efforts have only been partially successful. For example, in the feedback sessions in cycle three around a quarter of those who took part agreed with the statement that positive services reflect a reorientation of services working towards empowering young people. These primarily were from non-clinical backgrounds, although not exclusively so. A further quarter, agreed more closely to the idea that their role is to keep young people safe as they grow up, this may reflect a more risk-orientated approach. The remainder suggested that they held both viewpoints.

As such, this section reports the efforts to develop local buy-in, where and when it was successful, but also where and why it was not. For the sake of clarity the results pertaining to this are illustrated in turn, by case study.

In Stadford, it was felt that the cultural and structural platform prior to the launch of the web resource was one from which they could act. The lead commissioner highlighted that their senior stakeholders from the local authority, public health and national health agencies had a history of working together and got on well at a personal level. The commissioner believed that this meant the strategic leaders of the county had been used to collaborating and saw benefit in pooling together to tackle issues which cut across their remits, such as sexual health. These factors had, according to the commissioner, contributed to the retention of the project manager[26]. The commissioner also reported that they personally felt trusted by their senior executives, and had explicitly been given autonomy to pursue new ideas.

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[26] The project manager had previously been a Teenage Pregnancy Coordinator. At the time Stadford were setting up their campaign in 2012 many of these cross-cutting roles across the country were disappearing (as the Teenage Pregnancy Strategy came to an end in 2010).

The core team, in Stadford, also appeared to share common traits, for example, they were each prepared to recognise the strengths that other team members could bring. Most notably, the lead commissioner recognised the need to have a youth engagement specialist on board, and sought out local university academics working in health psychology to consider what behaviour change techniques might support the development of the campaign. They also had courage to pursue what they perceived to be a controversial, yet necessary, line of activity, as described in chapter seven. They reflected that they gained strength in having each other as support as they tried to establish the new approach.

This core group explained that they had an inclusive approach and had actively sought to engage the wider stakeholder network through the 'partnership conference' (see chapter five for details). This was partly because of a requirement by the European funding body, which had sponsored the study trip, to disseminate the beneficial learning. The commissioner and project manager also recognised, that in order to make substantial changes to the way in which sexual health work for young people was delivered, they needed to get support from senior decision makers and other key actors in the county. This corresponds directly to the theory developed in chapter four, that they would be motivated to work with others to maximise their success. This commitment was initiated at a conference where attendees were given information and time for discussion and then asked to 'sign up' to a 'pledge' to take positive approaches forward. The commissioner recalled that the event was very successful and that they had thought at the time…

> *"this is very powerful, we are going to change your thinking!"*
> *(Commissioner, Stadford)*

Not only did this event pass on the information, it was on a large scale and had a call to action which the project manager considered had raised the profile of the approach and its perceived importance in the strategic direction of the county's sexual health work.

The core team in Stadford had gained buy-in from senior management to a 'long term commitment' to support a positive approach. They had relayed one

of the key messages that they had learned from the Netherlands; that transformation to a positive approach would take time to come to fruition.

The core team used this pledge as gentle leverage for subsequently gaining sign off to the positive sexual health campaign and web resources. The local authority commissioner recalled that some of the senior decision makers understood positive principles and supported it because they agreed with them. They described one occasion when discussing with the Primary Care Trust commissioner they had said,

> *"somebody might contact you from the press and say 'do you know you've got the worst website and…one of the questions says if you have sex up the bum with somebody and they fart, will they die?' So I showed him that and he was just hilarious he said, 'I love this website, it is brilliant'" (Local commissioner, Stadford)*

Others apparently were more swayed because of the possible kudos the local authority might gain from being a pioneer of such approaches in England. Notably, the core team adjusted the way in which they introduced the approach to different people in order for it to appeal.

> *"I think it was the gravitas that they liked, I think it was about us being the leaders, the first to move away from the teenage pregnancy strategy, we were the first to talk about a long term campaign..." (Ex-project manager, Stadford).*

The project manager and lead commissioner also explained that, at the height of their positive sexual health campaign, they had been delivering extensive and regimented training for people working with young people in schools and in the communities. They claimed that this had a number of benefits. First, it raised the profile of the campaign. Second, it helped ensure the consistent transfer of messages between themselves and such stakeholders. This was neatly illustrated by the outreach worker, interviewed in cycle 2, who had attended the training and whose understanding and application of positive principles mirrored that of the core team. Third and related to the second point, the training curriculum ensured that young people were receiving complementary messages

from school, youth workers and from community outreach sexual health workers.

The Stadford project manager reflected that, combined with the twenty representatives who had attended the study trip and conference, the training programmes contributed to a wave of support, understanding and enthusiasm across the county. This, they believed, created momentum and contributed to the short term success of the programme.

By contrast, perhaps, work by the core team to engage the clinical teams appears to have been more limited, (although it should be noted at the time of the conference the clinical service was commissioned by the primary care trust and not the local authority). Most of the clinicians in the Stadford cycle 3 workshop, who were by the time of the fieldwork, the managers of the integrated sexual health service, remarked that they had not been aware of the conference, (which had occurred some years earlier) despite being in clinical posts in the county at the time. A senior contraceptive nurse had attended and recalled that one or two at the conference had been surprised they were there,

> *"I only went to represent someone else, so the people on the ground never got that exposure really. I only went by mistake really. Someone told me to go and even my manager turned to me and said 'what are you doing here?" (Lead Contraceptive Nurse, Stadford (cycle 3)).*

On reflection in the feedback session, this group of clinicians questioned their exclusion. They thought that it was strange that they, a core group delivering sexual health services for young people, had not been more central to the campaign and that the focus had been so strongly weighted towards the commissioning, education and social work communities. This feeling is supported to a certain extent in the Children and Young People's report (written prior to the transition of the sexual health services into local authority commissioning framework), which specifies the education settings and not the health settings.

> *"all services and sectors to empower young people in educational settings by giving them the skills they need to develop healthy relationships" (C&YP report Stadford)*

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The local authority commissioner believed that they had attempted, subsequently, to instil sex-positive approaches, when they had the opportunity to do so, when they put the sexual health services they commission out to tender. They explained that they had amended the service specification for the requirement for sex positive approaches in the clinical service. This document reads:

> *"the broad aim of the integrated sexual health service is to equip residents to maintain positive sexual health and wellbeing…prevention focus and provide holistic sex-positive approach to sexual health" (Service Specification, Stadford)*

A mystery shopping exercise in Stadford did reveal that the clinical service performed well on being welcoming and being non-judgemental. There was no evidence which might reflect other characteristics for example relating to the language, framing of services, holistic practice or user involvement.

In addition, the local authority commissioner explained that following the Health and Social Care Act 2012, service commissioning was very fragmented. They explained that they had made many attempts to influence other commissioning bodies, for example through advising the CCG's procurement of abortion services,

> *"I used to commission the abortion services and don't any more, the CCG does that, badly, but we have worked with them, for over one year to make sure that their specification is right. And I am on the evaluation panel". (Commissioner, Stadford)*

They conceded that this commissioning fragmentation had made a comprehensive and overarching approach more difficult.

In Rissfield, gaining buy-in to positive approaches from the broader network was also problematic. The transition to a nurse-led, holistic youth service had caused some friction with the universal sexual health service. The new model meant that youth services at Level 1 and Level 2 were removed from the universal sexual health care service which provided adult services at Level 1 and Level 2 and specialist care for all. According to interviewees from both the youth and the adult service, this was not a move that was collectively

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welcomed. One of the outreach workers and one dual trained nurse remarked that they believed the 'powers that be', by which they meant the service provider of the universal sexual health care service, had wanted the project to fail.

"And it's split from the [adult services], with as far as I gather…an expectation of failure." (Dual-trained nurse, Rissfield)

This nurse went further to highlight that they felt certain aspects of the new service had originally not been well enough thought through with certain protocols mandated that were not appropriate for young people.

One nurse consultant, who remained in the universal provision, admitted that they had not been in favour of the project, at the beginning. They explained that this was, in part because they no longer saw as many young people as they had in the past, an aspect of the job that they enjoyed.

"they were taking away a whole part of the service and that's what I didn't like. Very selfishly I suppose in one way because I enjoyed working with that age group." (Nurse consultant, Rissfield)

This nurse did subsequently acknowledge, however, that now it was established and the young people were familiar with the offer, it seemed to be working well.

At the time of the cycle 2 fieldwork one of the commissioners in Rissfield reflected that they personally felt that they had established a service focussed on young people's health and wellbeing, but not a district-wide strategy around sexual health. For example, they recognised that outreach and health promotion outside of the service was lacking.

"we only get a certain percentage of young people coming through sexual health services" (Commissioner, Rissfield)

When questioned how the transformation to sex positive approaches would be done, the commissioner explained that there was a 'work plan' attached to the Sexual Health Partnership Group which,

"would look at various areas where they felt improvement could be made, [and] look at actions" (Commissioner, Rissfield)

This implies that this commissioner appreciated that the positive approaches were broader than what could be delivered by one service. In fact, they remarked that it was broader than the remit of the local authority and was about 'culture change'.

> *"it is beyond the services [we are] commissioning, far wider…"*
> *(Commissioner, Rissfield)*

It was at this point, that a new commissioner took over the commissioning portfolio which included the youth service. They, in particular felt that they could begin to introduce sex-positive approaches and messages to the work being carried out. Their personal interpretation was similar to the core team in Stadford understanding that is, having personal affinity with values-based arguments but positioning positive approaches to colleagues as the best long term strategy for reducing young people's sexual ill-health. When questioned about their strategy for introducing positive approaches to the wider stakeholder group, the commissioner explained that they believed an incremental approach would be more successful in the long term than a dynamic shift.

> *"…it's just a drip, drip kind of thing isn't it with this sex positive message… if you go all at once and say 'right I want you to do this training'… 'oh I've got a full clinic', that's what I always get."*
> *(Commissioner, Rissfield)*

The choice to try to shift perceptions gradually may also have been because the services had already undergone a radical shift and a further reorientation would be unsettling for the team.

Between cycle two, and three fieldwork, three simultaneous activities were in train which were intended to support the development of positive approaches (as described in chapter five): building of the holistic youth team's understanding and application of 'positive' ideas, provision of a sex positive web resource to reach the broader youth community, and development of a network wide understanding of sex positive approaches. These will now be covered in turn.

At the same time as the cycle three fieldwork, the idea of sex-positivity was being introduced to the youth service practitioners as an overlay to the holistic

model that had been developed in the youth provision. With the exception of one or two practitioners who were from non-sexual health backgrounds, the majority saw this as an incremental and natural addition to their existing model which was already based around the needs of young people.

> *"As a service I think we manage a blend given the resources, particularly time, available. Personally I would like to have a more 'sexual being' approach" (Non-clinical manager, Rissfield)*

However, it cannot be said that the principles of positive sexual health services were really driving the team forward. This is evidenced by the low confidence in describing positive approaches and discrepancy between the team members in Rissfield.

> *"So I think we are all motivated, but we're all motivated slightly differently. We want the service to succeed but it's not one big team" (Dual-trained nurse, Rissfield).*

Here it can perhaps be inferred that where team members have a variety of values, confidence, experience and professional backgrounds, a subtle and incremental approach to introducing positive approaches runs the risk of variation in awareness, understanding and acceptance. This may compare to Stadford where the conference and training was explicit, clear and consistent which made it more likely that stakeholders gained a broadly shared understanding.

At the same time as the sex-positive overlay was being introduced, the commissioner in Rissfield had recognised that there was a gap in service provision at Level 1 and self-care for young people. This combined with a gap in RSE encouraged them to invest in the web resource that had been developed in Stadford. They recalled that there were no problems getting buy-in from the senior executive. They attributed this to the fact that the resource had been developed and tested positively elsewhere and because it was positioned as a cost effective way of providing a service for local young people. There was also no discernible backlash from the community, although the usage of the resource had only just begun at the time of the fieldwork.

During this time period, the new commissioner had also re-established the work plan for the broader sexual health network, based on the national policy document *The Framework*. All of the objectives from the current policy had been translated into actions, by the commissioner. This included the broader overarching objectives, such as 'Building and Open and Honest Culture' which do tally with positive principles, as well as the specific ones relating to the PHOF (see chapter 3).

The Sexual Health Partnership meetings, which were attended by a broad range of agencies, including clinical services, youth work, SARC, organisations for LGBT communities and school nursing, operated mainly as update and feedback sessions, with some special segments which were dedicated to specific topics, such as supporting transgender people. The minutes of one meeting acknowledges that the commissioner,

> *"noted that [they] have met with [the youth service manager] and have looked at the development of a holistic approach. The group discussed feeding in to RSE in schools. [The commssioner] noted that the [web] resource was being used to start conversations in school around sex positive. [the commissioner] also noted that the SHP workplan included work around supporting the Brook sex positive campaign". (Rissfield, Sexual Health Network Minutes)*

This reflects the position of the commissioner to lead the network towards a sex positive approach. There was broad agreement from the network group, although, the extent to which the wider sexual health network was working towards the same vision and strategy was not clear. There was no evidence, yet, of sex-positive approaches specifically being taken up due to the timing of the fieldwork, which was running concurrently with this development.

In Ponston, some of those with an understanding of and conviction in positive services from a values-based perspective were, at the time of the fieldwork, trying to sustain commitment to positive principles and characteristics. Others had given up.

The ex-community manager, who had, prior to integration, been the community contraception and sexual health promotion lead, explained that they had

resigned their position within the integrated service, in part due to the lack of shared understanding of positive sexual health and the service's role in supporting it.

> *"My own experiences in sexual health is the person with power doesn't share those aspects of positive sexual health…it's about gatekeeping, making sure the budget balances…tick the box in terms of keeping the commissioner happy". (Ex-community manager, Ponston)*

They further explained that, when they had been asked, by senior management, to share their vision for the integrated service, they had been confounded by the lack of coherence between their ideas and the rest of the management team.

> *"I'd been thinking about all the values that I wanted to take us forward…it was like different languages…I was like, 'well we can be fair, can't we', 'Oh no people won't think we're fair', 'but we can try, they're aspirational values…a values based environment,'…[I believe these values] were not clinical enough." (Ex-community manager, Ponston)*

This indicates that shared understanding may also extend to having a shared value system when it comes to implementing positive sexual health services, based on underlying core beliefs about what might be the best way to support young people.

These results also underline the importance of *who* it is who is trying to implement such an approach. In Ponston, whilst the commissioner and local service manager understood positive approaches and may have seen them as a long term broad strategy to tackling sexual ill-health (as described in chapter seven), they were not sufficiently convinced in their efficacy to reduce sexual ill-health to prioritise this approach over a medical model. The ex-community manager, despite their previous role and local credibility, was no longer in a senior enough position to influence the strategic direction, resulting in their perception that their role was no longer tenable.

In Ponston, in cycle three, there was a distinct disparity between participants' personal interpretation of positive services, and that which they felt was realistic under current operating conditions. Several participants in Ponston also explained that the emphasis in their service was on 'safeguarding'. This

particular aspect of sexual health work can be seen by some to be in tension with positive approaches. One of the management team, who does not have a clinical background, wrote in the cycle three feedback.

> *"Emphasis is still on safeguarding…rather than pleasurable or healthy relationships or gender/sexuality - this then defines expectations of service delivery." (Manager, Ponston).*

A co-worker considered that societal viewpoints are at the root of these decisions to prioritise safeguarding.

> *"I believe there is a real culture shift towards a risk averse society where there are fears about young people's 'safety', so sexual health becomes focussed on 'things to avoid', 'problems' etc" (Outreach, Ponston).*

In addition, as highlighted before, some felt that the non-clinical aspects of sexual health should not be delivered in NHS settings.

> *"What they need, to promote happy relationships, is sometimes needed in a different setting with more time…and the youth being aware [of the purpose of the session so] joining in with that discussion" (Health advisor, Ponston (cycle 3)).*

This lack of priority may be down to fundamental differences in underpinning philosophies regarding sexual health services, as described in chapter six and seven. There are also other factors at play, in particular the limitation of time, and to a certain extent, resources which will be covered in the next section.

Participants, still working in the local NHS, who felt that their service was not performing as a positive service attributed this to a lack of direction. For example, when questioned about what would need to change in Ponston to move back towards a positive approach, one participant suggested that,

> *"it rests on you having a vision and a strategy that you can share and you unpick and you work out who's going to do what bits of it." (Outreach worker, Ponston).*

This participant suggested the team needed an explicit unifying aim in order to make progress towards it, even if each team member then took a different

strand according to their roles. Within the research interview this was challenged, particularly with regards to whether this was an aspect exclusive to delivery of *positive services* or any kind of service. For example, the participant was questioned about the *Teenage Pregnancy Strategy*, which had provided a vision and strategy, but, at the time had been criticised as pathologising young mothers. On reflection, the participant recognised that this strategy had allowed for practitioners to undertake positive approaches, despite the fact that these had not been explicitly called for within the document.

> *"One of the strengths of the Teenage Pregnancy Strategy was the fact that it felt like they were focussed individuals…funding…there was an ability to be flexible in response…what we're missing is partly vision, partly funding, partly coordinated partners…" (Outreach worker, Ponston).*

The ex-community manager also highlighted that the Teenage Pregnancy Strategy focussed people's attention.

> *"you could argue for prevention, promotion, women's self-esteem, work with young mothers". (Ex-community manager, Ponston)*

This implies that it was not the strategy itself which determined the direction but the ambitions and goals of the individuals operating within the policy framework. Their goals and ambitions might either be facilitated by a complementary strategy (such as in the case of the Teenage Pregnancy Strategy) or else obstructed (as appeared to be the case currently, where *The Framework* was seen to lack vision, funding and a mechanism on which collaboration could be harnessed).

Ponston's 'Sexual Health Strategy', further illustrates this point. This document does include numerous references to holistic, positive approaches to sexual health. This document was authored by the Sexual Health Network in the city and intended to provide a strategy from 2012-2015, it was prepared in conjunction with the local authority, clinical commissioning group and NHS commissioning board. One section is subtitled *A Holistic Approach to Sexual Health* and reads:

> *"This strategy proposes a holistic model of sexual health which acknowledges the social, cultural, and political factors, as well as the health inequalities, that affect and determine people's sexual health. Frequently, sexual health discourse focuses solely on the negative aspects of sexual health such as STIs, unwanted pregnancies, abortion, regret, 'promiscuity', abstinence and 'delay'. A disease focussed approach does not fully describe the complexities of sexual health and does not adequately allow for effective and appropriate responses to prevent and treat sexual ill health; or to promote good sexual health." (Ponston, Sexual Health Strategy).*

No participant from Ponston mentioned this document during the fieldwork, which began shortly before this period had ended. This may illustrate that whilst some work had been done to produce a shared strategy, which included arguments, 'actions' and outcomes associated with positive approaches, these ambitions had not been implemented because other factors played a stronger part in determining outcomes.

Within the interviews in cycle two, when a small number of participants in Ponston were asked to consider whether a goal could be built around something as imprecise as positive services[27], they suggested that the first step would be to agree a definition of positive sexual health. In addition, they reflected that whilst general ambitions do exist, they appear to be hard to operationalise. The commissioner in Ponston explained that for them,

> *"it is actually getting your needs assessment right and your policy and commissioning framework right, right at the very beginning." (Ponston, Local Authority Commissioner).*

The current Needs Assessment[28] in Ponston was written in 2011 and includes the statement:

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[27] Not all participants were asked all the questions given their roles and ability to respond to certain aspects of the theory refinement, see chapter five for details.
[28] A needs assessment is a process for determining and addressing the needs (that is the gap between current and desired conditions) of a particular population. The sexual health needs assessment is collated by the commissioning body. The needs assessment is often published and publically available

"health promotion and education remain integral to STI and HIV prevention…Further development of this sexual health needs assessment is required to incorporate sexual health services from promotion and prevention through to treatment" (Ponston Sexual Health Needs Assessment).

At the time of writing this thesis, this 2011 Needs Assessment had not been updated to incorporate the activities and needs addressed by the health promotion team as suggested in 2011. This seems to underline the perception that whilst commissioners and service managers may recognise health promotion and other broader activities are important to maximise young people's sexual health, they have not been able to prioritise them strategically.

During the process of integration of the contraceptive and GUM services, this lack of strategic priority appears to have resulted in severe losses to the health promotion and community outreach team and was a source of great frustration. For example, one contraception nurse in Ponston explained that they had been given multiple promises during the integration process that their views would be represented. However, it was her perception that none of these promises had been acted upon.

"I think the people at the higher level, they pay lip service to [positive principles and characteristics]. They talk the talk but actually they've got no idea what we do" (Contraception nurse, Ponston).

They explained that during the integration process a number of management roles had been consolidated. Following a reapplication process the two posts had both been filled by clinicians with a GUM background. This particular nurse explained that whilst they had good management experience, they were not aware of everything that contraception nurses undertook as part of their role, nor, they believed, considered it as important as sexually transmitted infections. In their view this was a judgement which was hard to make;

"Unplanned pregnancy has a devastating effect…the people making decisions are looking at 'this is really bad if you get gonorrhoea'…who can say what matters more…you're talking about people's lives, how can you measure?" (Contraception nurse, Ponston).

Similarly, one outreach worker recognised tension within and across the service which affected them directly,

> *"How I fit within a medical model…causes differences and conflict…the*
> *paths by which we might reach outcomes might be very different"*
> *(Outreach worker, Ponston)*

In their view, conflict arose because the new integrated service was designed around a medical model of delivery, focussing on diagnostics and treatment. They would have preferred a model built around the needs or holistic outcomes for clients.

A separate but related point is that individuals across the same service may recognise some of the same priorities but disagree about the best way to tackle it. For example, at the time of the field work, child sexual exploitation appeared to be high on the agenda[29]. It appeared to be an important issue related to sexual health for all. Some, in line with national policy, focussed on what young people should do, or what interventions were necessary to build 'resilience' in young people. Others reflected that this seemed too narrow,

> *"children have always been sexualised…our response is to penalise the*
> *young people 'you shouldn't be on social media'" (Ex-community*
> *manager, Ponston).*

This participant went on to explain that their experience as a social worker had highlighted that children and young people who were being exploited didn't have the language or understanding of what was happening to them. They elaborated that without an open and honest culture about sexual health, these young people would have nothing to measure their experience by or know where to go or the language to use to explain it.

Health promotion and prevention activities may be seen in the context of a medical model as discretionary. When the sexual health service budget came under pressure, as a consequence of austerity measures, these activities were targeted for cuts. The ex-community manager explained it thus;

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[29] The fieldwork period was 18months - 2 years after the Rotherham CSE review (Jay, 2014)

"When you fall on hard times, you get rid of luxuries, don't you?" (Ex-community manager, Ponston)

The local authority commissioner, whilst aware of the different roles played by the different professionals across the service had reluctantly pushed for these efficiencies. Their disappointment was evident in the following quote:

"It is frustrating that we know that prevention works and we should invest to save in the longer term but many decisions are reactive and have to be made in the short term. It is important that we maintain enough capacity to deal with outbreaks [meaning STI outbreaks]" (Local commissioner, Ponston)

In summary, various efforts were made in each of the case studies to grow an understanding and awareness of positive approaches amongst peers, colleagues and local networks. In Stadford, this manifested in high profile, well-funded, and well supported activities with the explicit intention to transform thinking. However, this only extended as far as the education and community sectors and had not penetrated the clinical settings to any great extent. In Rissfield, efforts were more subtle and piecemeal with a combination of the commissioner injecting positive services into the strategy, work plan and resources and the service manager working with the local service practitioners to develop a shared understanding. In Ponston, local buy-in to positive principles and characteristics was not evident having been all but eliminated during the process of integration. Efforts to maintain these values had been rejected resulting in the loss of many of those holding such interpretations and convictions to the charity sector and the frustration of those that remained.

8.3.3 Theory 3c-g: Structural integration

The previous section referred to cultural features and socio-cultural interactions which support or hinder attempts to gain local buy-in to positive services. This set of theories relate to structural features which, arguably, enable or constrain local buy-in to positive services. Data from the cycle three fieldwork highlighted a distinct disparity between individuals' personal interpretation of positive services, and that which they felt was realistic under current operating

conditions. That is, that they perceived structural integration was particularly challenging. For example, far fewer of those who stated they interpreted positive services as empowering young people in the cycle three fieldwork felt that it was currently achievable.

As noted in chapter four, the theories presented here to account for this challenge are not intended to be an exhaustive list of structural facets, but a small number of possible aspects which were selected because of the influence they appeared to have during analysis of the literature review. These are theories about *evidence and accountability*, *user involvement* and *integrated working.*

In addition, the context of reduced funding and the policy drive towards integration of GUM and contraception services are considered given the particular historical context in which the three case studies in the empirical research were situated. In each section the data for each of the case studies is presented in turn.

Evidence and accountability related to a positive approach (theories c and d)

In Stadford, the local authority commissioner and project manager recognised the necessity of measuring the impact of the new approach in order to justify its continued funding. They explained that there were a number of challenges involved with measuring their activities.

The first related to a 'data lag' associated with the existing outcomes measurements. For example, they explained that the national outcomes indicators from the PHOF, which, as previously detailed, for young people are under 18 conceptions and chlamydia detection rates, are published the year following that to which they relate. This makes it difficult to correlate the service activity to the statistics in any meaningful way. Second, they explained that there was a lack of validated measurements which could accurately measure sexual wellbeing and doubted whether these would ever be preferred over the clinical outcomes. Third, they highlighted that it was hard to demonstrate the positive changes they were hoping to achieve,

"how on earth do you measure someone changing their behaviour as a result of some of the information you have given them" (Commissioner, Stadford).

As a result they committed to *'measuring everything'* and *'hoped that the [indicator data] would 'catch us up'.* They sought an early pre-post evaluation, commissioned through a local university. This demonstrated some modest, indicative evidence that the sex positive campaign increased young men's likelihood to attend sexual health services following the launch of the web resource. They measured footfall. They commissioned a mystery shopping exercise which measured the services performance against the You're Welcome Criteria[30] (Department of Health, 2011). At first the clinical services resisted the mystery shopping, but then saw it as a good thing when the feedback they received was positive[31]. This, the project manager claimed, had the unintended positive outcome of raising the profile of the sexual health services in the Trust.

The commissioner and project manager also stipulated that people who attended the training completed evaluation forms after implementing the learning in their own settings. Feedback from this source suggested that the requirement to feedback had the dual impact of ensuring that trainees used their new knowledge and tools, and of accruing more data for the commissioner about how the lessons were being received.

Outcome statistics on under-18 conceptions did appear to support the campaign initially. There was a drop in conceptions compared to other 'statistical neighbours' (such as those with similar level of multiple deprivations) for the relevant timeframe (at a time when rates were dropping across the country). Although no statistical claims for cause and effect could be made, the team did use this evidence to build their case.

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[30] Service standards and accreditation criteria to demonstrate youth friendly services, for further details see chapter three.
[31] this coincided with initiatives across government to measure customer service for example the Friends and Family score https://www.gov.uk/government/publications/nhs-friends-and-family-test-guidance-on-scoring-and-presenting-results-published

> *"We were reducing teenage pregnancy rates and we were seeing young people reporting that it was very positive what we were doing" (Project manager, Stadford).*

At the time of the fieldwork, the overarching campaign, that is the website, training programme and marketing activities had been much reduced. The project manager had moved on to a different role in a different company, the commissioner had taken a broader role and a new commissioner was managing the website. This new commissioner, who also interpreted positive models in line with the original core group, explained that the training programme had been curtailed. They explained that this was due to reductions in funding as a result of the austerity measures imposed by the coalition government of 2010 and reorganisation of sexual health service commissioning which they believed had ultimately resulted in less money being available for sexual health services in local councils.

The results highlight that the positive sexual health campaign appeared to have suffered more in the face of these cuts compare to the clinical service, although pressure appeared to be mounting on the whole of the service at the time of the cycle 3 fieldwork. This was despite clear conviction from many participants that investment in sexual health services was far more cost effective than treating the results of poor sexual health.

Outcomes figures published in 2016 referring to 2015 appear to suggest that Stadford had not maintained the positive downward trend in under 18 conceptions[32]. In one particular area of the county, which regularly demonstrates conception rates higher than the national average, an extremely high figure was published. Two of the participants attributed this to the curtailment of the campaign over the last few years as a result of funding reductions and other priorities, such as the integration of the services. The measures are too blunt, however, to illustrate this connection.

The increase in conceptions in this particular area of Stadford was considered as leverage to lobby for additional money and to re-prioritise the positive sexual

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[32] This must be treated with caution as the overall number per thousand is already low, any changes can suggest a disproportionate impact on conception rates

health campaign for one outreach worker. This may demonstrate a perverse relationship between the statistics and the funding allocation. For instance, low rates of sexual ill-health, to which positive service may contribute, may make such services a target for budget cuts, whereas poor rates attract more funding.

In Rissfield, the service manager and commissioners explained the youth service was measured against the national indicator sets as illustrated thus;

> *"We go through the quality outcome indicators that are in the contract to make sure they're on track…in the specification, based on the national specification" (Commissioner 2, Rissfield).*

The commissioners had tried, however, to be more relaxed about these Key Performance Indicators (KPIs).

> *"[there has been a] shift in terms of expectations from the commissioners" (Service manager, Rissfield).*

> *"…we do try to look at increasing access to services and the qualitative outputs of those rating the services" (Commissioner 2, Rissfield).*

The service manager believed this was because the commissioners understood the youth service was trying to deliver a more subtle, multifaceted and values driven intervention, which might not be measured simply. This reflects a commonly held view across Stadford and Ponston as well,

> *"So with an STI it's easier to measure…what's not so easy to measure is that person coming into that clinic and you're not going to do all the work on that one visit…we're talking about contraception, preventing an STI, right support for their mental health…safe in terms of sexual exploitation…it's difficult to measure that, and write it down, and say because I do this, this is going to be the outcome". (Service manager, Rissfield).*

Accordingly, it was harder to demonstrate the activities and outcomes of the longer appointment times maintained in Rissfield. These were typically driven by patient need where they had hidden agendas which were hard to pry out, but hard to record.

*"You'd see it documented in their clinical notes, so reason for
attending…flow through the different templates to summing up at the
end…but who has the time to go through all of that". (Service Manager,
Rissfield).*

Providing an evidence base for the frequency of these types of consultation,
which might justify the longer appointment time, was therefore problematic.

There was growing appreciation of the inadequacy of the measurements across
the board. For example, the nurse consultant working in the universal sexual
health service reflected on the limitations of the chlamydia detection rate
indicator, (which at the time of writing referred to detection rate per 100,000
aged 15-24, with a recommended detection rate of greater than or equal to
2,300)',

*"To me that logic didn't work…we're getting more positives then more
people are coming in to be tested, therefore we're picking up more and
therefore our message is getting out. Well to me, it was the opposite, the
fact that actually if we were doing our job correctly then those rates
should drop" (Nurse Consultant, Rissfield).*

Evidencing the work that they did, despite awareness of the measurements'
weaknesses, was still important in Rissfield. The commissioners were wary of
methods which might present a biased picture, for example with qualitative
exercises,

"they could cherry pick the best cases" (Commissioner 1, Rissfield).

They were also bound by the expectations of their own chains of command,

*"commissioning…at senior level decision making is about numbers which
has this perception of demonstrating hard facts about what is actually
happening" (Commissioner 1, Rissfield).*

At the time of the fieldwork the service manager was becoming involved in an
academic study looking at more sensitive and bespoke outcome measurements
which would be suitable and reliable for this particular model of delivery.

In Ponston, questions about the evidence base and measuring the impact of a positive approach were discussed less than in other areas, because of the participant's perception of the more immediate challenge of maintaining employment and negotiating contracts.

One documentary source does illuminate how evidence was used to support the commissioning and running of the service in ways that did not reflect positive principles or characteristics. The Sexual Health Strategy, which included a great deal of rhetoric about holistic positive approaches, cites national, regional and local needs assessments and indicator sets within the section on strategies and targets. Of all of these measures, only one, to reduce stigma, can be directly related to positive principles and characteristics.

This demonstrates that despite the rhetoric, the actual targets which determine the priorities for action remain within a risk-based and medical model. The Sexual Health Strategy further describes an 'implementation strategy' which does include a raft of actions and broader desired outcomes relating to reducing sexual health inequalities and improving access to services. However, there are no outcome measures which are closely related to positive aspects of sexual wellbeing.

It is perhaps, unsurprising that, at the time of the fieldwork, the PHOF outcomes indicators appeared to have been translated into targets, of sorts, for the local sexual health network. For example, whilst these meetings did have open slots and special sessions where any of the agencies could raise issues the regular agenda items were based around the three 'key indicators'; under 18 conceptions, chlamydia detection rates and late presentation of HIV. Observations, made by myself, in network meetings highlighted that this agenda structure had the dual effect of prioritising discussion and actions towards these outcomes, whilst at the same time distancing the work of agencies with other objectives, for example, working with women living with HIV, psychosocial aspects of sexual health, child sexual exploitation and supporting LGBT youth. This highlights the possible narrow focus and priorities imposed on the group by the service managers and commissioners, driven by the nature of the measures they were held accountable to.

In summary, for commissioners in particular, the ability to demonstrate the impact they are getting as a result of the money they are spending was a fundamental aspect of their role. In Stadford and Rissfield, tension was observed between this requirement and the ability to measure the effectiveness of the positive approaches. No validated measurements for young people's sexual wellbeing were available, and these were considered difficult to develop given the highly individual nature of such a state. There were thus no established processes for routinely assessing how positive approaches might contribute to young people's sexual wellbeing.

In both Stadford and Rissfield, the core teams were exploring different ways to evidence their activities. They were however, still bound to the core national indicators. Their performance on these measures dictated what funding they might receive, and could justify in future commissioning rounds. In contrast, medical and individualised approaches such as LARC, have been demonstrated to affect indicator values which make for an easier business case. In Ponston, where arguably, the clinical services had been condensed to core activities directly aimed at influencing the national indicators, the requirement for evidence and accountability was a barrier to maintaining positive services.

This links the generative mechanisms associated with clarity, to coherence. That is, because it is difficult to be clear about the benefits of positive approaches in terms of short-term hard outcomes that can be measured, it may be difficult for positive services to be coherent in a system that is judged against such outcomes.

Users' views central to a positive approach

In Stadford, involving users appears to have been a cornerstone of the positive sexual health campaign. The local authority advisor, who was the facilitator for the young person's input to the process, explained that they had at first been sceptical about the local authority's ambitions.

> *"… plenty of experience of professionals saying they would like to hear the voices of young people and consult - however, behind the scenes*

they have already made all the decisions…very little interest in hearing what young people actually have to say" (Local Authority Advisor, Stadford).

They had, however, been convinced that the local authority commissioner and project manager genuinely wanted young people to influence the direction of the project, as they believed it had a greater chance of success with their insight.

"without young people's input they risked spending all that money and ending up with something no young person would use!" (Local Authority Advisor, Stadford).

The three core protagonists in Stadford each explained that special measures were introduced to ensure users' views were taken on board. First, they agreed that they wanted to engage with young people who were not the 'top performing' or 'best behaved' in the school. Rather they wanted outspoken young people, who may occasionally truant or be at risk of exclusion.

"I don't want all the good kids - I like the gobby ones, the ones that will occasionally shout out" (Local Authority Advisor, Stadford).

Second, they wanted to make it as easy as possible for the young people to take part. The rest of the partnership board would travel to the school to run the meetings during the lunch break meaning that young people did not have to make any additional time commitments or travelling arrangements[33].

Third the sessions were designed to run on young people's terms. The advisor explained that this was for ethical reasons; the young people should benefit from attending where possible, for example, by being able to gain some information and training in sexual health.

"…encourage them to ask questions" (Local Authority Advisor, Stadford).

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[33] The young people were not paid for their time, but the local authority did sponsor occasional trips as treats to say thank you, for example to play laser tag.

This measure was also to ensure the insight gleaned was relevant as the local advisor suggested that if the session was sterile and young people were asked the questions directly, they would be more likely to offer simple answers they thought the adults wanted to hear.

Fourth, it was seen as important that there was a genuine chance to influence decisions. The team demonstrated this was the case to the young people by converting their feedback into genuine changes to the web resource by the following meeting. Again, this was seen as ethical but also produced greater buy-in from the young people themselves as they recognised that their input was valued. This aspect meant, necessarily that the core team themselves had to be prepared to support and even advocate for the decisions the young people came to, even if they, personally, might prefer a different course of action.

The local authority commissioner and project manager each explained that the advisor's input and way with the young people greatly contributed to the quality of the information generated.

The user involvement appeared to contribute both to the quality of the web resource as well as provide essential 'evidence' on which the core team relied upon to justify the content they included. The local authority advisor recalled the input of one young person as saying,

> *"'well it's all very good and I don't want to be rude but - why would we download the app in the first place"(Local Authority Advisor, Stadford).*

The content influenced by the young people's input (for example a 'sextionary' of slang terms for sexual activities, FAQs, graphic illustrations of 'pleasure zones' and photographs of genitalia) was assessed by them as engaging and explicit, sufficient to attract their peers. The core team fought to retain these elements as crucial to its success. This was later vindicated, through google analytics, which demonstrated the more explicit pages attracted young people to the site and triggered their use of other content related to the service finder, emotions, healthy behaviours and relationships. As highlighted in chapter seven the young people's input was also considered a valuable evidence base which provided,

*"true insight into the minds of young people and helped the project team
stay true to their vision… To create a resource for young people with
their needs right at the heart of the matter" (Ex-project manager,
Stadford).*

Another unanticipated and positive impact involving young people was that it
appeared to have been instrumental in the young people's lives. One example
given by the local authority commissioner was of a young person, who joined
the group in year 8 and had previously been at risk of exclusion, who had
reengaged with school subsequent to being involved in the project and
eventually becoming head pupil.

In Rissfield, the new holistic model had been tested with the young people, but
by the commissioner's own admission, the model was already relatively fixed.
The consultation document outlines the rationale for such a model, for example,
it reads,

*"There is gathering recognition of the integrated care model and the
benefits of offering a holistic, patient-centred, team-based care and of
generalism, as well as specialist knowledge" (Rissfield, Consultation
report).*

The engagement with young people demonstrated that they were looking for
verification and ways to mitigate any perceived shortcomings, rather than the
young people leading the ideas. Again, evidence from the consultation
document shows that,

*"Overall, the majority of young people expressed a view that a 'One Stop
Shop' style integrated service would be beneficial to service uses. There
were a few concerns raised; however these are not insurmountable".
(Rissfield, Consultation report).*

When questioned about this consultation in the interview, the commissioner
explained that the young people had been given the chance to ask three
questions on the panel to select the provider.

*"And those questions were weighted, so they went towards the final
score of the tender, so it wasn't like they were just token questions that*

they just kind of threw in there and they evaluated the response as well".
(Rissfield, Consultation report).

However the commissioner accepted that more could have been done to include young people in the development of the service. They further explained the challenges in reaching the right young people.

"Sourcing the kids can be a bit difficult…they go to the youth council. Now the youth council consists of a very specific type of young people…it would be the difficulties around getting a cross section of representation." (Commissioner, Rissfield)

They discussed the challenges with how to use the information in conjunction with their own autonomy,

"[it's also about] the mind-set of us, as commissioners, relinquishing a bit of control…"

…the issue of governance,

"…oh this is terrible, as kind of 'responsible commissioner' that you need to ensure that the service is safe, effective… if it did fail, how would you ensure the safety of the service users?..."

…and the perception of risk involved with adopting users' input

"And I know it sounds awful, but in this kind of climate of funding cuts… I just don't think we have got the luxury of…have a go and see how it works out' that kind of thing …I think it is kind of erring on caution…the potential is that you are going to waste money or you are not going to see the outcomes that you are wanting to see". (Commissioner, Rissfield)

This data demonstrates the opposite viewpoint of those from Stadford who saw user input as integral to ensuring value for money.

In Ponston, there was little evidence of users being centrally involved in any of the recent service reconfigurations, which had largely been built around the internal and structural systems.

> *"I certainly don't feel that I work in a service where young people are the first point of contact in order to shape a service." (Outreach worker, Ponston).*

The commissioner recognised that there were lots of assumptions about what young people might want or need, but that without asking them, they could be wrong.

> *"we assume that young people don't want to have a chaperone with them when they're at service when actually they might do, we assume that young people want to be treated like an adult when actually they don't, they want to be treated like a young person. I think that links into User-led because the consultation is really important, we can't assume because that might not necessarily be the case". (Commissioner, Ponston).*

Practitioners in Ponston were undecided about the necessity of including young people in service design. They ranged from full advocates,

> *"some want central services, and some want them close to home…we will never meet the targets if we don't resolve their access problems so we must do both" (Contraceptive nurse, Ponston).*

…to tempered advocates,

> *"I am not saying to young people here you go, we can do absolutely anything you want; there is a complete blank sheet of paper". (Outreach worker, Ponston).*

…to those who rejected the idea wholesale,

> *"Why would we ask the users, they're not the experts". (GUM nurse, Ponston, (cycle 3)).*

This variety of viewpoints highlights the lack of shared belief or understanding on the centrality of user involvement. It also highlights the tension for those who advocate for positive services, but are nervous about how to include young people in decision making, and how to balance their viewpoints with other necessary components of the service specification.

In Stadford, conviction in positive approaches was bound up with conviction in the central role of young people. This process was managed and prioritised and provided valuable insight and evidence, supporting the theory that user involvement can be catalytic in progressing a positive approach to sexual health services.

Additionally, when testing theories of user involvement in the fieldwork, practitioners related the concept to user-led, holistic consultations. For example, those, in Ponston and Rissfield, reflected that time with a client was limited, placing restrictions on what they could actually do.

> "Reality of what a short 20 minute consultation can achieve in a sexual health clinic is limited" (Health advisor, Ponston (cycle 3)).

These participants reflected that they didn't always get a chance to discuss wider issues with young people, even if the young people were willing and hoping to do so. However, it was also highlighted that in some cases clients would not want to discuss their broader sexual health.

All the services reported to be running at full capacity, and in the case of Ponston, failing to meet the BASHH standards for offering an appointment within 48 hours. On discussion, the dramatically reduced budget for delivering sexual health services appeared to be affecting the frontline practitioners' capacity to respond to demand. This put pressure on appointment lengths. Some also felt that they did not want to ask the questions for fear of opening up issues which would not be able to be resolved within the appointment length.

Integrated provision

This theory theme initially related to the idea that where there is broadly shared understanding and conviction commissioners, managers and practitioners would be motivated to work with other practitioners in the network. There is data to suggest that this was the case is illustrated in section 8.3.2 because as the theory became refined, it became more closely related to cultural coherence.

The data presented here relates more to the underlying structures that hinder or enable collaborative, multi-disciplinary working (which also provide a platform for cultural coherence).

In Stadford, the core team, worked effectively to develop a consistent approach across multiple systems - with people from the education sector, community sector, and sexual health outreach teams all taking on board the key principles and characteristics of positive approaches and applying them where possible in their respective practices. This suggests that the structural conditions complemented elaboration of systems within these sectors. In addition, the reciprocal actions of the various stakeholders in the different sectors served to reinforce the actions in others.

When the local authority commissioner gained responsibility for the clinical services, no such consistency emerged. One participant who worked in an outreach setting who was often unable to contact clinical colleagues suggested that,

> *"Ideally we're all working together. But obviously, each service does have their own goal and their own viewpoint" (Outreach worker, Stadford)*

The commissioning arrangements following the Health and Social Care Act 2012, had further complicated matters, as highlighted above and further reflected in the following quote.

> *"Yes, with the same organisation, although, with all the stupid changes with the bloomin' NHS the SARC that I used to commission is now commissioned by NHS England. So it is all bonkers. And also, we haven't let the commissioning separations, stop us working together". (Local Authority Commissioner, Stadford).*

In Ponston, the health promotion and community outreach team had operated within a different local structure to the GUM and clinical service. During this time, the separate services had worked relatively well together. Subsequently, the local structures were disrupted, due to the Health and Social Care Act 2012 and encouraged to integrate, the health promotion team and clinical team became reliant on the same social structures. This, under the condition of reduced budgets, forced competition between the factions.

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One premise of the public health policy document *Making it Work* was that the fractured commissioning model and reduction in funding would compel agencies to work together and create innovative solutions. Data from this research, however, demonstrates a mixed response. The opposite was observed in Ponston, where agencies were observed to focus on their core business in order to survive.

> *"what happens is when people are under pressure or people go into their own silos". (Ex-Community Manager, Ponston)*

In Rissfield, the message to integrate services was interpreted as integrating the service around the needs of young people. This, at least, in its nascent beginnings seems to have provided a platform on which to compromise, without losing professional kudos.

In discussion in cycle 3, one dual-trained nurse, from a contraception background, reflected that the model of integration in Rissfield was different to that in other services in the region. They highlighted that ex-colleagues had remarked that integration in other Trusts looked more like co-location, whereby clients were triaged at reception to see the seemingly appropriate specialist. This participant attributed the difference in Rissfield to the way in which the frontline practitioners had been continually consulted on the prospective changes.

> *"…we were included in the way that it developed and transformed we have become a team…a young person can come through our clinic doors and see any person on the team for any of those issues that our service provides…although we're slightly smaller, we are no different to CASH and GUM coming together, it is just the way that we have been led" (Dual-trained nurse, Rissfield).*

In this nurse's opinion, there was a degree of shared understanding amongst those working in the service, brought about through a model of transformational leadership which consults and engages the whole workforce, as the changes are brought about. This gave opportunities for individuals to raise concerns and make suggestions as the new service was forming. As the suggestions are considered and where appropriate implemented, staff felt more ownership of the

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developing offer and greater understanding of and commitment to their ambitions.

8.4 Refined theories

8.4.1 Refined theory 3 a-b Cultural cohesion based on shared understanding and commitment to positive approaches

Communal specification that is, the extent to which a new approach was understandable to, and shared by, people whose work it might concern was one of the concepts extracted from the conceptual model of theories in cycle 1 (chapter four). This, along with the data from the literature reviews, contributed to the initial rough programme theory that commissioners, managers and practitioners would need to share an understanding and pursue the same goals for positive approaches to be adopted.

Table 16 outlines processes which may contribute to shared understanding of positive approaches leading to favourable conditions for collective action. The data has demonstrated that shared understanding can be developed by inspirational leaders influencing a team and/or network of stakeholders (such as in Ponston before integration) or a core group of protagonists whose shared understanding, and conviction are aligned (as in Stadford). These situations occurred where there were concomitant complementarities in the cultural realm, that is where the new idea was compatible with existing ideas such that it could be assimilated easily (Archer, 1995). This provided favourable conditions in which positive approaches were considered, and formed the basis of action towards implementation of positive principles and characteristics, such as taking a holistic approach or being user-led.

Table 16 Cultural coherence based on perception of shared understanding and conviction

Prior conditions	Stable favourable structural conditions which are compatible

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	with positive approaches (concomitant complementarities)
	Individual(s) with clarity about and conviction in positive approaches AND influence
	AND/OR a number of individuals with the same interpretation of and conviction in positive approaches
	AND shared scrutiny and naming of the approach
Habitus or internal conversations	Collectively triggers: Perception of shared understanding
Transformed or reproduced states	Leads to: Foundation for collective action

In contrast, where ideas about positive approaches were introduced into the clinical sphere, which were led by medical consultants, there were constraining contradictions, in other words ideas were not aligned. In Stadford, this largely led to the ideas about positive services being repressed within the clinical sphere. In Ponston, because of its vocal support from the health promotion and community outreach team, but their relative lack of power, the ideas about positive services were eliminated. In Rissfield, this tension was arguably temporarily alleviated by creating a separate structure in which to base the holistic youth service.

In addition, where ideas about positive approaches were in competition with other approaches, whether or not they were reliant on the same structures, due to budget cuts, all of the services retrenched from a positive approach and prioritised the clinical services (although these too were asked to make efficiencies). This can be explained by socio-cultural interaction beyond the services themselves. For example, they may relate to capitalist neoliberalist politics, medical hegemony and social taboos concerning young people's sexual health in which policy and local bureaucracy are arguably, imbued. These

dictate the need for narrow outcome measures (associated with outcomes which reflect poor medical and socio-economic status), accountability, which drives bureaucratic processes, and subsequent lack of freedom to pursue new ideas and restrict collaborative working on the basis that it might undermine professional status.

8.4.2 Refined theory 3c-e Structural coherence based on contextual integration

The conceptual framework of theories and initial theory building suggested that structural coherence should be analysed separately from cultural coherence. The data showed that these two realms could not be entirely separated (as demonstrated in 8.4.1) but approaching the analysis in this way support exploration of the causal processes involved in three key areas of positive approaches; user involvement, evidence and accountability and integrated provision

Where positive approaches reflect a *reorientation of services* notions of both user-involvement and integrated provision suggests the need for elaboration of the structural realm. This would resemble a redistribution of power from current corporate agents, in this case commissioners and service managers (who in general are consultants) to young people / and other staff members. Practices and processes would need to be altered to account for their views in decision making.

In addition, a *reorientation of services* interpretation also suggests the need for elaboration of the structural realm whereby new processes for gathering evidence is required to demonstrate the broader benefits that might be expected. In addition, new processes for accountability might be expected, for example, paying less close attention to KPIs and placing more trust in frontline staff to support young people to the best of their ability.

Table 17. Structural coherence based on 'reorientation of services'

Prior conditions	Shared understanding of positive services as a reorientation of services

	Commitment to action towards reorientation of service (actions towards flourishing, pro-choice, non-prescriptive) Corporate agency
Habitus or internal conversations	Collectively triggers Corporate agent action (on behalf of an organisation)
Transformed or reproduced states	Leads to: Work to: • redistribute power 'down' the hierarchy • alter practices and processes in line with *'reorientation of services'* characteristics of service

The data has shown however, that, due to a lack of shared understanding, and a resistance from corporate agents who are protecting their vested interests, in retaining power in the system, this configuration is highly unlikely. In practice, positive approaches appear to be in constant threat of 'elimination', due to a contingent incompatibility. That is that the dominant approach (risk-reduction) and positive approach are not reliant on the same structure to the degree that one cannot survive without the other. It is in the best interests of corporate agents to repress or get rid of positive approaches to maximise their own interests.

Where positive approaches reflect a *strategy to reduce sexual ill-health* participants were able to assimilate positive principles and characteristics with the existing structure. Tensions were alleviated, at least initially through compromise. User-involvement was positioned as a mechanism for improving the effectiveness of the services. Integrated provision was a way of moving users around the system to retain a focus on specialisms. Notably, positive approaches were positioned as a way to bring about the outcomes which were predetermined as important by society. This is illustrated in table 18.

Table 18. Structural coherence based on 'strategy to reduce ill-health'

Prior conditions	Shared understanding of positive services as a reorientation of services Commitment to actions towards broadening ambition for service delivery but still bound to medical model, meeting requirements of the role Corporate agency
Habitus or internal conversations	Collectively triggers Corporate agent action (on behalf of an organisation)
Transformed or reproduced states	Leads to: Work to: - realign processes to accommodate user input - realign processes to effectively signpost to other specialisms

8.5 Chapter conclusion

This chapter has substantially refined the theories related to chapter one. Two factors are important to gaining local buy in to positive services. These are cultural coherence and structural coherence

Cultural coherence means developing a shared understanding of what positive services mean in practice. With this shared understanding, commissioners, managers and/or practitioners will act on their convictions on the faith that others will act with them.

Structural coherence means the extent to which the new approach can be integrated into the existing context. The data has shown that an approach which positions positive services as a strategy to reduce sexual ill-health is

more easily assimilated with existing contexts. However, compromises must be made which may threaten its long term sustainability. In contrast, the data has shown that a reorientation of services would require substantial revision of roles, practices and processes. Whilst this has been shown to be possible, (for example in Stadford in the community services and in nascent form in the youth service in Rissfield), this requires substantial effort and commitment. This approach would also be in jeopardy in the long term if changes to the broader culture and structure are not made.

Chapter 9. Discussion

9.1 Chapter outline

The overarching aim of the study was to increase understanding of what works to deliver positive youth sexual health services, for whom, under what circumstances and why? This chapter draws together the empirical evidence and theories to show how this research aim and the research objectives have been met.

First the proposed principles and characteristics of positive youth sexual health services, derived from case studies in the literature, are discussed in light of the empirical study and the principles for youth sexual health research, practice and policy making outlined in chapter one. These principles and characteristics extend current conceptualisations of positive services present in the literature. Second, the refined programme theories which explain how local buy-in to positive services can be gained are presented. The data from cycles one, two and three, supporting these programme theories will be examined in relation to the original conceptual framework and further, pre-existing substantive theory to complete the fourth research cycle. This section will culminate by drawing the data and theories together to provide a novel overarching theory to support the sustained buy-in to positive services at a local level. Third, a critique of policy will illuminate the enabling and constraining levers affecting the delivery of positive sexual health services. This section ends with recommendations for policy and practice.

The strengths and limitations of the study will then be described. This will detail, inter alia, the original tools that were developed to assist the building of programme theories for this project. The implications of the research study for future research will follow. This chapter ends with a conclusion which draws the threads of the thesis together and a reflective account illustrating my own learning over the course of the study.

9.2   Proposed principles and characteristics of positive youth sexual health services

This section corresponds to the first objective to propose principles and characteristics of positive youth sexual health services.

My programme of research has shown that there is no uniform application of a positive approach to youth sexual health service in practice. Each of the six case studies examined had interpreted the general ambition in a different way. As a result, there were no standard outcome measures relating specifically to positive approaches by which successful implementation might be measured and compared. This study looked for activities which are connected to the general policy direction and might serve, in combination, as the outcomes for theory building.

Aspects that could be identified as indicators of positive services were identified through a synthesis of principles and characteristics applied in practice. Initially, these aspects were identified in the documentation relating to the case studies from the academic literature which had attempted implementation of positive services: London, Lothian and Oregon. These aspects were then refined by comparing them to concepts in policy affecting services in England, documentary evidence from Rissfield, Stadford and Ponston, and extracts from the interviews with participants and feedback workshops.

The initial principles and characteristics: *to acknowledge young people's sexuality*, *to support sexual wellbeing* and *to be person-centred* were supported in the empirical research. However, the final synthesis illustrates that the purpose for adopting these principles may differ which may have led to variations in the way that services were delivered. Three interpretations, each orientated to a different purpose were illuminated. The relationship between these three interpretations is illustrated below in figure 26 below.

One interpretation of positive services in practice, the *quality marker,* does not reflect the principles and characteristics identified in chapter three and did not stimulate a substantial change of approach because it is rooted in a narrow, medical, risk-reduction model of health. This is covered in chapter six and

seven in some detail and, because it does not support the delivery of local positive services, will not be further addressed in this discussion. Two interpretations of positive services; the *reorientation of services* and *strategy to reduce ill health* do reflect the principles and characteristics identified in chapter three and did stimulate a change in practice at a local level. These interpretations have some shared traits, for example, they recommend holistic, youth centred, inclusive approaches. The *reorientation of services* interpretation, however, reflects the three inter-related principles and characteristics most closely because of its focus on young people's choice, emerging capabilities and ethics. The *strategy to reduce ill health* interpretation partially reflects these principles and characteristics in that it promotes wellbeing and user involvement and was sufficient to stimulate a change of approach but ultimately, under pressure from external forces, this interpretation remains consistent with the current dominant approaches (which do not sit easily with a positive approach) as will be described below.
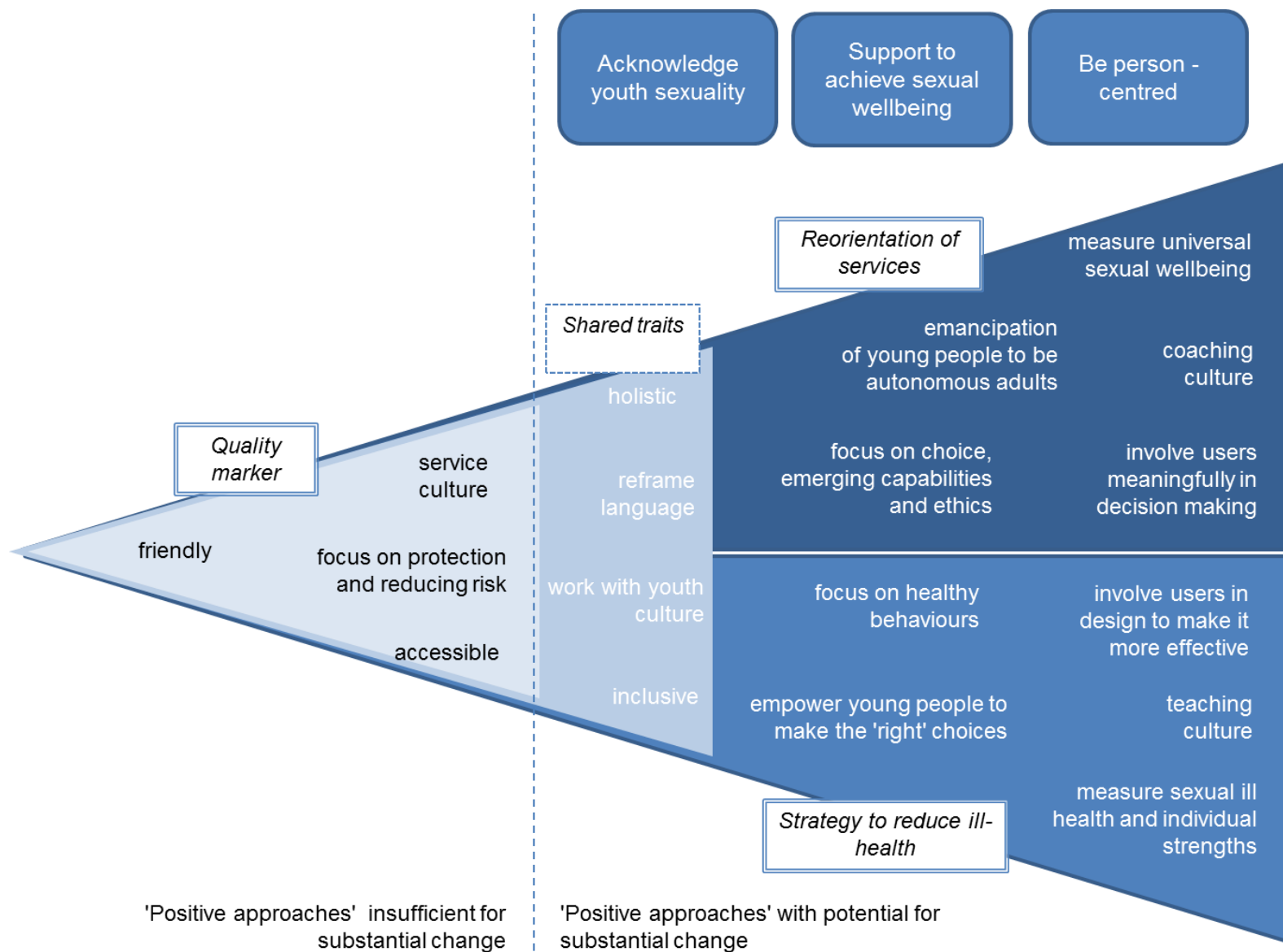
Figure 26. Interpretations of positive service in practice

9.2.1 Principle 1: Acknowledge young people's sexuality

The first principle is that all people, including young people, are sexual beings, with a sexual identity, whether or not they are sexually active. Those most closely aligned with this principle were individuals who interpreted positive services as requiring a *reorientation of services.* The data particularly from Oregon and the community services of Stadford demonstrated a clear move away from approaches which repress or silence youth sexuality, (see chapter 1 for a critique of these approaches), by recognising young people's sexuality as integral to their health and wellbeing. The results in these case studies indicate perceptions that young people's sexuality should be nurtured as a central part of their development and transition to adulthood. This principle is consistent with general premises outlined in some of the academic literature. For example that sexual health is an element of overall health (Ivankovich, Fenton, & Douglas Jr., 2013; Satcher et al., 2015; Williams et al., 2015) and that young people should be able to explore, experience and express their sexuality in healthy, positive and pleasurable and safe ways (Braeken & Rondinelli, 2012).

Further to existing literature this study illustrates ways in which this principle might be translated to service provision. In Oregon the youth development policy literature urges agencies to adjust thinking, language, programmes, policy and measurement in ways that support young people's development. This meant, for example, that young people were entitled to have access to support and advice concerning their sexuality whether or not they fall into 'high risk' categories. In Stadford practice was adjusted through efforts to provide universal, wide-ranging, low level sexual health support and advice through a web resource which included graphic illustrations designed to help young people learn about their bodies. These resources explicitly recognised and validated young people's interest in sexual matters and presented engaging information orientated to maximise their health and wellbeing.

Efforts to acknowledge young people's sexuality were also illustrated where services had consciously adopted discourses that valued young people and their choices. To this end, the protagonists in Stadford spoke of 'changing their language' away from a risk-based discourse. This provides an exemplar of one of the principles advocated at the Centre for Positive Sexuality (which has

issued one of the frameworks for positive approaches, see chapter one), which encourages critical appraisal of language to ensure it is inclusive, supports the establishment of trust and is not stigmatising (Williams et al., 2015).

This affirmative practice of acknowledging young people as sexual subjects may provide an illustrative example of what Giami (2015b) perceives as a move towards a rights-based practice. Although it should be noted that those who interpreted positive services as a *reorientation of services* towards well-being and youth development spoke more readily of values-based services or ethical approaches than 'rights' per se. Consideration of young people's sexual rights (United Nations Population Fund, 2013) in light of the United Nations Convention on the Rights of a Child (UN General Assembly, 1989) may be possible. A positive approach fits well with concepts such as providing 'access to reliable information' (article 17), supporting their right to 'express their views…and have them taken seriously' (article 12) and the 'best possible health and well-being' (article 24) (UN General Assembly, 1989).

Nevertheless, this present study has identified tensions between this set of rights in practice, highlighted by the differing interpretations of positive services. When interpreted through the lens of a *strategy to reduce ill health*, the principle *to acknowledge young people's sexuality* took on a slightly different meaning. Participants who interpreted positive approaches in this way spoke of the need to engage with young people's culture, use inclusive language, and address gender inequality, but their primary reason for doing so was not to promote young people's rights per se but to make the health promotion messages and resources more relevant and thus more effective at driving down incidence of ill-health. Where they may make claims to be non-judgemental, there is an implicit judgement in the notion of 'healthy choices'.

This demonstrates the tension between respecting 'a child's increasing capacity to make their own choices' (article 6) and inherited notions of what good choices are. The results provided many examples where services which claim a positive approach include the assumption that young people will make the 'right' choice, as a result of open access to support, information and the means to protect themselves. For example, in Lothian, holistic services were centred on young people 'respecting themselves' and 'acting responsibly', which was

interpreted as having sex within the context of loving relationships and always using protection. Similarly, the holistic services in Rissfield were arranged to combat various risk-taking behaviours to reduce chances of the 'wrong' sex, for example, under the influence of drugs or alcohol. This, arguably stems from inherited notions that children and young people are not capable of making good decisions for themselves as they do not have the emotional and cognitive capacity to do so (Dixon & Nussbaum, 2012). This view is contested, for example, by Bessant (2014) and Braeken & Rondinelli (2012) who suggest that young people, can make informed judgements if they are supported to do so, with information and advice. In addition, these narrow conceptualisations of right and wrong sex may not tally with young people's concepts of good or right sex which may, for example, include having sex with multiple partners, albeit not unsafe (McGeeney, 2013). Dixon and Nussbaum (2012) recognise the difficulty in balancing concern for physical vulnerability with the need to respect young people's agency. They suggest that more work needs to be done to look critically at local customs and norms concerning young people.

The alternative position, described as a *'reorientation of services'*, represented by only a handful of participants in the study, aims to respect young people's choices, even if they are different from the normative choices society would make for them (described in the introduction). This resembles Caballero's (2016) conclusions when considering young people's sexual wellbeing through the lens of the capability approach (which argues that human development should be measured by the substantive freedoms of people to pursue the things that they value) who suggests that this may mean accepting some young people may choose sexual lifestyles that policy makers and parents might consider 'unhealthy'. These positions, arguably, most closely aligns with Williams and colleagues where they stress the need to allow for *freedom of language, concepts and ideas that differ from our own or current social norms can help establish trust and safety that are necessary for personal growth* (Williams et al., 2015)*.

The tensions between these competing rights are not resolved by the study, although contrasting these results with McKee et al's (2010) principles (described in chapter 1) would suggest that focussing attention on young people's capacity to make healthy choices, for example by given them access to

full comprehensive information, services and reducing societal stigma, rather than on the behaviours themselves may be a route forward. What is important for this study, however, is that the tension is real, as it has real effects on delivering positive services as will be discussed in section 9.3.3.

9.2.2 Principle 2: Support to achieve sexual wellbeing

The second principle suggests that services should support young people to achieve sexual wellbeing. Sexual wellbeing would encompass the positive aspects of sexuality such as the possibility of pleasure as well as negative impacts of sexual activity as represented in figure 27. This principle reflects the multi-dimensional constructs of sexual health reported in the introduction to the thesis (chapter 1) (Hensel & Fortenberry, 2013; Smylie et al., 2013).

Those who interpreted positive approaches as the *re-orientation of services* highlighted that aspects of sexuality like sexual identity, or pleasure, should be privileged in service as they contribute to overall wellbeing. This was illustrated in Oregon where the policy stated that *integrating positive aspects of sexuality could be positively enriching and enhances personality, communication and love*. Aspects of positive sexuality were also stressed by those who interpreted positive services as a *strategy to reduce ill health.* However, there was a subtle difference in the purpose as they recognised that positive aspects are intrinsically linked to negative aspects that are of public health concern, for example, preventing STIs. Thus an effective way of dealing with these concerns is by looking at the problem holistically.
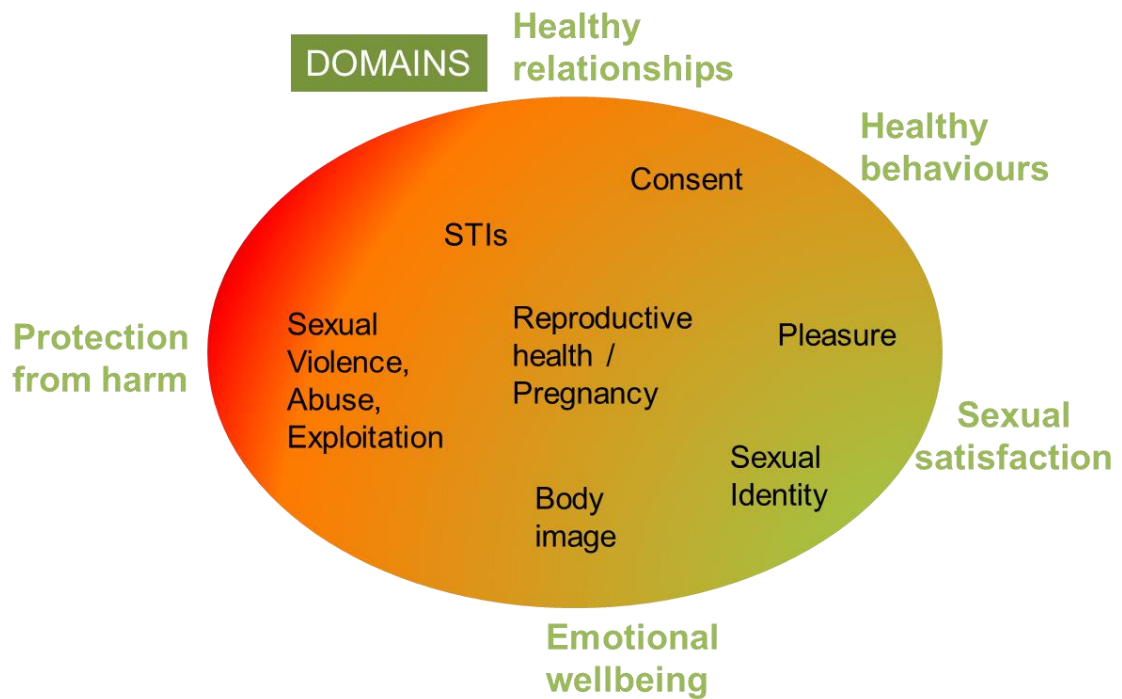
Figure 27. Multi-dimensional model of sexual health

Data from the services in this study suggested that the principle to offer support to achieve sexual wellbeing can be operationalised when sufficient attention is given to all aspects of sexuality. This is apparent where positive services are endorsed as a *reorientation of services* or as a *strategy to reduce ill health*. Different types of activity reflected the principle. For example, in Ponston some participants incorporated questions about pleasure and sexual identity in their clinical practice, whether or not this was recognised by their line managers. In Rissfield, practitioners were encouraged to conduct full consultations to cover all the aspects of sexuality that were important to young people. To allow for this, consultation times were made longer and more flexible. In Stadford's community work, efforts were made to foreground aspects of pleasure for example in their web resource, by providing interactive pages for young people to explore 'pleasure zones' of the male and female body. This included pleasurable sensations which could be attained without sexual intercourse.

Individuals in Rissfield, Oregon and Stadford, who were promoting positive services recognised the current outcome measurement tools that were available to them for measuring positive approaches and sexual wellbeing were inadequate. In all three of these cases, the services had made rudimentary attempts to gather more data or test a broader range of constructs. Arguably,

however, none of these attempts were sufficiently robust or powerful to justify positive approaches or significantly add to the evidence base for their effectiveness. This is a limitation which is discussed in more detail at 9.3.3. It reflects the consensus from an international group of scholars that there is an urgent need to develop and implement adequate measures of youth sexual wellbeing (Michielsen et al., 2016).

Some services attempting to implement positive approaches made efforts to reduce taboos associated with sexuality and stigma associated with youth sexual health. This is supported by literature which recognises that stigma associated with youth sexual health can prevent young people from seeking the support they are entitled to (Fortenberry, 2013, 2016). In Oregon the public health teams aimed to diminish perceptions that young people are promiscuous or reckless by building recognition of a youth positive approach across a wide variety of sectors and organisations. Their efforts were intended to 'normalise' positive conceptualisations of youth sexuality and young people's potential contribution to society across the state. In London, the branding, look and visibility of the service was changed to make it more prominent in an attempt to visually signify that attending to your sexual health was not shameful or wrong. Notably, these interventions did not target individual risk groups, which arguably reinforces stigma (Fortenberry, 2013, 2016, Scambler, 2006, 2009), but sought to address the structural and cultural contributors to stigma in practical ways. My study may therefore lead to recommendations of how to reduce stigma and build an open an honest culture around sexuality thereby extending current English policy and guidance (Department of Health, 2013a).

All participants who advocated positive approaches, for which ever purpose, saw the prevention of sexual ill-health and protection from risk as paramount. From a *reorientation of services* viewpoint this was simply translated as people having the right to health. From a *strategy* perspective this view was often reinforced by rehearsing the evidence that investment in contraception and prevention measures saves money in the long run by reducing unwanted pregnancy and incidence of ill-health. In all of the cases within this study, prevention interventions were, at some point in their evolution, intended be multi-modal. For example, the Healthy Respect campaign in Lothian included a package of clinical, education, skills based, and health promotion campaigns.

This is arguably, in contrast to the current policy guidance in England which favours clinical interventions (see chapter 3) and which is described below.

9.2.3 Principle 3: Be person-centred

This study found that the intention to meet Principle 2, to support young people's sexual wellbeing, had an impact on the way in which young people's specific needs were assessed and catered for. Data derived from the literature reviews stressed that young people's sexual health services should be person-centred, using possible synonyms of patient or user-centred care. This principle is much advocated in health care, however, it can have different meanings in different settings (De Silva, 2014) as was observed in this study. In addition intentions for person-centred services at one level of policy can be lost at subsequent levels of policy and practice as demonstrated in the analysis of current sexual health policy in England (chapter 3). In the context of my study being person centred meant a commitment to placing young people's needs at the centre of decision making, as opposed to political, professional or societal needs.

Data from the literature and empirical studies suggested that person-centred-ness in youth sexual health could involve three specific actions: fully involving users in design and evaluation; tailoring services to meet the diverse and evolving needs of young people over the life-course; and integrated provision (by which I mean, breaking down professional silos to work together seamlessly).

My results highlighted examples where decision makers had prioritised the involvement of young people. This may be for two reasons, again, depending on the purpose for positive services are adopted. Through the lens of the *'strategy to reduce ill health'* this was to improve the efficiency and effectiveness of the service design. For example, in Lothian, young people were consulted on the type of service that would meet their needs. This generated accreditation criteria which were used by partners to establish 'high quality' services. Through the lens of the '*reorientation towards youth development'* this was to support fulfilment of their rights to influence services which affect them. This

means in some cases, taking young people's view over that of adults involved in decision making. For example, in Oregon, there was a conscious transfer of power towards service users both in terms of their ability to manage their own health, and informing decisions that are made about them or their services.

In addition, as an unanticipated, but positive consequence, involving young people meaningfully may impact on the self-esteem and confidence of the young people themselves. For example, in Stadford, young people's inputs to the design of the web resource and mystery shopping provided valuable insight for the services but also led to the cohort building skills and confidence which transferred to their academic careers. These purposes of user involvement mirror previous work which describe the benefits of patient and public involvement in research: methodological (that is, to make it more effective), policy (that is, to redress the balance of decision making) and moral (that is, to fulfil people's right to participation) (Wilson et al., 2015). My study however, provides examples of active participation in youth sexual health services which others have argued is necessary (Villa-Torres & Svanemyr, 2015) but currently underreported in the academic literature.

Person-centred services must also acknowledge what it means to respect diversity and evolving needs over the life-course. The empirical results demonstrated that respecting diversity and evolving needs over the life course overlaps with the need to support sexual wellbeing. Examples of actions taken by services included: the provision of free advice, support and information on all health issues, including sexual health, in Lothian, extending clinical consultation times in Rissfield and providing resources which give information to everyone whatever their age, experience or sexuality in Stadford. This supports previous research which has suggested that services need to be inclusive and support the needs of all young people (Sundby, 2006).

My study highlighted differences in perspectives about the role of the practitioner in supporting diverse and emerging needs. Practitioners who interpreted positive services as a *reorientation of services towards youth development*, referred to the intention to develop a coaching culture within practice. This would not dictate to young people what their behaviours should be but (within the confines of brief interactions), supported young people to take

control of their sexual health. Those who interpreted positive services as a *strategy to reduce ill health* did not refer to a specific organisational culture, other than to be welcoming and friendly. It can be implied that, implicit within this interpretation is a role of services to provide resources which will teach young people about healthy behaviours.

Person-centred services were further exemplified where the multi-disciplinary teams were able to recognise each other's skills in supporting young people. This meant down-playing professional egos and sharing resources. This also meant putting trust in frontline staff. Rissfield best demonstrated this with a nurse-led team made up of GUM nurses, contraception nurses, health promotion, addiction, youth development and social work specialists. These findings agree with previous studies which argue that for partnerships to work in sexual health, partners need to recognise the strengths of others (Best et al., 2016; Hadley, Chandra-Mouli, & Ingham, 2016; McCormack et al., 2013; Villa-Torres & Svanemyr, 2015).

The team in Rissfield were protected from 'over-bearing' bureaucracy by their manager, and to a certain extent the commissioner who had intentions to be relaxed about KPIs. This left frontline staff to focus on the needs of the young people. This may help to explain with previous work which suggested that 'basic commissioning and poor leadership'[34] was related to better performance in sexual health services in England (Blackman, Byrne, & Wistow, 2010; Hadley, Ingham, et al., 2016). Practitioners working with young people are typically expert at doing so and given freedom in consultation are able to tailor their approaches accordingly to meet their client's needs. Restrictive protocols and policy which might be expected from certain types of authoritative leadership and bureaucratic activity inhibits this freedom and may in fact be detrimental to young people's outcomes. This reflects other analyses presented in this thesis that focussing on the user (as opposed to professional status)

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[34] The study in question used a qualitative comparative analysis which pre-coded answers to a series of questions across diverse fields and the compared clusters of responses to outcomes measures. One such characterisation was 'poor leadership' which was associated with narrowing of the teenage conception health inequalities between areas of high deprivation and the rest of England:

provides a mechanism for strengthening integration and collaborative work which is called for by those advocating positive services (Satcher et al., 2015).

9.2.4 Section summary

This section has described three overarching positive principles for research, policy and practice with regards to youth sexual health and characteristics of services which embody such principles. Two contrasting interpretations of positive approaches mean that the purpose for meeting these principles can differ and as a result the characteristics of the services exemplifying positive services may also be different.

Positive services as a *reorientation of services* contributing to youth development may be characterised by:

- Service focus on supporting young people to exercise their choices and develop capabilities associated with sexual health.
- Use of a broad range of measurements that assess holistic wellbeing (or place no emphasis on measurements at all).
- A coaching culture.
- Users as equal partners in decision making about services.

Positive services as a *strategy to reduce sexual ill-health* may be characterised by:

- Service focus on encouraging healthy behaviours.
- Use of measurements that assess ill-health, and individual strengths.
- A teaching culture.
- Users as key informants on service design and evaluation.

Shared traits of both interpretations include:

- Affirmative and inclusive language.
- Flexible, holistic care.
- Adequate clinical time to address multiple needs.

- Collaborative care which necessitates mutual respect amongst professionals.
- Long term efforts to reduce stigma.
- Positive preventative, multi-modal health promotion work.

These principles and characteristics of positive youth sexual health services may be considered a contribution in their own right as it extends existing guidance but also illustrates confusion at a basic level in the language used to describe sexual health services in policy and practice. It should be noted that no service exemplified all of the principles and characteristics described. Therefore these might be considered tentative, aspirational definitions of what positive services could look like or aspire to be.

9.3 Developing programme theory

This section corresponds to the second objective of the thesis, *to develop and test programme theories which lead towards successful delivery of positive youth sexual health services.* As is common in realist projects, the research questions become focussed as part of the iterative process. When my study suggested that positive services are not uniform, I chose to focus the empirical study on what works to *secure and sustain shared understanding of* and *local buy-i*n to positive services. Accordingly, the detailed theory development presented below concerns this aspect of what would be a larger implementation chain.

Three overarching factors were identified that could lead to sustained buy-in to positive approaches. These are illustrated in Figure 28. These relate to clarity, conviction and cultural and structural coherence. These factors summarise a number of processes but, in an abstract way, can give an explanation for buy-in to positive approaches which would be apparent where there is a shared understanding of positive services and work to integrate the services in the local context.

In sum, the following partial, fallible theory (depicted at figure 28) suggests that:

- Where individuals have access to ideas about positive services and are able to critically reflect on these ideas compared to current practice they will have *clarity* about what positive services mean and how this might affect their day to day role.

- Where they perceive that this approach is either compatible with their values and/or provide a means to reach their objectives they will have *conviction* in positive approaches.

- Where this conviction is shared with other individuals, there is *cultural coherence.* This provides a platform and shared motivation on which changes towards positive services can be based.

- Where work is compatible with existing processes and practices, s*tructural coherence* supports changes to processes and practices.
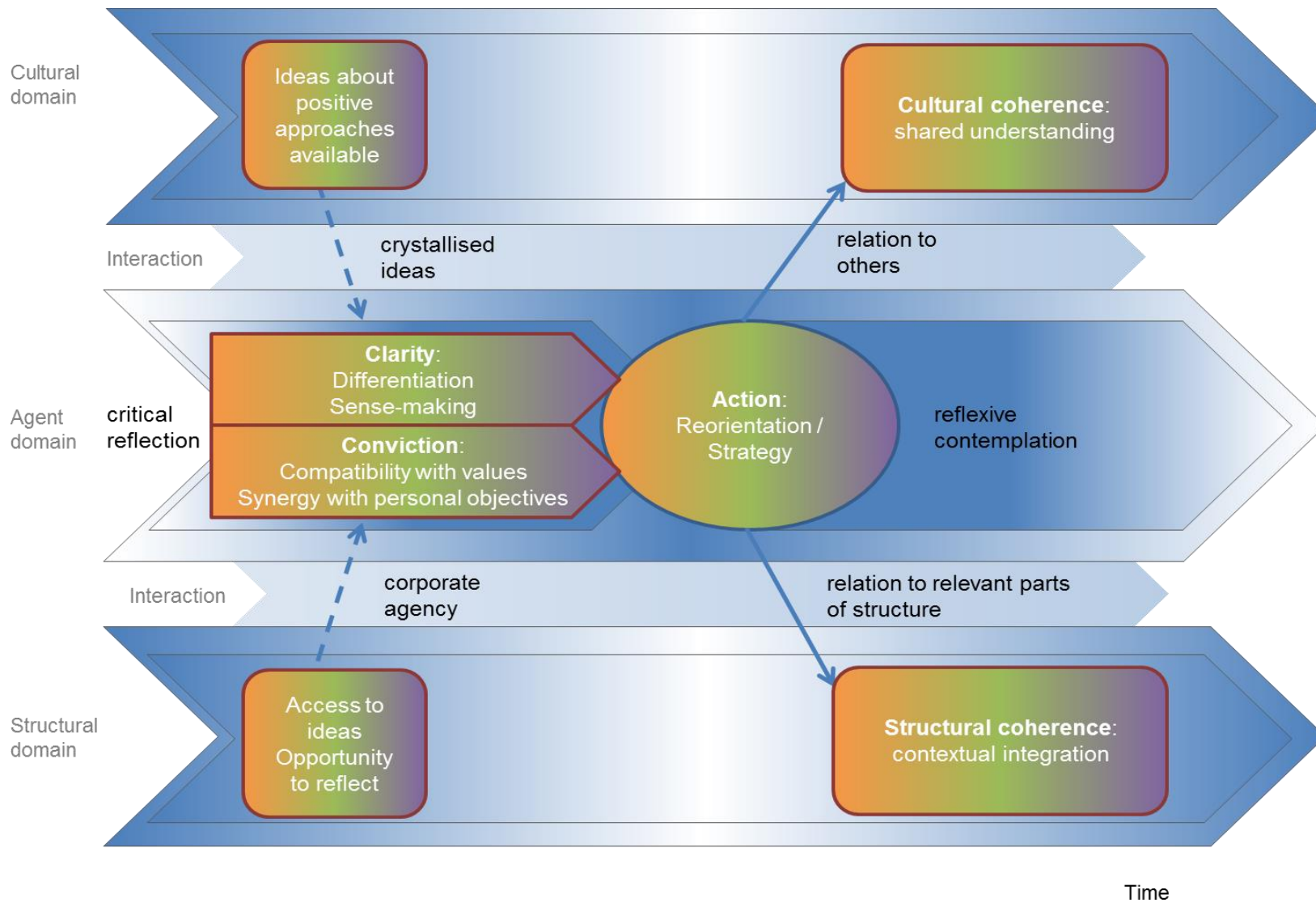
Figure 28. Factors associated with local buy-in to positive services mapped to the explanatory model

The data which supports these factors will now be discussed in relation to the explanatory model and existing theoretical literature. By way of recap, the explanatory model refers to:

- Prior (and enduring) cultural, structural and agential conditions which have effects, through conditioning, on individuals' actions (this includes an account of agency relative to other individuals within the social system). This is illustrated in the dotted arrows on Figure 28.
- Habitus and/or knowledge skills and internal conversations of actors which lead to actions. This is illustrated in the block arrows in agential domain on Figure 28.
- Emergence of transformed agential, structural or cultural states, or alternatively reproduction of 'prior' conditions. This is illustrated by the solid arrows in Figure 28.

9.3.1 Clarity

The results illuminated two specific processes relating to *clarity*: 'differentiating' and 'individually specifying' or making sense of a positive approach. These processes may apply whether or not the interpretation related to a '*reorientation of services'* or *'strategy to reduce ill health'.*

The data from the study illustrated that one first step in delivering positive services was that stakeholders across the local sexual health system had to distinguish positive services from other models of care. Initially these theories were developed with reference to Normalisation Process Theory (May & Finch, 2009) which suggests that local stakeholders need to differentiate, but does not specify how. My study has outlined two potential routes for differentiating positive services: via transformative learning or via experiential learning.

The transformative learning configuration is illustrated in table 18. It relates to availability and access to new material from an external source, time for reflection and a perception that practice could be improved. These collectively trigger critical reflection and an appreciation of positive services as different from other models (Mezirow, 1997). The empirical findings suggest that this form of learning was often observed in those in more senior decision making

roles, such as commissioners or senior managers, for example, the commissioner in Rissfield who had learned to distinguish positive approaches through their attendance at conferences.

Table 18: Differentiation through transformative learning

Prior conditions	Availability of ideas about positive approaches / themes of sexual wellbeing in relation to youth sexual health services
	Access to these ideas about positive approaches (for example through training, networking or conferences)
	Time to reflect
	Perception that practice could be improved
Habitus or internal conversations	Collectively triggers:
	Critical reflection of practice compared to new material (Mezirow, 1997)
Transformed or reproduced states	Leads to:
	Individual appreciation of positive approaches to youth sexual health services as different from other models of care

This compares with participants who gained clarity about positive services through experiential learning, as illustrated in table 19. The experiential learning (Kolb, 2014) configuration relates to exposure of working with young people to support their wellbeing, mostly in settings outside clinical practice where there has, in the past, been more time and flexibility associated with such meetings. It also reflects informal learning opportunities such as discussion with respected peers (Kolb, 2014). The same internal mechanism is proposed, that is, critical reflection leading to an appreciation of positive services as different from other models. This form of learning was observed in frontline practitioners and particularly those with a social work or community backgrounds. Some GUM clinical staff, however, had developed an appreciation of positive models often through critical reflection of personal experiences, particularly where heteronormative assumptions are challenged.

Table 19. Differentiation through experiential learning

Prior conditions	Exposure to working with young people (in settings outside clinical practice), AND/OR access to respected peers and information discussion AND/OR exposure to situations in which heteronormativity is challenged Time to reflect Perception that practice could be improved
Habitus or internal conversations	Collectively triggers: Critical reflection of practice (Kolb, 2014)
Transformed or reproduced states	Leads to: Individual appreciation of positive approaches to youth sexual health services as different from other models of care

The data highlighted that some participants, even those working in services which claimed a positive approach to sexual health, did not differentiate this from other models of care. This appeared to be through a lack of critical reflection of current practice compared to themes around youth sexual wellbeing. Some participants suggested that this was due to circumstances outside their control, for example, a lack of direct contact with information or training materials or a lack of time to engage due to pressure associated with immediate work priorities.

These results therefore may contribute to a more detailed understanding of individual differentiation, within processes of organisational change, such as those reflected in Normalisation Process Theory by highlighting the importance of stimulus, time and motivation to critically reflect on novel ideas in relation to their own practice.

The results further demonstrated that differentiation from other models does not bring about a uniform interpretation of positive services. As highlighted in section 9.2 there is variation in interpretations which are summarised as *'a*

reorientation of services towards youth development', 'a strategy to reduce ill health' and *'a quality marker'.*

The variation of interpretation may be because individuals assimilate new ideas with current discourses, in this case about youth sexual wellbeing (Paley, 2016). For example, those who were previously aware of ideas about sexual wellbeing, particularly if this extends to young people, or youth development, interpreted positive services as a *reorientation of services* (see table 20)*.*

Table 20. Making sense of positive approaches: reorientation of services

Prior conditions	Aware of discourses about sexual wellbeing and human flourishing Not in strategic decision making roles Differentiated positive approaches from other models of care
Habitus or internal conversations	Collectively triggers: Critical reflection of practice Influence of flourishing discourse on sense-making
Transformed or reproduced states	Leads to: Individual interpretation of positive approaches as a *reorientation of services*

Alternately, those who were previously ensconced in ideas from public health or medicine about the avoidance of sexual ill-health, who had not had access to material about sexual wellbeing and youth development, interpreted positive services as a *quality marker*. In contrast, where people had accessed material about sexual wellbeing and youth development there was an opportunity for them to recognise a 'new discourse'. This led them to accommodate their beliefs about youth sexual health depending on the persuasiveness of the arguments. In some cases, individuals recognised the strength of positive approaches as a *strategy to reduce sexual ill health*. In a small minority, individuals additionally bought-in to ideas about youth emancipation and developed an interpretation in line with a *reorientation of services.*

Table 21. Making sense of positive approaches: strategy to reduce ill-health

Prior conditions	Dominant discourse about protection, ill-health and risk
	Aware of discourses about sexual wellbeing and human flourishing
	Policy reflecting narrow sexual health outcomes
	Strategic decision making role
	Differentiated positive approaches from other models of care
Habitus or internal conversations	Collectively triggers:
	Critical reflection of practice
	Accommodate beliefs to reflect positive attributes
Transformed or reproduced states	Leads to:
	Individual interpretation of positive approaches as a *strategy to reduce ill health*

My study highlighted that those who were making decisions about the priorities for services, tended to interpret positive services as a *strategy*, or as a *quality marker*. Those who interpreted positive services as a reorientation of services, tended not to be the ones who were in decision making roles, at the time of interview. The implications for this will be discussed at 9.3.3 and 9.3.4.

This study demonstrates how differentiation may be brought about by different processes, for different people and at different levels within organisation, adding nuance to the concept of differentiation in Normalisation Process Theory. Differentiation, in Normalisation Process Theory relates to distinctive features which distinguish it from other established practice and that holds together well enough to be operationalised (May & Finch, 2009). This is influenced by decision making status, role and access to learning material. Importantly, actors within the organisation must have time and be able to critically reflect on current and other models of practice in order to differentiate. In addition, Normalisation Process Theory holds that the distinctive features must be made sense of by individuals (May & Finch, 2009). The results illustrate that this is a

natural process associated with learning, but also suggest that these processes cannot be seen in isolation from background theories about a topic, that existing discourses will affect how new ideas are interpreted (Paley, 2016). In the case of sexual health services for young people, there are strongly competing background theories, and associated values, as identified in chapter one. As such interpretation can vary widely.

This variation is compounded by the lack of unified view in academic or policy sources, as demonstrated in chapter three. Williams and colleagues maintain that this diversity is a strength because it allows for local interpretation (Williams et al., 2015). However, this study has demonstrated that variation in ideas at a local level is contra to local buy-in as will be described in section 9.3.3.

9.3.2 Conviction

Running concurrently with processes relating to clarity, are processes relating to conviction. The results suggest two explanatory theories of conviction: *compatibility with values* which is related to the interpretation of positive approaches as a *reorientation of services towards youth development* and; *synergy with objectives* which is related to the interpretation of positive services as *a strategy to reduce ill health* respectively. This is in contrast to those who made sense of positive approaches as a *quality marker*, who did not have conviction sufficient for it to be a prioritised approach.

Theories about conviction were initially developed based on COM-B, where 'personal conviction' offers a motivation to act with different combinations of automatic (emotions and impulses) and reflective (evaluative) motivation in the balance (Michie et al., 2011). Following data collection, I judged that these theories provided a good framework for building explanations, but did not help in articulating the generative mechanisms at work. Other theories were supplemented to explain the processes. Specifically these relate to the idea that courses of action are produced through the reflexive deliberation of subjects who subjectively determine their practical projects in relation to their objective circumstances and what may be described as 'cautious' agent

'typologies'[35], coined by Margaret Archer (2007) and developed by Graham Scambler (2013a, 2013b) which will be considered below.

The results suggested that some individuals who interpreted positive approaches as a *reorientation of services* have developed a conviction in positive approaches based on compatibility with their values. These participants appeared, in the context of this project, to be 'meta-reflexives' that is individuals who questioned the prevailing social order and were compelled by a need to 'make a difference', rather than a willingness to simply meet their own immediate needs and wants (Archer, 2007; Scambler, 2013b). These participants' internal judgements were orientated to arguments that demonstrated how a positive approach might meet these values and present the prospect of effective action in society (Scambler, 2013a). In addition, those who interpreted positive approaches as a *reorientation of services* spoke of their emotions and impulses, their 'passion' and a sense that it is the 'right thing to do'. This seemed to be a particularly important driver given the perceived likelihood of receiving criticism from the press or community. These reflect automatic motivation processes.

Table 22. Conviction based on compatibility with values

Prior conditions	'meta-reflexive' individuals critical reflection of practice in relation to youth sexual health AND/OR exposure to ideas about positive approaches/sexual wellbeing
Habitus or internal conversations	Collectively triggers: Internal conversation resulting in judgements of compatibility of the approach with values and prospect of effective action in society, that is, reflexive motivation (evaluative) and Intuitive and emotional response that this is the 'right thing' to do, that is automatic motivation (emotions and impulses)

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[35] These typologies describe individual agent types and patterns of reflexivity. Whilst this level of analysis is centred on the individual it is an inherent assumption that being a certain typology involves prior interaction with culture and structure.

| Transformed or reproduced states | Leads to:
Commitment to actions towards flourishing, pro-choice, non-prescriptive |
|---|---|

My study also demonstrated that those who interpreted positive services as a '*strategy to reduce ill-health'* developed conviction in positive approaches based on synergy with objectives. For example, some of the commissioners in Rissfield and Stadford pursued holistic/positive approaches because they felt that they were the best way to reduce incidence of unwanted conceptions and a range of other adverse outcomes. These individuals might be described as 'autonomous-reflexives' in the context of this project in that they tended to pursue their own interests, without necessarily needing to confirm their direction with others. In this context, protagonists were able to engage with the new material about sexual wellbeing and positive approaches and reinterpret it as a way to reach their objectives for reducing sexual ill-health, despite the fact that this might mean taking a different direction to the status quo. The refined theory is highlighted below in table 23.

Table 23. Conviction based on synergy with objectives

| Prior conditions | 'autonomous reflexive' individuals
critical reflection of practice in relation to youth sexual health AND/OR exposure to ideas about positive approaches/sexual wellbeing |
|---|---|
| Habitus or internal conversations | Collectively triggers:
Internal conversations resulting in judgement that positive approaches are the best way to reduce ill-health, that is reflexive motivation (evaluative) |
| Transformed or reproduced states | Leads to:
Commitment to actions towards broadening ambition for service delivery but still bound to medical model, meeting requirements of the role (which in this case do not reflect positive ambitions for young people) |

These findings concur with the assertions of Sayer (2011) and Scambler (2013b) that internal conversations linking 'knowledge about particulars' to 'judgements about courses of action' have causal efficacy. This arguably enhances conceptualisations of reflexive and automatic motivation outlined in the COM-B (Michie et al., 2011) model (although I acknowledge that this model is only a summary of a much deeper body of psychological behaviour change theories). Different people, depending on their objective situation and subjectivity will weigh up the possibility of acting on their beliefs about positive approaches differently. Those who are constrained to enact a job role, where, for example they are accountable for targets, may in the context of compelling evidence, pursue actions (described earlier related to a strategy interpretation), on the basis that they believe it is the *best* way to reduce ill health. Those with compatible values may pursue action on the basis that it instinctively feels like the *right* thing to do. However, the latter form of conviction is problematic for cultural coherence because there may be others, with different value systems, who disagree as will be discussed next.

9.3.3   Coherence

This section discusses the theory theme of coherence, where both cultural and structural coherence appear to be critical for sustained buy-in to positive approaches. This set of theories describes how individual life politics and actions (discussed above) contribute to the reproduction, elaboration, transformation of structure and culture of the local service system. It also discusses the influence of structural and cultural entities outside the local service system which inhibit or enable local buy-in.

Theories relating to coherence were originally developed using the conceptual model, with particular reference to the morphogenetic approach (Archer, 1995) and Normalisation Process Theory (May & Finch, 2009). The Morphogenetic Approach, in particular, encouraged the analytical separation of organisational culture (that is ideas about how youth sexual health services should be run) and structure (that is the processes and practices associated with youth sexual health services). Once more these theories provided a framework for data

collection and analysis but additional theory was sought to help develop explanations for the underlying processes leading to change.

Cultural coherence (shared ideas and understanding)

The results showed that cultural coherence came about where a conviction in positive services, be it *strategy* <u>or</u> *reorientation* was held by someone with influence (or corporate agency (Archer, 1995)). These 'pioneers' could influence other individuals working with them, for example, in Ponston participants said that prior to integration there had been strong, progressive leaders (subscribing largely to a *values based/reorientation of services* view) within the community outreach team who were able to set the tone and direction for the service.

Alternatively, as in Stadford, the core team, who were interdependent agents in the local authority scrutinised, and named[36], the approach, through the study trip to the Netherlands and subsequent high profile interactions. Those who held similar interpretations and convictions to each other were therefore aware of each other. These processes triggered perceptions that others agreed with their beliefs which generated a pre-cursive faith that others would act with them. This appeared to be a stimulus for action.

The results of these actions reinforced the ideas, in the main. They became more and more crystallised in the minds of the core team and more and more compelling to those who were exposed to the results. This process may be referred to as repetitive reciprocal cycles of cultural elaboration (Archer, 1996). This, I argue, would be necessary to overcome the medical hegemony associated with sexual health (Weick, 2009).

Conversely, in Ponston, after integration there was no sense of shared understanding or commitment in positive approaches. Positive approaches were not pursued because, despite there being a number of individuals with a conviction in it within the organisation, their views were diluted. This highlights that an interpretation, based on values and experience, as opposed to

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[36] 'Naming' in this context means to specify the phenomenon of positive services.

'evidence' was particularly precarious because alternate ideas, for example to prioritise medical capability in services could be presented with equal conviction.

My study suggests that when people perceive a shared commitment this provides a foundation for collective action. In the case of positive approaches to youth sexual health, which can be described as a contentious issue, this may take the form of a 'social movement', or a network based on shared beliefs and solidarity. This social movement can then legitimate actions which lead to the enactment of the principles and characteristics of positive services.

Table 24 Cultural coherence based on perception of shared understanding and conviction

Prior conditions	individual(s) with clarity about and conviction in positive approaches AND influence AND/OR individuals with the same interpretation of and conviction in positive approaches AND shared scrutiny and naming of the approach
Habitus or internal conversations	Collectively triggers: Perception that others agree with you Faith that others would act on these beliefs
Transformed or reproduced states	Leads to: Foundation for collective action Network based on shared beliefs and solidarity

These results tally with Normalisation Process Theory (May & Finch, 2009) which holds that shared understanding can lead to collective action. This study additionally argues that where the new practice concerns a controversial or sensitive development, there needs to be some emotional attachment to the outcome. This passion may be necessary to drive a social movement where

negative fallout can be expected, for example from the media or community groups.

Shared understanding and conviction in positive approaches may not be enough to secure local buy-in. Positive approaches may need to be structurally coherent in terms of their integration with the specific organisation and government level policy, practices and processes to secure and sustain local buy-in. The next section discusses processes which support or hinder structural coherence of positive approaches.

Structural coherence

Theories of structural coherence were developed with reference to the Morphogenetic Approach (Archer, 1995) and Normalisation Process Theory (May & Finch, 2009).

The results of this study showed that progress towards local buy-in to positive services was observed most commonly where there was shared understanding of positive services as a *strategy to reduce sexual ill-health.* This interpretation was the dominant view in Stadford, Rissfield, Lothian and London, although of these, Stadford also exhibited elements of *'reorientation'* in some of their practices (as described above). In Ponston, where there was a lack of shared understanding, the principles and characteristics associated with positive work were, in effect, eliminated following integration of community and clinical provision. In Oregon, there was greater shared understanding of positive services as a *reorientation of services* but this was left to local interpretation of which specific details were not found through the literature search.

I suggest that the *strategy to reduce sexual ill-health* interpretation was primarily used as the foundation for collective action as it was easier to integrate with the existing structure. The theory underpinning this proposes that structural elaboration (as opposed to transformation) may take place if there is compatibility with the dominant models of sexual health which reflect current neoliberal economics and hegemonic medical approaches. This perceived compatibility may, perversely, be the result of a *'necessary incompatibility'* or in other words, a compromise, between the core principles of positive approaches

and neoliberalism or medical models (Archer, 1995). This is because both approaches are reliant on the same structures within society writ large (such as bureaucratic processes, social hierarchies, dominant political discourses). For example, decision makers who bought into positive services commonly felt the need to make the case that improving sexual wellbeing, through holistic, inclusive, affirmative activities would increase young people's likelihood to engage with service provision and health promotion messages and as a result reduce their adverse outcomes which dominate discourses about youth sexual health.

User-led design, as interpreted through the lens of a *reorientation of services* is a threat to the medical model, not least because it can question medical authority over issues to do with sexual health. It is also a threat to structures associated with evidence based-policy making, because, by its very nature would derive local solutions which are inappropriate to evaluate via current 'gold standard' measurement tools such as Randomised Controlled Trials. As a result, user-led design was framed, through the lens of the *strategy to reduce ill-health* as maximising the efficiency of tools by increasing their cultural relevance. In the case of Rissfield, this was merely a tick-box exercise. In Stadford, this was more reciprocal, but still within the context of developing a specific output, that is the web resource, which had been predetermined as necessary for young people.

When viewed through the lens of a *strategy to reduce sexual ill health,* accountability measures such as under-18 conception rates are consistent with risk-reduction/protectionist approach. This consistency arguably poses a risk to the sustainability of positive services because the existing measures would not recognise any wider benefits offered by a positive approach. If positive approaches are in direct competition with medical or technical fixes, such as LARC then decision makers may favour a medical or technical solution on the basis of proven return on investment. The possible wider benefits of positive approaches such as confidence or equal relationships are, however, difficult to quantify. This calls into question the possibility and role of accountability measures when interpreting positive services as a *reorientation of services.*

Collaboration, as interpreted through the lens of a *reorientation of services* is another direct threat to the medical model, because once again it can question medical authority. Arguably, an increased role for non-clinical professionals requires medical staff to cede control and professional authority over the patient which may challenge their sense of purpose and identity. This was evidenced in Ponston, following integration. As a compromise, through the lens of *strategy,* collaboration and integration is interpreted as co-location and signposting between services.

As alluded to, with regards to cultural coherence, the two interpretations of positive services are incompatible where those advocating the approaches rely on the same underlying structure (Archer 1995). In contrast to my earlier theory, the weight of evidence in this study suggests that where interpretations of 'reorientation' and 'strategy' co-exist the *reorientation* interpretation will be eliminated. This is because they are currently reliant on the same, dominant structure which favours a medical model rooted in neoliberal economic policy and risk-reduction discourses of youth sexual health.

9.3.4 Evolution of positive services over time

The previous three sections have summarised and discussed explanations of key factors *clarity*, *conviction* and *coherence*, which may lead to local buy-in. These may be described as 'vertical' explanations of local buy-in in that they are its constituent parts. Although, as discussed in section 9.3.3, I suggest that these factors are not singular moments, but would operate in reciprocal cycles to establish and build confidence and understanding in positive approaches.

I now turn to summarise and discuss 'horizontal' explanation of how positive services were established. This relates to the successive events which led to local buy-in, in each of the empirical case studies, over time. This is discussed with reference to the morphogenetic approach advocated by Margaret Archer (Archer, 1995).

The evolution of services in Stadford is described first. This is illustrated diagrammatically in Figures 29 and 30. I have separated out the community and outreach sexual health services (Figure 29) and clinical sexual health

services (Figure 30). At Time 1, those involved in community and health promotion youth sexual health work held a range of ideas about youth sexual health services. By Time 2, socio-cultural interaction, that is interpersonal cultural influence between experts in the Netherlands and those on the study trip and subsequently between those on the trip and the wider stakeholder base had taken place, resulting in unification of ideas about positive approaches. This brought about clarity and conviction. This cultural morphogenesis inspired structural morphogenesis through the actions of agents with conviction in positive approaches. Between Time 1 and Time 2 this was observed in the transformation of the community sexual health practices, processes, resources and messages which increasingly reflected positive principles and brought about coherence at a local level. External threats to the system, such as the reduction in funding, and internal threats, such as the loss of key personnel, between Time 2 and Time 3 resulted in dilution in the strength of the ideas and the extent to which they were shared in the cultural realm. At the same time a scaling back of practices and processes exemplifying positive approaches was observed.

The clinical services have a different analytical history. In part, this is because they operated within a different overarching structure prior to the reconfigured commissioning framework which resulted from the Health and Social Care Act 2012[37]. In addition, the clinical team were not included in the activities which resulted in the cultural morphogenesis observed in the community team. As a result figure 30 is dominated by practices and processes related to safety and risk reduction, which are strengthened by a unification of ideas that these approaches are appropriate for the clinical team. Between Time 2 and 3, the local authority commissioner gained some authority over the clinical team. However, the attempt to instil positive principles and characteristics, via the service specification, did not seem to be sufficient to challenge the existing structure and culture of the medical profession. In short, there was a lack of clarity, conviction and coherence and thus the status quo was not challenged.

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[37] See introduction
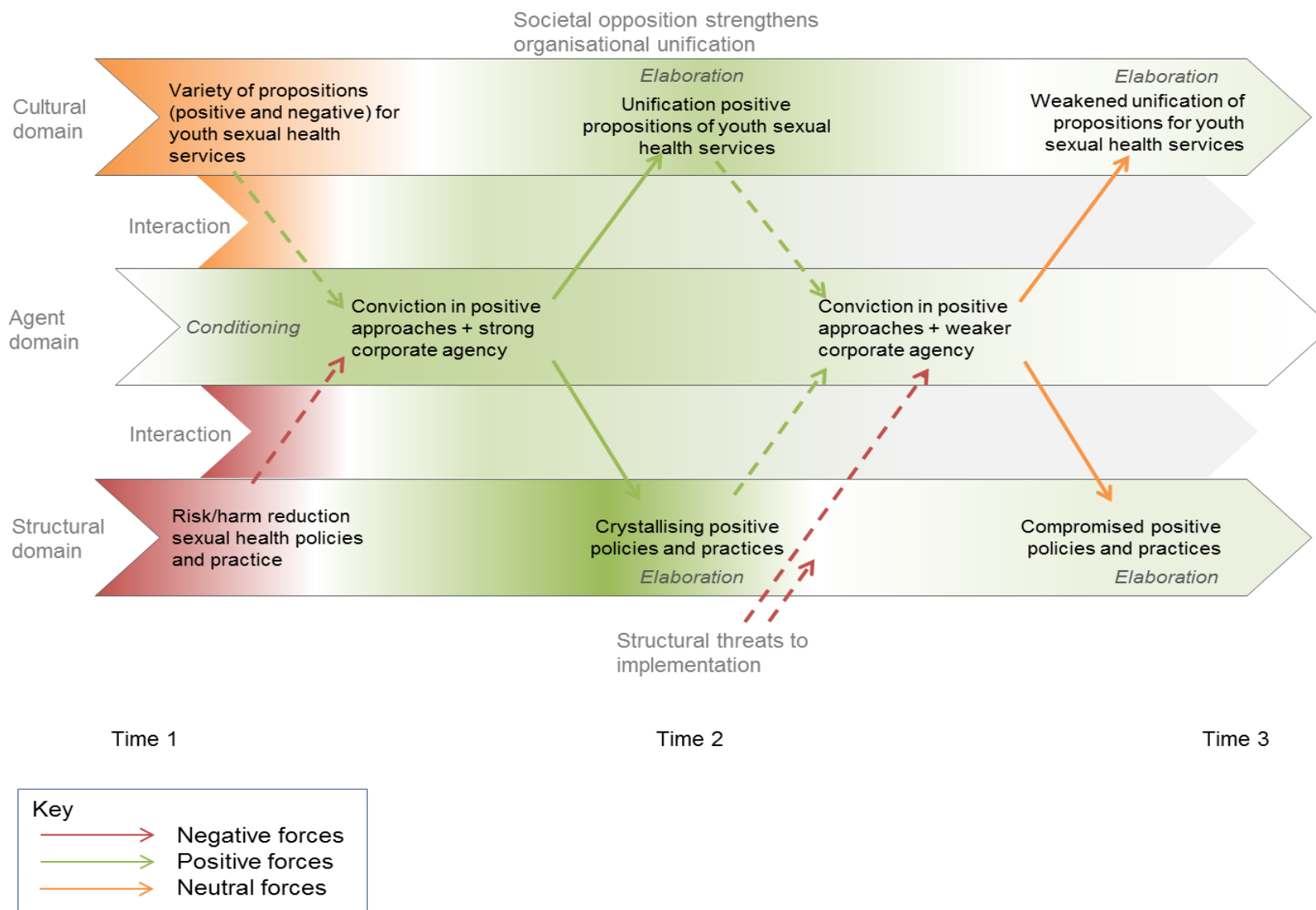
Figure 29. Analytical history of community services in Stadford
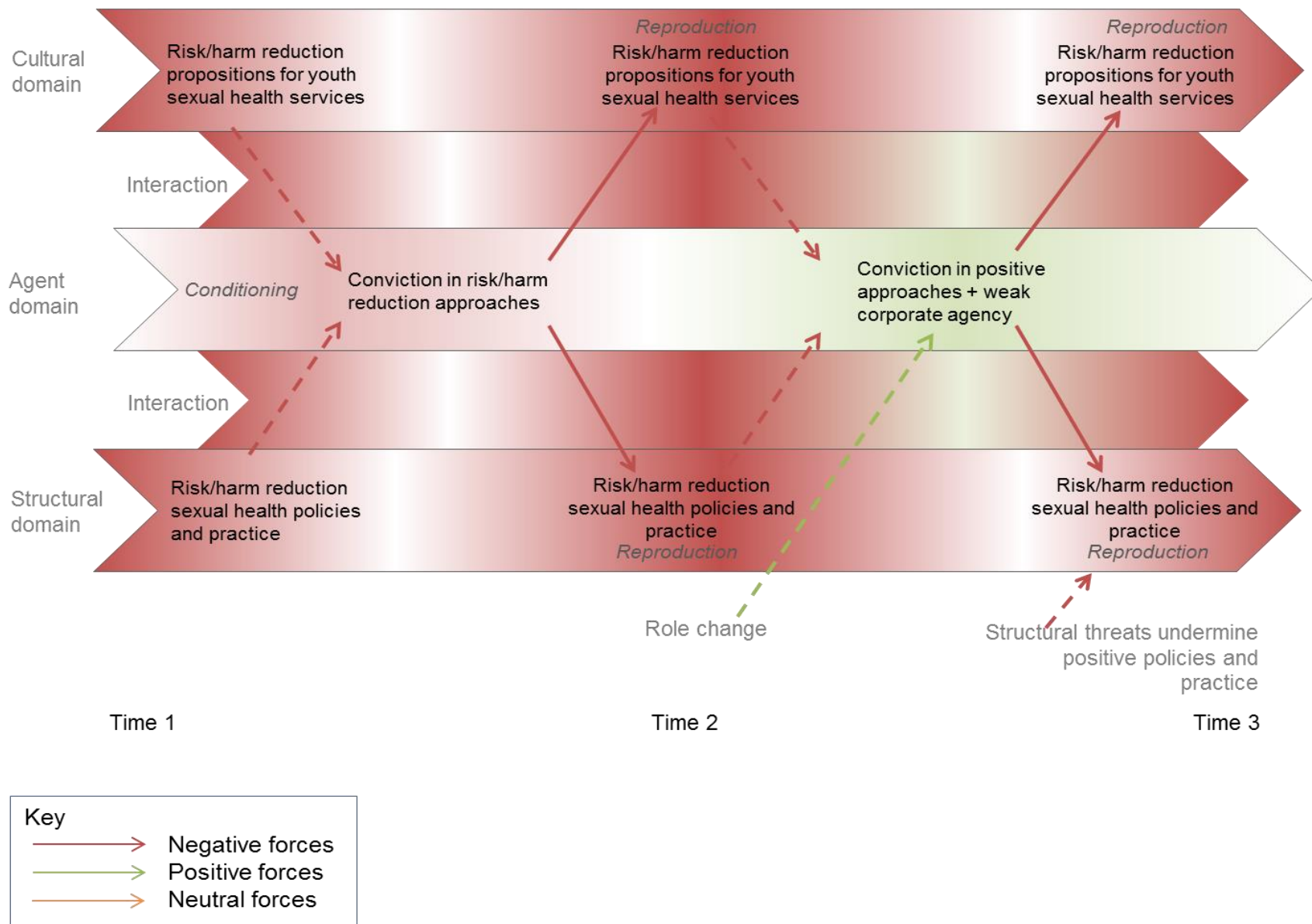
Figure 30. Analytical history of clinical services in Stadford

In Rissfield, prior structural changes had resulted in a holistic youth service model. The restructure provided a compatible context in which to add positive approaches (Figure 31 Time 1) due to the flattening of the medical hierarchy and an emphasis on user needs as central to the service. This arguably made structural coherence between a positive approach and existing practice possible.

Key decision makers were developing clarity and conviction in positive approaches and beginning to influence the structural processes and practices, for example, in seeking broader ranges of outcome measures, and maintaining the longer appointment time. At the time of the fieldwork, however, this fledgling service was facing external threats to its development due to the funding reductions which were affecting the commissioning of services (Figure 31 Time 2). This threatened structural coherence. Ideas about sex positive approaches were beginning to become familiar to the wider stakeholder base but inconsistencies and different interpretations were apparent.

Societal opposition not apparent

Cultural domain

Variety of propositions (positive and negative) for youth sexual health services

Establishing positive propositions of youth sexual health services

Elaboration

Interaction

Agent domain

Conditioning

Introduction of positive approaches

Interaction

Structural domain

Risk/harm reduction sexual health policies and practice

Holistic youth service model, flattened hierarchy

Elaboration

Crystallising positive policies and practices

Structural threats to implementation

Time 1

Time 2

Key

Negative forces
Positive forces
Neutral forces

Figure 31. Analytical history of youth services in Rissfield

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In Ponston, prior to integration, the two separate organisations, the GUM clinic and the community, health promotion and contraceptive services operated independently. They did not depend on the same structure and were thus able to adopt different approaches in a way that didn't compromise the other's efficacy. In the community health promotion and contraceptive services successive leaders had pioneered positive approaches under limited external influence from funders (See Figure 32 Time 1-2). Here there was clarity, conviction and coherence at a local level. However, in the process of integration, the two organisations became reliant on the same organisational structure (Figure 32 Time 3). Roles, practices and processes associated with this organisational structure favoured the activities of the GUM clinic. The existing power structure, dominated by the medical establishment also prioritised approaches relating to safety and risk reduction. This threatened the structural coherence of positive approaches. The impact of this has been to marginalise positive ideas through the loss of key managers and practitioners and to diminish the role of those undertaking health promotion work (Figure 32 Time 4). This threatened the cultural coherence of positive approaches. The ensuing lack of opportunities to learn about or critically reflect on positive approaches meant that factors of clarity and conviction were also diminished. Subsequent funding cuts which were disproportionately targeted at the health promotion and outreach work resulting in further marginalisation and elimination of positive approaches in practice.

| | Time 1 | Time 2 | Time 3 | Time 4 |

Cultural domain — Contingent complementarity between positive and risk/harm approaches | *Elaboration* Variety of propositions (positive and negative) for youth sexual health services | *Elaboration* Marginalisation positive propositions of youth sexual health services

Interaction

Agent domain — Corporate agent pioneering positive services | Lack of conflict between corporate agents in different structural systems | Prioritising of risk/harm reduction approaches

Interaction

Structural domain — Contingent compatibility between positive and risk/harm approaches | Integration of risk/harm reduction sexual health and positive policies and practice *Transformation* | Gradual elimination of positive policies and practices *Elaboration*

Structural threats (integration) undermine positive policies and practice

Structural threats (austerity) compound elimination

Time 1   Time 2   Time 3   Time 4

Key
→ Negative forces
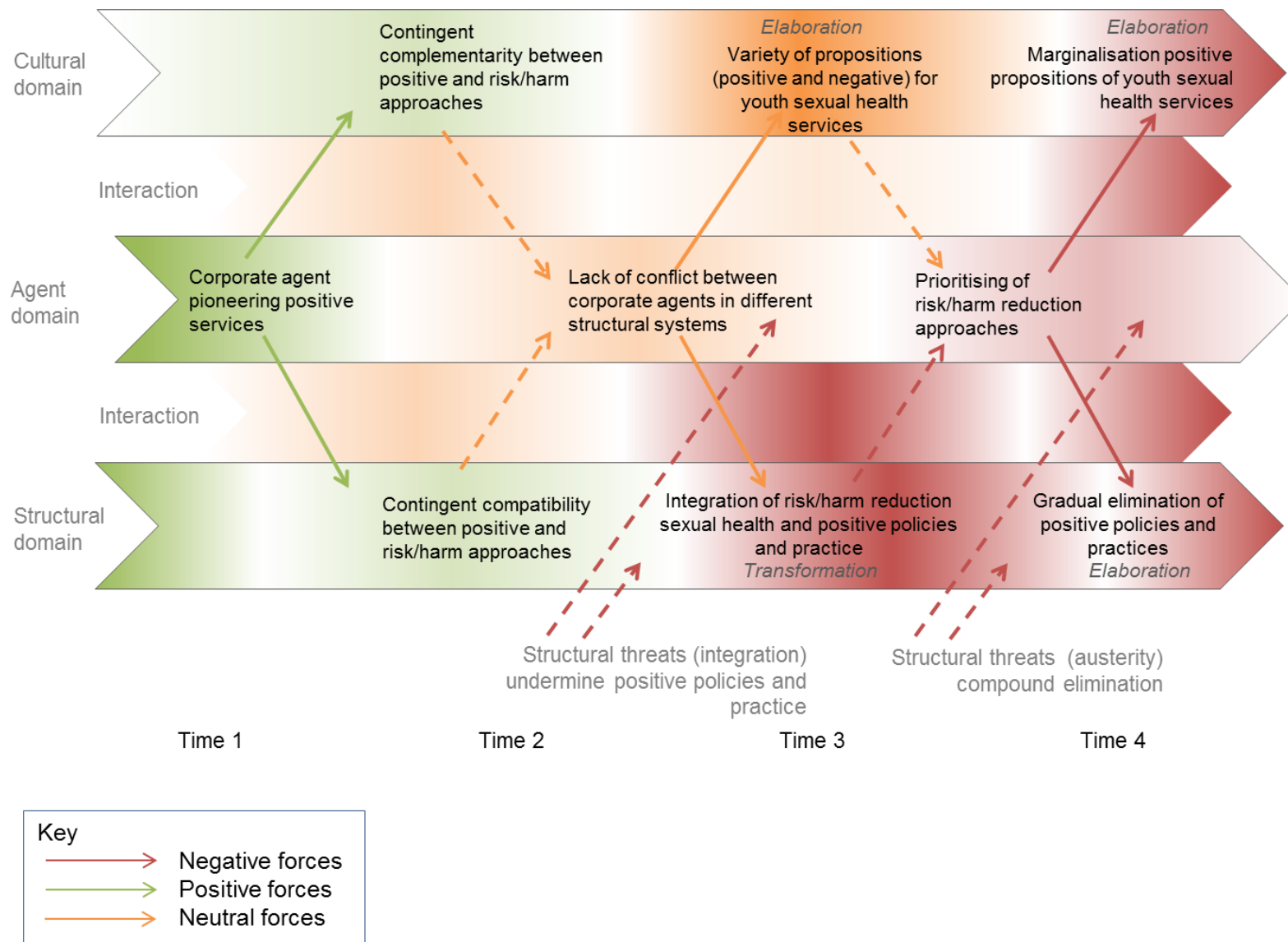→ Positive forces
→ Neutral forces

Figure 32. Analytical history of separate then integrated services in Ponston

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In sum, these three cases studies highlight that for a brief time positive approaches did gain local buy-in where agential, cultural and structural assets were aligned. This was primarily when there were:

- individuals with crystallised ideas of what a positive approach means and conviction in the approach as the most appropriate course of action.
- enacting roles with influence.
- within an environment which was not tightly bound to (current) accountability measures.
- practitioners were orientated to meet users' needs rather than professional dominance.

These histories also reinforce the view that gaining buy-in for positive services as a *strategy to reduce ill health* (such as in Rissfield and Stadford) is more likely due to its synergy with the dominant risk-reduction discourse about sexual health and evidence-based discourse about public policy making. However, for the same reasons, a clinically proven, narrow, medical approach will provide a stronger case for success, on the same measures, due to the lack of experimental evidence on the effectiveness of positive approaches.

Implementation of positive services, which represent the *'reorientation'* interpretation, runs counter to the hegemony of medical approaches and sex-negative discourses about young people. Attempts to implement such an approach, in the current context are thus delimited from the outset. In other words forces (in the cultural domain) favouring positive approaches can be overridden by those disfavouring discourses where the latter are already established and where the structural domain itself disfavours positive approaches.

The fragility of these systems must be underscored. Each of the three systems, which provided the empirical case studies were retrenching and returning to a medical model of health at the time of writing. This arguably had multiple causes in each case but common to all was the impact of austerity in reducing the funding available. The Kings Fund (Robertson et al., 2017) have highlighted that sexual health services have been disproportionately impacted by austerity measures compared to other clinical services. This may be because of the changes in commissioning, which moved these services to local authority

control. It may also be because of the persistent stigma associated with such services which can deter user groups from having a strong voice in social and political spheres. It also highlights that within these services the clinical services, which have maintained a medical, risk-averse discourse have retained power over any positive approaches because whilst the funding cuts have impacted on the whole system they have disproportionately affected the latter (Robertson et al., 2017).

Whilst the future of positive services in this context looks bleak, it is argued that individuals and groups interact over time to set agendas and formulate policies. Their success may be down to their ability to recognise critical moments when problems, policies and politics converge. For example, historical analyses of the development of the Dutch model, frequently referred to by policy makers both in the UK and the US explain that culturally, the Dutch had been a conservative people, but in the 1970s when (culturally) the sexual revolution had just finished and a politics of accommodation was bedding in, positive approaches were adopted as part of a wider social and political movement towards liberalisation (Herzog, 2009; Schalet, 2011b).

Therefore within the current structural and cultural climate in England, there is a possibility for change by better utilising current policy levers and developing more appropriate tools to measure progress. This takes us on to the issue of current policy.

9.4   Critique of current policy

The section relates to the third objective: to provide evidence and theory to critique policy and inform future models of practice.

9.4.1 Current policy limitations

As discussed in chapters one and three, current English policy acknowledges the concept and aspiration of sexual wellbeing (Department of Health, 2013a; Public Health England, 2015) which arguably represents a different perspective

and broader scope (Public Health England, 2014) compared to the previous iteration (Department of Health, 2001).

This aspiration is complemented by principles set out in other national policy documents, such as the *Five Year Forward View* (NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, 2014) which focusses on prevention, integration and being patient centred. The Marmot review and subsequent iterations which focus on reducing health inequalities (Marmot, 2010) and the introduction of Accountable Care Systems will, in theory, support collaboration between agencies (Department of Health, 2012b).

In chapter 3, I highlighted the lack of conceptual clarity, inconsistency and a lack of coherence within and across policy documents. For example, *holistic* services may mean taking a 'whole person' view in one document or a comprehensive service package in another. In addition, several of the ambitions set out by policy are in tension with each other. For example, the ambition to build an open and honest culture about sexual health which is in tension with targeting populations at high risk of ill health (Department of Health, 2013a), or the adoption of a broad definition of sexual health which is in tension with policy mandates that only apply to a narrow slice of it (Public Health England, 2014) (for details see chapter 3). This lack of conceptual clarity about positive services and related principles and characteristics arguably dilutes the impact that national policy and guidance may have.

Data from the empirical studies and the refined theories have also illuminated inherent contradictions in local policy tools. The success or otherwise of positive approaches cannot be measured by the current indicator set which are process orientated (BASHH 2010) or a narrow subset of clinical outcomes (PHOF, Department of Health 2013b), because, as discussed in chapter eight, the possible wider benefits would be missing from the data collected. In addition, the use of accountability measures can cause tunnel vision, whereby practice is focussed on the indicator and drives narrow and not broad delivery. This is because local stakeholders' performance is gauged on the trends of such measures. Furthermore, as previously described, user involvement in design is hard to reconcile with evidence-based policy and practice on the basis

of so-called 'gold standard' evidence of RCTs which stress fidelity and replicability.

This study thus gives rise to a number of policy recommendations which are outlined next.

9.4.2 Future policy and practice recommendations

The following recommendations should be considered to be *realist* because they recognise the constraints that operate within youth sexual health services in England. These constraints concern the overarching capitalist (political), neoliberalism (economic) and cultural norms (relating to sex-negative discourses associated with youth sexual health) which may delimit the possibilities of establishing positive approaches in practice. Whilst these recommendations relate to England they may have implications for other contexts with similar regimes and norms.

This study indicates that the following may support the delivery of positive services:

1) To publish a long term strategy which acknowledges and affirms young people as sexual beings and is directed at helping them to achieve sexual wellbeing. This should:

- Be embedded in wider government policy in recognition that successful approaches will be multi-sectoral.
- Be centred on young people's rights and tenets of 'proportional universalism', that is universal actions with a scale and intensity proportionate to the level of disadvantage.
- Reduce conceptual ambiguity by clearly defining principles of positive services which are supported by examples of practice that characterise such principles.
- Encourage conscious efforts to promote more positive and holistic discourses about youth sexual health.

2) Develop outcomes indicators which reflect positive sexual health and wellbeing. Where possible these should be locally determined. These should reflect the individual, structural and cultural aspects relating to sexual wellbeing and which stress personal mastery of skills, choice and capabilities as opposed to clinical outcomes. Ideally these indicators would inform policy, service needs assessments, commissioning frameworks, service design and specification, consultation approaches and service evaluation. Nevertheless, any indicator set should be used with caution in recognition that:

- Measures can only give a partial insight into young people's sexual health and wellbeing.
- If used as KPIs or targets they can drive unintended perverse consequences by increasing tunnel vision of decision makers and funders.
- Health services are only contributing contexts (not determining contexts) for young people's sexual health and wellbeing and should only be assessed based on what they contribute towards the overarching goals of the broader system.

3) Consider programming across a broader range of agencies, as opposed to programming based on clinical specialisms. This might include:

- Maximising the opportunity of Accountable Care Systems to resolve fragmented commissioning, establish shared goals across agencies and develop better processes for collaborative working.
- Develop leaders who can provide direction and support, but who put trust in and devolve decision making to frontline staff and service user representatives.
- Develop a patient centred culture which puts users' needs before political, professional and social needs in all aspects of decision making.
- In consultation, protect longer appointments by writing them into service specification, allowing the practitioners to cover multiple issues and brief interventions where needed.
- Encourage staff members to interrogate their own perspectives on sexual health and examine the basis of these beliefs.

- Provide multi-disciplinary training which promotes the specialist skills of all practitioners whether they have medical training or not.

4) Invest in processes which support young people having a democratic role in the design and evaluation of services which are for them. User involvement is already specified in policy (Department of Health, 2013a), but it needs to be clearer on what this actually means.

- Make space, prior to decision making, to consult with and include the opinion of young people. Prepare for this to disrupt authoritative knowledge and accept that this may include allowing young people's view to be prioritised over that of adults.
- Develop processes for continuous improvements based on user feedback.
- Recognise that young people are systematically excluded from participating in consultation opportunities. Tailor such opportunities accordingly to improve their access, for example by conducting meetings in convenient locations and providing training for them to develop the confidence and skills to take part.

9.5 Project strengths and limitations

9.5.1 My theoretical developments

Work to elaborate the CMO heuristic

The intermediate outcomes of interest for this study were to secure and sustain local buy-in to positive approaches. This meant developing an adequate conceptualisation of mechanisms between and within layers of social structure. Mechanisms are postulated by the theorists of realist approaches to operate at all levels in social structure (Archer, 1995; Bhaskar, 2008; Pawson & Tilley, 1997; Sayer, 2000; Westhorp, 2012); this means operating not just at the micro-level of agential reasoning in response to resources as has frequently been utilised since Pawson & Tilley (Pawson & Tilley, 1997) but also, for example, at

the macro level where structures also have their own, prior influence on behaviour.

Inspired by the work of Astbury and Leeuw (2010), Bhaskar (2008), Archer (1995), and Sayer (2011) I developed an overarching model of social action which builds upon the simpler heuristic of the CMO.

The new explanatory model describes:

- prior (and enduring) cultural, structural and agential conditions which have effects, through conditioning, on individual's actions (this includes an account of agency relative to other individuals within the social system).
- habitus and/or internal conversations of actors which lead to actions.
- the emergence of transformed agential, structural or cultural states, or alternatively reproduction of 'prior' conditions.

This also, arguably, supported theorising about generative causation as it provided a framework for the development of theories which may operate simultaneously in varying degrees of tension or harmony, for example, between cultural tendencies towards a medical model of sexual health and organisational actions towards a positive model of sexual health.

This model may contribute to the development of realist projects specifically where they are investigating interventions, programmes or policies that are large and complex.

Work to assist theory building

I developed a broad conceptual framework to provide a scaffold for theory building to frame and reduce the possible theories that could have been postulated from data alone. This method has been developed into a paper (Shearn et al., 2017). This broad conceptual framework was specifically built to complement the overarching model of social action and support theorising over and between multiple layers of social structure.

This model was broadly successful at containing the theory building and highlighting concepts which might provide an explanatory framework. In the

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latter stages of theory refinement, however, other substantive theories were used to enhance explanatory power and support refined middle range theories.

It is possible that the use of this framework early on in the process may have placed some limitations on the breadth of the initial theories developed. However, I would argue that some means of containing the theory development was necessary to make this PhD feasible and doing this on the basis of established theory is arguably in keeping with Pawson's ambition to accumulate a body of knowledge (Pawson, 2013).

9.5.2 Limitations

There are limitations to the conclusions drawn in my study.

The literature review, described in chapter 3, found only limited evidence related to whole service transformations to positive models of care. This was despite a wide search strategy that could capture variations of the model that might be in practice. In part, this may be explained by the focus of the service being on delivery and less likely to be written up for academic or professional articles which others can learn from.

In addition, the nature of the intervention under investigation meant that there was little uniformity across the case studies in the use and concept of positive services. In order to undertake a realist evaluation, I established some principles and characteristics of services which appeared to connect the policy vision with activities on the ground. These were later enhanced to represent the variety of interpretations and activities associated with positive sexual health services. This groundwork illuminated the lack of an agreed set of outcomes by which other forms of evaluation may have orientated themselves.

These combined factors could suggest that the sample size was not large enough and that I was not comparing like for like. However, I draw here on the work of Nick Emmel (2013) who argues that cases, in realist research, may be used to work out the relation between ideas and evidence and that the number of cases is not as important as the methods used for analysing the data in order to develop explanations. In this case, I used processes of abduction to develop

ideas based on the cases and processes of abstraction to compare across cases in order to develop theory. I had the opportunity after cycle 2 to take the initial theories to a wider sample. However, I chose to go back to the original case studies to test the theories developed there, thus increasing their credibility. I contest that this groundwork was necessary to explore the constraints and enablers common across the case studies to produce useable theories which might help to convert an ambition for positive services to reality. However, in recognition of the distinction between this type of evaluation and that initially proposed by Pawson and Tilley (that may be discrete innovations with defined outcomes) I consider this to be an organic, exploratory, formative realist evaluation of positive services. The premises within the study may warrant further testing to improve their explanatory power.

In addition, this study had no consistent external advisory panel over its lifespan. This may have provided some initial steers for areas of focus, and provided reflections on the outputs increasing either their explanatory power or practical application. I did however strive to obtain feedback over the course of the project which helped shape the results. This included feedback:

- On an early draft of the principles and characteristics of positive approaches and early initial rough programme theories from a local sexual health network. This, alongside the literature reviews helped to focus the empirical research on local interpretations and buy-in.
- From young people on the draft principles and characteristics of positive approaches involved in peer education at a local conference. This reinforced the existing literature concerning young people's views of what they want in services and which the principles and characteristics already reflected.
- On early iterations of the refined theories from other academics with whom I formed a 'virtual realist journal club'. This encouraged me to consider different ways of framing the research outputs.
- On early iterations of the conclusions and recommendations for practice from a regional commissioning group and representatives from Public Health England. This strengthened my critique of existing policy and its compatibility with positive ambitions.

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There are further limitations arising from applying the philosophy of realism to applied research projects. These related to the examination of internal processes and the selection of theory for use in realist studies, which I turn to next.

The process of extracting data relating to the internal dialogue is difficult and may include biases. This was observed when testing propositions related to what might be perceived as 'undesirable' judgements, or mechanisms at the level of the individual which participants may not want to be open about in research interviews. For example, commissioners choosing to act on the basis of self-preservation, as opposed to the best outcomes for the population may not be comfortable admitting to this in an interview. This is related to feminist critique of research practice in which participants may exercise power by withholding information (Duncombe & Jessop, 2002, p. 119). In recognition of this eventuality, I utilised a combination of tools and techniques such as juxtaposition (providing examples of other cases where people had acted in line with their vested interests) to help participants to open up. I also reinforced notions of confidentiality by conducting parts of two of the interviews with the recorder switched off, while I took minimal notes. This helped participants feel comfortable that they could be honest. I have not used these insights directly although they inspired me to seek evidence regarding the issues raised from other data sources. Despite these measures, I recognise that some of the political or sensitive information may have been withheld which potentially compromises the credibility of the findings.

I developed a relatively systematic process for choosing existing psychological, organisational and social theories to support the development of initial rough programme theories due to a lack of methodological guidance for this process (Shearn et al., 2017). However, it is possible that other substantive theories may have been more useful. For example, existing theories which applied to similar programme theories could have been identified earlier on via the use of a rapid realist review. This may be the benefit of hindsight as it may not have been possible to focus the study effectively, if I had not started from a reasonably abstract position. However, this study does highlight the need to be able to locate and utilise relevant existing theory in a systematic and auditable way. This is particularly important as realist projects become more popular and

provide refined middle range theories which, Pawson (2013) argues, should be the basis of fresh inquiries and support the accumulation of knowledge.

9.6 Recommendations for future research

The theories and evidence about sustaining local buy-in to positive services developed in this study are based on theory, secondary data and a small sample of primary case studies in England. Arguably, the explanatory power of these theories could be strengthened with additional evidence and statistical analyses based on the proposed underlying causal pathways. In addition, this study has focussed on one key step of a larger implementation chain, which may be investigated, with a realist lens to support widespread transformation from a model of ill-health to one of wellbeing.

The principles and characteristics of positive services in practice are positioned as tentative for the purpose of this study. The appeal and practicality of these, alongside their competing definitions could be explored amongst various stakeholder groups including policy makers, commissioners, managers, practitioners, community leaders, parents and young people to determine their relevance and ultimately derive a consensus for future policy directives and practice priorities. These principles and characteristics could also, arguably, inform sexual health practice in other settings, such as general practice or social work. Research may therefore be needed to explore the assimilation of these principles and characteristics into other care pathways.

The study has highlighted that the evidence base and accountability measures currently utilised are inadequate to capture data relevant to sexual wellbeing. Further studies would be required to develop a measurement tool which better encapsulates the relevant constructs and can be utilised in service. My study recommends that this is based on a broad interpretation of sexual wellbeing and considers young people's perception of choice and autonomy as well as functional outcomes.

Finally, this study has demonstrated that a realist approach is appropriate for researching areas of complexity. This study has utilised two novel models for supporting the articulation and development of theory in realist projects. More research is needed to apply these models in different contexts, to identify if they work to support theory building, for whom, in what contexts and why.

9.7 Conclusion

This thesis proposes an original definition of principles and characteristics of positive youth sexual health services. It outlines novel, detailed (albeit partial and fallible) programme theory on how buy-in to local services might be secured and sustained.

The results highlight agential, structural and cultural constraints which have delimited previous attempts to sustain local buy-in to positive services. Nevertheless, where there have been fortuitous circumstances, or concerted efforts, to ensure that cultural, structural and agential interests are aligned, at least at a local level, progress towards positive service delivery has been made. Three factors related to *clarity*, *conviction* and *coherence* appear to be important in achieving this progress.

This study contributes to the theoretical and evidence base regarding the transformation of services from those focussed on sexual ill health to those focussed on wellbeing. Policy and practice which incorporate the principles and characteristics and attend to these hypothesised processes of implementation may, in the future, realise the ambition of delivering positive youth sexual health services.

9.8 Reflexive account

9.8.1 Developing my skills as a researcher

I had a number of years as a contract researcher prior to commencing my PhD. I therefore had well established skills of project management, client liaison, time management, establishing a network, primary qualitative and quantitative research techniques and team working. These skills have served me well and enabled me to have the confidence to persevere through the more challenging moments of the PhD.

My academic skills have greatly improved. I had little experience of dealing with and analysing information from academic and grey literature. Developing literature reviews that would contribute to my realist evaluation was therefore a daunting task not least because of the wealth of literature and possible directions I could take. I have gained skills useful for prioritising the literature related to the research question, for example by focussing on examples in practice and building a rich account of these examples. I have also developed a more critical mind-set, which allowed me to identify shortcomings, inconsistencies and occasional incoherence in the secondary literature. These skills will support me in my future academic career.

I have also developed an in-depth, critical appreciation of realist philosophy and its application to the research process. Over the course of my PhD, I have had the opportunity to immerse myself in this approach through attendance at three conferences, training sessions, by developing and chairing a seminar series, establishing two realist journal clubs, detailed discussions with my supervisors and advising three other students in their own studies (two masters and one PhD). This exposure had enabled me to appreciate the strengths of the approach but also the necessity to tailor its application according to the needs of the research project.

My dissatisfaction with the CMO heuristic to support theory building for this complex and messy 'intervention' led me to experiment with a number of modelling techniques. I strove to find a balance between theory development which reflected the complexity of the underlying reality but was also practically

useful. Initial attempts to expand the CMO resulted in interwoven theory so dense as to render it impossible to capture in an audit trail or test with any effectiveness. Alternatively, my attempts at summarising key factors which appeared to be important in delivering positive services were at times so broad as to be anodyne.

My solution was to find a 'sweet spot' by consolidating the more specific code frame and reduce the conceptual complexity in order to capture 'essence' of the mechanisms, to produce theory which was both insightful and practical.

I believe that my academic writing skills have improved considerably over the course of my PhD. I am immeasurably grateful to my supervisors for their time and critical appraisal of my methods paper and early versions of each of the chapters present within this thesis. They have pressed me to refine my writing skills to harness and describe this small aspect of the complex, often nebulous, often intangible social world to the best of my ability.

9.8.2 Changing my perspectives on life and research

As alluded to in the introduction, I began this process with a relatively narrow view of the world, with inherited notions of right and wrong, of goodies and baddies, of, from my position of privilege, wanting to 'help people', namely, young people, avoid getting pregnant. This PhD gave me an opportunity to stop and question my own beliefs. Through extensive discussions with my supervisors, my fellow PhD colleagues, attending sexual health network meetings, shadowing services, and reading widely around the subject matter I developed an awareness of alternative perspectives and viewpoints on youth sexuality. In particular, I became aware of the alternative discourse about wellbeing and human flourishing.

The feminist lens that I developed encouraged me to attend specifically to these somewhat marginalised perspectives and contrast them against dominant discourses associated with youth sexual health. This enabled me to recognise ways in which the social system may deny young people's agentic potential, (albeit often well-meaning attempts to protect them).

My broad immersion and reading led to a resolve to retain a breadth in my work concerning the wide ranging aspects of sexual health and wellbeing as well as a commitment to look at the underlying structures which may lead to inequalities. This was a hugely stretching conceptual challenge because of the breadth of the topic. In addition, the fieldwork and interview process was at times difficult as I attempted to explore participants' underlying professional motivations and values, which influenced their decision making, and which at times did not always chime with their personal viewpoints.

I am however, ultimately pleased that I did not focus solely on one aspect of sexual health. I believe that having done so would serve to reproduce the status quo which generates knowledge based on certain conditions because it is simpler, when in fact it does not reflect the complexity inherent in the subject. I recognise that there are many areas left un-researched in this project, not least because of the need to focus, for the sake of feasibility on the initial buy-in to services. More research with young people and stakeholders is warranted to extend the reach and applicability of the findings.

Throughout, I have tried to be critically aware of my position as a knowledge producer and the necessity to challenge my interpretations. My supervisors, being from different academic and professional backgrounds were an excellent foil for this purpose and challenged me to address any biases which might have been reflected in early iterations of the results. For example, I was aware that the new ideas concerning human flourishing which led me to change the focus of the study could also influence my interpretation of the data gathered. This may be caricatured as positive approaches which reflected a risk-based discourse as 'wrong', compared to those which reflected a 'flourishing' discourse as 'right'. I worked to develop a more nuanced appreciation of the 'risk-based' interpretation and concluded that it may fulfil a different purpose, although be insufficient for substantive change. These interpretations were further tested through presentations and discussion activities with commissioners, managers and practitioners who might use the findings in the future. These activities confirmed that the results both resonated with their experience and enlightened them.

Personally, the opportunity to read widely and time to develop critical reflexive awareness has led me to become more reflexive in my everyday life, to become more politically active and contribute in a more meaningful way to friendships and family.

It has also led me to be aware of myself as a knowledge producer and the privilege and responsibility that comes with it. It has been challenging to approach a subject of youth sexual health from a realist perspective, which is rejected by many feminist scholars. I believe that my contribution provides a sensitive addition to this body of work. It demonstrates the potential for an investigation of inequalities and disparities, based on an explication of underpinning causal, but not deterministic forces for suggesting actions for change.

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Appendices

Appendix 1: Coding framework for concept development of positive approaches

Coding framework taken from a screen shot of NVivo version 11 on 12.12.2017

Nodes

Name	Sources	References	
Macro context	21	194	
Meso context	10	63	
Micro context	0	0	
Positive service	5	6	
Characteristics	21	188	3
Broad conceptualisation of SRH	10	23	0
Clients	2	6	3
Outcomes of interest	13	52	3
Priority practices	13	80	3
Abortion	1	1	0
Address needs	2	3	0
Body image	1	1	0
Cancer screening	1	1	0
Contraceptive choice	3	4	0
Counselling	6	16	0
Dysfunction	2	4	0
Health promotion	4	4	0
Infertility	1	1	0
Nurture positive language, attitudes and value	9	19	0
Provide knowlede skills attitudes to make infor	6	15	0
Sexual violence	2	4	0
STI prevention access treatment	2	5	0

Nodes

Name	Sources	References	
Support parents	2	2	0
Staff	10	27	3
Principles	18	160	3
Accessibility	7	19	0
Accountable	3	12	0
Acknowledge youth sexuality_rights_values	10	27	0
Awareness of gender and gender power	3	7	0
Kindness_Respect_Non-judegemental	3	4	0
Confidential	3	5	0
Cost effective	2	2	0
Evidence-based	4	18	0
High quality	5	17	0
Improve sexual wellbeing	9	22	3
Long term programmes	3	3	0
Risk and vulnerability	2	8	0
Safe	2	10	0
Tackle stigma	6	10	0
Leadership (transformational)	4	9	0
Person_user_patient-centred	11	29	0
Appropriate_youth friendly	6	11	0
Inclusive	8	22	0

Nodes

Name	Sources	References	
Integrated	14	64	0
Lifecourse	9	25	0
Tailored	3	4	0
User design_evaluation	13	35	0
Rationale	3	3	
Related cases	8	20	
Comprehensive service	3	5	
Holistic service	6	9	
Integrated service	2	3	
Preventative service	1	1	
Wellbeing services	2	2	
Standard high quality service	14	304	
Characteristics	10	33	
Principles	12	264	
Rationale	2	2	

Appendix 2: Full list of shortlisted middle range theories

Search strategy	Papers identifying theories	Middle range theories extracted	Criteria				
			Social strata	Fit	Utility	Compa ti-bility	Total
Literature review of sexual health service delivery	Greenhalgh et al., 2009;	Diffusion of innovations (Greenhalgh, 2004)	2	1	0	1	4
	Macfarlane et al (2013)	Neo-institutional theory in healthcare (Scott, Ruef, Mendel, & Caronna, 2000)	2	1	1	1	5
	Aggleton, De Wit, Myers, & Du Mont, 2014	Social Learning Theory (Bandura, 1977)	1	0	1	0	2
	Macpherson, 2013	Structuration Theory (Giddens, 1984)	1	0	1	0	2
Review of realist accounts of health service transformation	Rycroft-Malone et al., 2012, 2013, 2015	Knowledge to action (Graham et al., 2006)	1	0	1	1	3
	Rycroft-Malone et al., 2012, 2013, 2015	Promoting Action on Research Implementation in Health Services (PARIHS)	1	1	1	1	4

		(Kitson et al., 2008)					
	Goodridge, Westhorp, Rotter, Dobson, & Bath, 2015	Normalisation Process Theory (May & Finch, 2009)	1	2	2	1	6
	Goodridge, Westhorp, Rotter, Dobson, & Bath, 2015	Theory of Cognitive Dissonance (Festinger, 1957)	1	0	1	0	2
	Herepath et al., 2015	Realist Social Theory / Morphogenetic Approach (Archer, 1995)	2	1	1	2	6
	Herepath et al., 2015	Neo-Institutionalism (DiMaggio & Powell, 1983)	2	1	1	1	5
	Herepath et al., 2015	Bureaucratisation (Greenwood, Suddaby, & Hinings, 2002)	1	1	1	1	4
	Herepath et al., 2015	Normalisation Process Theory (May & Finch, 2009)	as above				
Suggested theory / own reading		Power, knowledge, discourse (Foucault, 1979)	1	1	0	0	2
		Foundations of Social Theory (J. S. Coleman, 1990)	2	0	0	1	3

		Theoretical Domains Framework (Cane, O'Connor, & Michie, 2012)	1	1	1	1	4
		Systems Theory (Von Bertalanffy, 1968)	1	1	0	1	3
		Behaviour Change Wheel / Com-B (Michie et al., 2011)	1	2	2	1	6

Appendix 3: Coding framework theories

Coding framework taken from a screen shot of NVivo version 11 on 12.12.2017

Nodes

Name	Sources	References
C Agency	29	288
C Culture Macro	28	100
C Culture Meso	33	380
C Structure Macro	30	133
C Structure Meso	37	585
C Structure Micro	26	140
T Doncaster T1	4	6
T Doncaster T2	9	111
T Sheffield T1	5	5
T Sheffield T2	6	16
T Sheffield T3	10	36
T Sheffield T4	13	145
T Warwickshire T1	7	29
T Warwickshire T2	8	37
T Warwickshire T3	12	32
T Warwickshire T4	11	116
TH Clarity	18	62
Differentiation	15	44 1
Making sense of positive approaches	7	18 1
TH Coherence	36	739
Th Engaging with the Community	14	35 1
Th Evidence and accountability	28	86 1

Nodes

Name	Sources	References
Th Make Explicit P+ Ambitions and Methods for Achieving Them	31	119 0
Th Resource	27	97 1
Th Shared Values, Language, Culture	27	101 1
Th Structural Coherence	22	60 1
Th Users Lead Design and Evaluation	29	80 1
Th Working Together	32	141 1
Time	9	20 1
TH Conviction P+	36	335
Why it is important - values	17	43 1
Why this choice is right for the individual - beliefs_efficacy	9	17 1
Th Raising awareness generally	13	34
Th Service Accessed wth Positive Experiences	31	140
Th Societal Response	22	47
Th Staff Autonomy	13	41

Appendix 4: Theory propositions early iterations

Conviction				
Proposition	Data	MA	NPT	COM-B
When commissioners, practitioners and managers understand what is meant by positive approaches (P.A.).	*		*	
and recognise a need to improve local young people's sexual health	*			*
and see P.A. as a means to improve young people's sexual health	*	*	*	*
they will develop conviction that it is most likely to work	*		*	*
and explore ways of implementing the approach	*		*	

Consistent with existing policy				
Proposition	Data	MA	NPT	COM-B
Where pre-existing policy mandates regarding youth sexual health reflect risk-reduction discourses	*			
and there is a need for accountability	*			
commissioners, practitioners and managers who intend to embed a positive approach in their work	*	*	*	*
will strive to find coherence between convictions, actions and short-term self-preservation goals	*	*		

Shared values				
Proposition	Data	MA	NPT	COM-B
When commissioners, practitioners and managers who intend to embed a positive approach in their work	*	*	*	*
share an understanding of positive principles and characteristics with other local decision makers	*	*	*	
and pursue the same goals	*	*	*	
they will be motivated to work together as this will enhance their chances of success		*		*

Integration with other contextual features				
Proposition	Data	MA	NPT	COM-B
When commissioners, practitioners and managers who intend to embed a positive approach in their work	*	*	*	*
they will develop local policy, practices and processes which makes explicit overarching positive aims and ambitions, roles and responsibilities	*	*	*	
thereby increasing coherence surrounding positive approaches and individuals roles within it	*	*	*	*

Evidence-based practice				
Proposition	Data	MA	NPT	COM-B
When commissioners, practitioners and managers who intend to embed a positive approach in their work	*	*	*	*
and there is a need for accountability	*		*	
they will seek to develop a	*			

broad range of data to justify efficacy and impact of positive approaches				
in order that it might continue to be supported	*	*	*	

Devolved decision making				
Proposition	Data	MA	NPT	COM-B
When practitioners who intend to embed a positive approach in their work	*	*	*	*
have autonomy to exercise discretion	*			
and feel capable, motivated to use positive approaches	*		*	*
will be able to utilise positive approaches where appropriate	*			*

Young people's voice at the centre of decision-making				
Proposition	Data	MA	NPT	COM-B
When commissioners, practitioners and managers who intend to embed a positive approach in their work	*	*	*	*
they will recognise that they can't hold all the answers to meet the needs of young people	*	*		
and will engage young people in service design and decision making	*	*		

Tension between practice requirements				
Proposition	Data	MA	NPT	COM-B
When commissioners, practitioners and managers who intend to embed a positive approach in their work	*	*	*	*
recognise a potential tension between this and other	*	*	*	

aspects of their work such as safeguarding				
they will explore ways of reducing the tension	*	*	*	
or one aspect will be side-lined for another	*	*	*	

Appendix 5: Interview schedule

Delivery of positive sexual health services - discussion guide outline

Notes:

1. Realist interviews are both structured and unstructured. Part of the realist interview is to test the researcher's theory. The participant will confirm, falsify or refine that theory

2. The interview guide will be thus adapted to suit the role of the participant and test specific theories pertaining to that role.

Section	Stimulus	Notes, adaptations

Introduction
• Explain project objectives - to understand what works to deliver positive sexual health services for young people and why
• Explain nature of the interview
   ○ Open discussion about their experience and perceptions about positive sexual health services, what works and why?
   ○ Test ideas that have been developed from the literature		

o Come up with ideas about what might work in the future and why • Recording interview for analysis purposes only • Stress confidentiality		
Participant view of positive youth sexual health services • What does *positive* sexual health work mean to you? • What do you think about *the idea of* positive approaches? • In what ways, if any, do you feel a positive approach *suits or opposes* the needs / wants of young people you work with? • Is it clear from policy documentation whether a positive approach / what approaches are recommended or not? • Are some elements of positive sexual health work *more or less appropriate* to consider in your day to day work? • Are some elements of positive sexual health work *easier or more difficult to apply* in your day to day work? • Are there *certain kinds of young people* for whom it is more or less difficult to take a positive approach?	• ***Stimulus 1*** Shared following spontaneous comments to avoid confirmation bias	As the fieldwork progressed some of the specific questions were not asked to focus more keenly on personal interpretations and what had informed these

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Current experience
 	
- To what extent does the work you deliver/commission take a positive approach *now*?
- Please outline the ways in which your work could be described as positive?
    ○ For each way mentioned:
        ▪ Why do you do things this way?
        ▪ What is it that makes this possible?
- What stops you from taking a positive approach?
    ○ For each barrier mentioned:
        ▪ Why do you do things this way?
        ▪ What is behind this barrier?
- If not already covered, to what extent does your practice mirror/complement others that you work with?
	Stimulus 2 Shared as a stimulus to identify aspects of practice which might be associated with a positive approach	This was orientated around developing an understanding of context and mechanisms from the perspective of the participant
		
		Focus shifted according to participants' role and perception of current performance

Theory testing - To what extent do you agree or disagree that these factors help or hinder the delivery of sex positive approaches? ○ (Where relevant explain the circumstances where these factors had operated to encourage disclosure (particularly	***Stimulus 3a/b*** Shared 'theories' as diagrams/images/quotes as opposed to detailed descriptions which the researcher had developed,	Stimulus evolved over time to be more specific, drilling down to pertinent theory areas as new data came to light

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where action may be perceived as self-serving)	for reference, but didn't share	

Past experience
 	
• Have you always approached sexual health work with young people like this?
    ○ If different, in what ways was it different - particularly explore if more or less positive in the past?
    ○   If different, why was it different?
	Where appropriate use previous stimulus to explore answers	This section allowed for subjective contrasting of historical contexts

Future opportunities
 	
• What would enable a positive approach to be taken in the future?
    ○ Explore fully spontaneous ideas - at each response ask how/why to get down to underlying mechanisms
• What would prevent a positive approach being taken in the future?
    ○ Explore fully spontaneous ideas - at each response ask how/why to get down to underlying mechanisms
	Section tailored according to whether the participant perceived it relevant to take a positive approach in the future	This section illuminated further inhibiting contexts

Sum up key lessons, outline next steps, close the interview		

Stimulus 1 - Interpretations (early cycle two fieldwork)

quality marker	In line with quality standards such as 'you're welcome' criteria	strategy	Re-think of approaches to tackle ill-health by promoting positive sexual health	just and fair	Radical overhaul of broader policy to promote young people's wellbeing and human rights
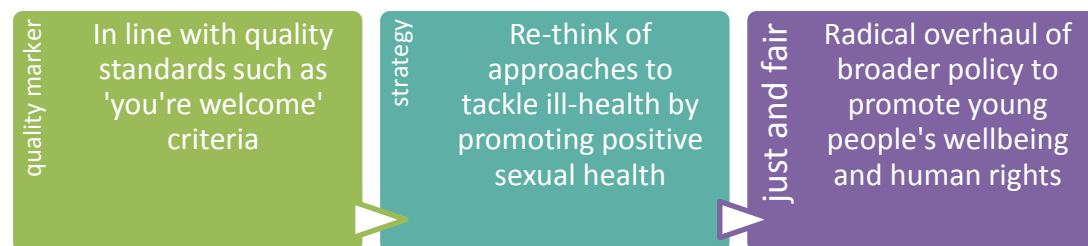
Stimulus 2 - Principles and characteristics (early cycle two fieldwork)

Indicator type	Indicator	Measurement
Values	• Young people's sexuality is a natural part of their development • Respect and promote equality, diversity and human rights	• Explicitly stated in terms of reference • Incorporated into CPD, performance reviews and evaluations

Management processes	• Shared values (above) across partner organisations • Engagement with the community • User-led in terms of design and evaluation	• Presence of networks and partnerships • Recent ongoing activity and influence • Recent ongoing activity and influence
Service provision	• Advice and support about relationships, wellbeing and sexual health • Open, rapid access • Respectful and non-judgemental staff - use of services positioned as mature and responsible	• Existence of the service • Meeting service specification • Service users evaluation

Stimulus 3a Representation of theories (early cycle two fieldwork) - explained by the researcher who had the full version in prose

1. Coherance, or lack of, in terms of policy and commissioning direction and the impact on priority setting and action in practice

2. Shared principles and values, or lack of, underpinning service development and practice and how they may relate to consistent adoption of a positive approach

3. Tension between practice requirements e.g. safeguarding (risk-based approach) and open access (positive approach) causing conflicts in service delivery

4. Evidenced-based practice and measurements available with their current narrow focus on negative outcomes which may direct resources away from positive approaches and prevent recognition of the impact of positive approaches

5. Devolved decision making and individual flexibility, or lack of, in determining which approaches will be adopted by frontline practitioners

6. The impact of participatory approaches which put young people's voice at the centre of decision making.

Stimulus 3b Representation of theories (late cycle 2 fieldwork) relating to interpretations (theory theme clarity)

Emerging results:
Translation of attitudes into behaviour
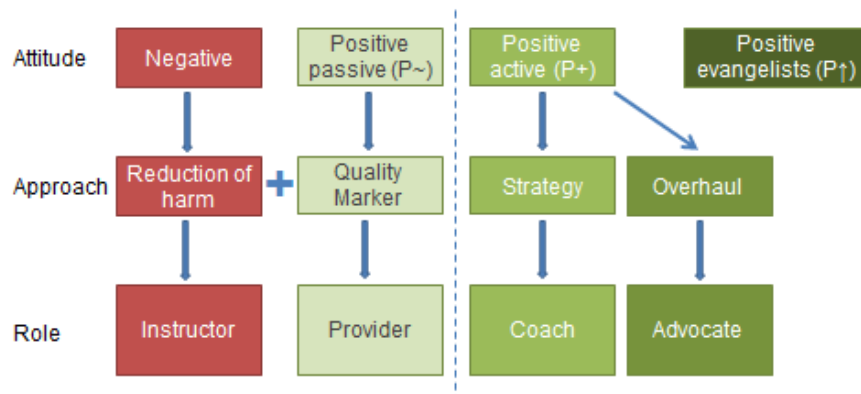
Stimulus 3a Representation of connectivity between theories - explained by the researcher to the participant
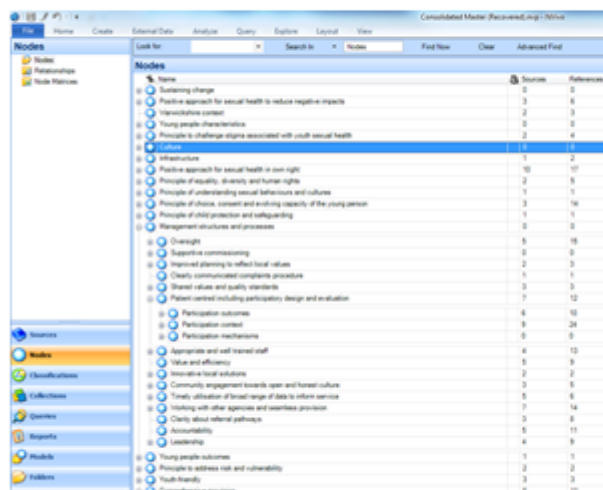
Emerging results: What works to deliver positive youth sexual health services
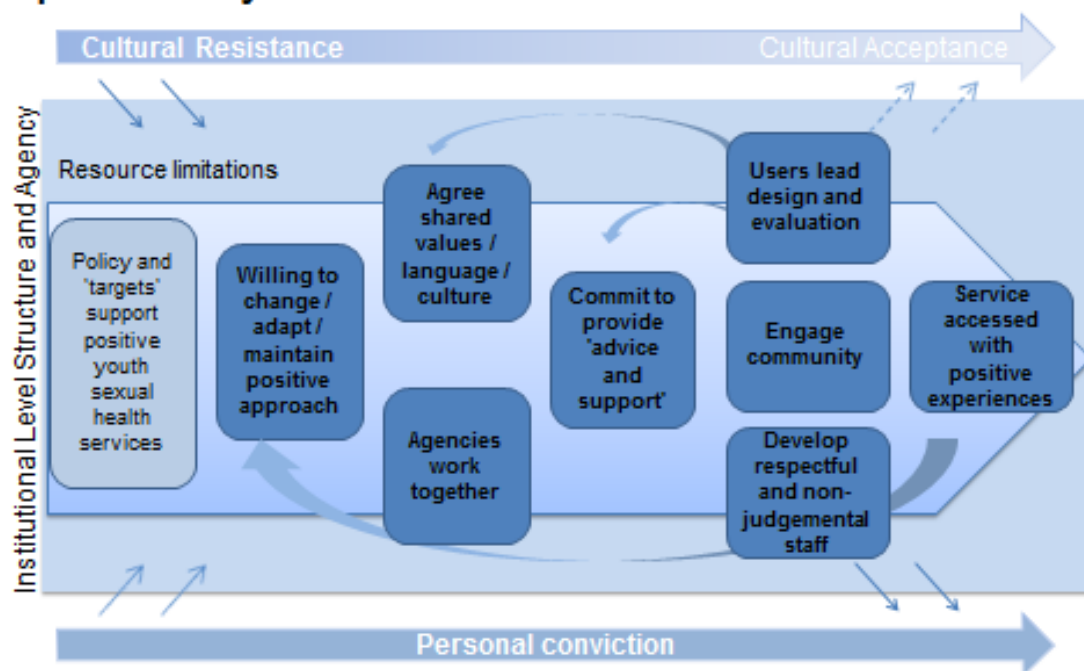
Appendix 6: Examples of theory models

Examples of ways in which I attempted to analyse the data with reflexive notes, prior to settling on the overarching theoretical model of social action

NVivo

Generated themes from policy / guidance

Coding and classifying theoretical constructs (but not always labelling CMO)

Highlighting relationships within the text using relationship nodes

Subsequent sources further building on theories

Nodes too detailed/precise. Losing the big picture, losing the theoretical model

Not currently recording abductive / retroductive inferences
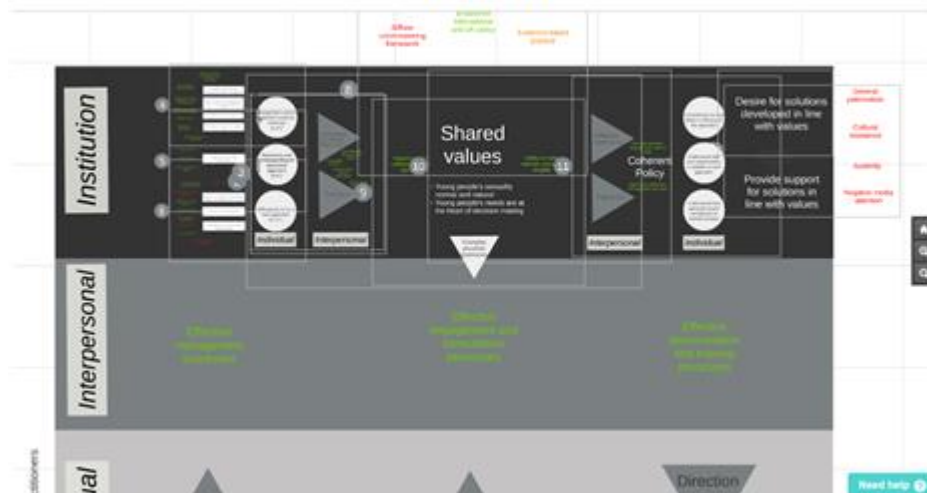
Visio

Mapped to conceptual model – generative causation

Strength of line indicating strength of relationship

Lack ability to attribute data

Lack conceptual depth

Prezi

Mapping constructs to conceptual model

Illustrate causal pathway

Lack ability to attribute data, audit trail / direct link to the evidence

Synchronic / Diachronic grid analysis

	Structure	Culture	Agency	Theory 1 :	Theory 2	Theory 3
Doncaster T1	" " #2					
Doncaster T2		" " #1				
Warwickshire T1						
Warwickshire T2			" " #3			" " #3
Warwickshire T3	" " #4			" " #3		

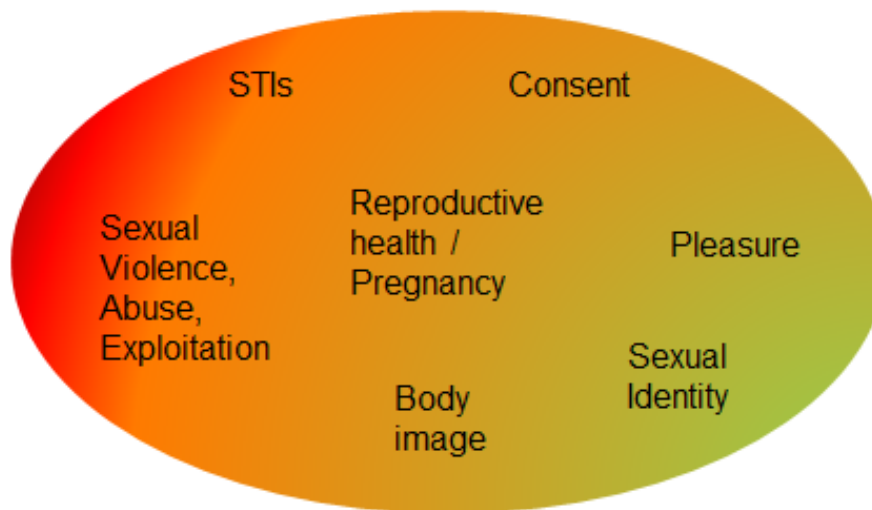In line with development of the conceptual model

Multiple sources (numbered) would be coded in the same cell

Could still use NVivo for synchronous? Any other way to cope with data analysis in multiple dimensions? Microsoft Access?

Appendix 7: Feedback presentation and handouts

These slides were introduced then presented and explained by myself, with time for discussion after each slide. The purpose was to refine, refute or substantiate the theories captured within them.

Overarching Sexual Health and <u>Wellbeing</u> Model

STIs

Consent

Sexual Violence, Abuse, Exploitation

Reproductive health / Pregnancy

Pleasure

Body image

Sexual Identity

Interpretations of positive services: a need for clarity?

"They are going to do it anyway so we must make sure they are safe"

"What do they need to grow up ready to express and enjoy their sexuality?"

Influences

- Experience working with young people and own experiences

- Training specifically on positive approaches to sexual health

- Career path and professional training e.g. social work / GUM / family planning

- Peers / organisational culture

- Evidence e.g. formal research and/or models of practice

Characteristics of positive youth sexual health services

Approaches	Service orientation
Normalises youth sexuality	Highly visible (normalising services)
Work with the community / other agencies	Easily accessible
Users lead design and evaluation of services	Prioritises and promotes healthy relationships
Staff - role includes support young person achieve sexual wellbeing	Prioritises and supports emotional wellbeing
Patient-centred (services and consultation styles to meet needs)	Time in consultation to address secondary / underlying issues

Conviction in positive approaches

"We need to re-think approaches to tackle ill-health by promoting positive sexual health"

"We should be promoting positive health because it is the right thing to do"

(at least) three routes to local buy-in

Radical - authoritarian
Individuals in authority imposing an entirely new way of working

Radical - transformational
'Leaders' or champions stimulating and inspiring colleagues to approach service delivery in an entirely new way

Incremental
Gradual development from a disease/issue based model to a positive model of sexual health

Coherence

Aspect of change	
Training on positive services	Finding suitable ways to measure activity/outcomes
Clear priorities/strategy relating to positive services	Working more closely with other organisations
Changes in societal unease / taboo regarding youth sexuality	Hearing from young people themselves that they want positive services
Allocation of funding / resource	

Handouts were provided to support the capture of individual feedback. This enabled politically sensitive comments to be made in confidence and provided some insight into different responses according to job role and experience.

2. Interpretations of Positive Youth Services

On the scale below please place:

a) a **"O"** to represent your personal interpretation of positive comprehensive youth sexual health services

b) a **"X"** to represent what you think is realistic within current operating circumstances

"They are going to
do it anyway so we
must make sure
they are safe"

"What do they need to
reach adulthood ready
to express and enjoy
their sexuality"

Comments / other interpretations

3. Influences

Who or what has most influenced your personal viewpoint on positive, comprehensive approaches to sexual health? Please tick in the columns below any that have had some influence and one that was most important. Please give detail about the most important

(If no prior consideration of positive sexual health approaches, tick here)

	Some influence	Most important
Experience (work)		
Experience (self)		
Training		
Career path		
Peers / culture		
Evidence		
Other_____		

Most Important_____
Because...

4. Positive Youth Sexual Health Services

a) First indicate whether you feel the following are important to a positive comprehensive approach to young people's sexual health (tick all that are appropriate)

b) Then indicate which of the following are currently being delivered within the service (tick any which are delivered)

c) Then indicate which of the following you feel are achievable, (in an ideal world*), within the service (tick any which are not delivered but achievable).

Approaches	n/a	Important	delivered	achievable
Normalises youth sexuality				
Works with other agencies				
Users lead design and evaluation of services				
Staff role includes supporting young person to achieve sexual wellbeing				
Patient centred (services and consultation styles to meet needs)				
Other _____				

Service orientation	n/a	Important	delivered	achievable
Highly visible (normalising services)				
Easily accessible				
Prioritises and promotes healthy relationships				
Prioritises and supports emotional wellbeing				
Time in consultation to address secondary/underlying issues				
Other _____				

5. Interpretations of Positive Youth Services

On the scale below please place the following symbol to represent the extent to which you think positive services are:

a) the best way to reduce sexual ill-health (place an 'o' on the scale)

b) are the right thing to do for young people (place an 'x' on the scale)

Not at all ←————————————————————————→ Completely

Comments

*please comment on any barriers preventing the achievement of this faced in reality

6. Routes to buy-in

Which route, if any, best represents Warwickshire's route to local buy-in to positive approaches? (Circle the best model or provide another answer)

| Authoritarian | Transform-ational | Incremental | Something else please describe |

Please explain your answer

7. Coherence

What would support change to positive services within your service? choose as many as you like or add your own

Aspect of change		Aspect of change	
Training on positive services		Working more closely with other organisations	
Clear priorities/strategy relating to positive services		Hearing from young people themselves that they want positive services	
Changes in societal unease / taboo regarding youth sexuality		Other_____	
Allocation of funding / resource		Other_____	
Finding suitable ways to measure activity/outcomes		Nothing	

8. Any other feedback

Appendix 8: Ethics and approvals

General Details

(Table cells will expand as you type)

Name of principal investigator or student	Katie Shearn
SHU email address	katie.m.shearn@student.shu.ac.uk
Course or qualification (student)	PhD
Name of supervisor (if applicable)	Hilary Piercy
email address	hwbhp@my.shu.ac.uk
Title of proposed research	Delivering positive and preventative sexual health services
Proposed start date	June 2015
Proposed end date	January 2016
Brief outline of research to include, rationale & aims (250-500 words). In addition for research with human, participants, include recruitment method, participant details & proposed methodology (250-500)	Introduction The World Health Organisation (2010) recognises that globally the sexual health programmes need to shift from treating sexual ill-health to promoting sexual well-being. In the UK, there is some recognition that a broader framework for sexual healthcare is necessary (e.g. Wellings and Johnson, 2013), which is now echoed in policy (e.g. Department of Health, 2013). However the transition from broad policy/research

	recommendations to action on the ground is under-theorised.
	One avenue for research is to identify triggers and barriers operating in local sexual health services in providing positive and preventative health services for young people. This would provide empirical data and deeper theoretical understanding, useful for the ongoing development of policy and practice.
	This protocol refers to the initial element of the project which, in turn, will inform the development of subsequent stages.
	Main research question
	What works to deliver positive, preventative sexual health services for young people, for whom, under what circumstances and why?
	Summary of methodology and techniques
	A realist informed approach, derived from the work of Pawson and Tilley (2006) will be used to undertake the investigation.
	This initial element is primarily concerned with developing ideas and uncovering existing evidence about what works or doesn't to deliver positive, preventative sexual health services.
	The initial phase will comprise a rapid realist synthesis of the literature and stakeholder interviews.

	Realist Synthesis
	The synthesis will include a range of sources which are relevant to the research question including published academic articles, grey literature such as national and local policy documents, best practice guidance, tender documents, and local unpublished evaluation reports.
	Stakeholder Interviews
	Stakeholder interviews will be used to understand what is happening currently and develop ideas about what would need to change, or be in place, to provide positive, preventative sexual health services.
	Sample and recruitment for interviews
	Research will be conducted in 3 sites in the North of England. These locations offer a range of: size of residential area; diversity of population; sexual health service models in operation (i.e. integrated hub and spoke, youth specific hub and spoke and city-wide network, respectively).
	The proposed sample is outlined below with around 15-20 individuals.
	Public health commissioners (minimum of 3 across sites)
	Local counsellors (minimum of 2 across sites)

	Director of services (minimum of 2 across sites)
	Clinical professionals (minimum of 4 across sites)
	Non-clinical professionals (minimum of 4 across sites)
	Quota-based convenience sampling will be used to ensure the mix of roles are included as well as a good spread of key demographic and other factors such as length of time in post. I have established good relationships with two of the three sites and have reassurances of their support in accessing individuals. I am beginning to develop relationships with the third.
	Consent, confidentiality and protection from harm
	Participation in the study is completely voluntary. Participants will be fully briefed on the nature of the interview, their participation and likely impacts of the research. A tailored information sheet will be provided to assist this dialogue. Participants will have the opportunity to ask questions at any point and are free to withdraw from the study at any time.
	The research data will be held confidentially and in accordance with the Data Protection Act. Services and individuals will remain anonymous in any publication of protocol or results. Where relevant, services will be described as a small/large town or city in the North of England, as appropriate. Any participating individual or organisation would be

	eligible to receive a copy of the results.
	Outcomes, impacts and benefits
	The purpose of this study is to contribute to the researcher's thesis for a PhD in Health and Wellbeing.
	The study has been designed to develop the theory of what works to deliver good quality sexual health services for young people and what conditions or circumstances help or hinder the delivery of such services. It is not designed to find fault, rather the ambition is to uncover the mechanisms for delivering good quality work. It is hoped that such information can contribute to the development of policy, commissioning and practice.
	Bibliography DEPARTMENT OF HEALTH, 2013. A Framework for Sexual Health Improvement in England. London: Department of Health. PAWSON, R. and TILLEY, T., 1997. Realistic Evaluation. London: Sage. WELLINGS, K. and JOHNSON, A.M., 2013. Framing sexual health research: adopting a broader perspective. Lancet, 382, pp. 1759-62. WORLD HEALTH ORGANISATION, 2010. Developing sexual health programmes: a framework for action. Geneva, Switzerland: WHO.

Will the research be conducted with partners & subcontractors?	**Yes/No** NO (If **YES**, outline how you will ensure that their ethical policies are consistent with university policy.)

1. Health Related Research Involving the NHS or Social Care / Community Care or the Criminal Justice Service or with Research participants unable to provide informed consent

Question	Yes/No
1. Does the research involve? • Patients recruited because of their past or present use of the NHS or SC • Relatives/carers of patients recruited because of their past or present use of the NHS or SC • Access to data, organs or other bodily material of past or present NHS patients • Foetal material and IVF involving NHS patients • The recently dead in NHS premises • Prisoners or others within the criminal justice system recruited for health-related research* • Police, courts, prisoners or others within the criminal justice system* • Participants who are unable to provide informed consent due to their incapacity even if the project is not health related	No

Question	Yes/No
2. Is this a research project as opposed to service evaluation or audit? For NHS definitions please see the following website http://www.nres.nhs.uk/applications/is-your-project-research/	No

If you have answered **YES** to questions **1 & 2** then you **must** seek the appropriate external approvals from the NHS, Social Care, or Criminal Justice System under their Research Governance schemes. Further information is provided below.

NHS https://www.myresearchproject.org.uk/Signin.aspx

* All prison projects also need National Offender Management Service (NOMS) Approval and Governor's Approval and may need Ministry of Justice approval. Further guidance at: http://www.ohrn.nhs.uk/toolkit/Toolkit4thEdition.pdf

 NB FRECs provide Independent Scientific Review for NHS or SC research and initial scrutiny for ethics applications as required for university sponsorship of the research. Applicants can use the NHS proforma and submit this initially to the FREC.

2. Research with Human Participants

Question	Yes/No
1. Does the research involve human participants? This includes surveys, questionnaires, observing behaviour etc. Note If YES, then please answer questions 2 to 10 If NO, please go to Section 3	Yes

Question	Yes/No
2. Will any of the participants be vulnerable? Note 'Vulnerable' people include young people under 18, people with learning disabilities, people who may be limited by age or sickness or disability from understanding the research, etc.	No
3 Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	No
4 Will tissue samples (including blood) be obtained from participants?	No
5 Is pain or more than mild discomfort likely to result from the study?	No
6 Will the study involve prolonged or repetitive testing?	No
7 Is there any reasonable and foreseeable risk of physical or emotional harm to any of the participants? Note Harm may be caused by distressing or intrusive interview questions, uncomfortable procedures involving the participant, invasion of privacy, topics relating to highly personal information, topics relating to illegal activity, etc.	No
8 Will anyone be taking part without giving their informed consent?	No
9 Is it covert research? Note 'Covert research' refers to research that is conducted without the knowledge of participants.	No
10 Will the research output allow identification of any	No

Question	Yes/No
individual who has not given their express consent to be identified?	

If you answered **YES only** to question **1,** you **must** submit the signed form to the FREC for registration and scrutiny. If you have answered **YES** to any of the other questions you are **required** to submit a SHUREC2A (or 2B) to the FREC. If you answered **YES** to question **8** and participants cannot provide informed consent due to their incapacity you must obtain the appropriate approvals from the NHS research governance system.

3. Research in Organisations

Question	Yes/No
1 Will the research involve working with/within an organisation (e.g. school, business, charity, museum, government department, international agency, etc)?	Yes
2 If you answered YES to question 1, do you have granted access to conduct the research? If YES, students please show evidence to your supervisor. PI should retain safely.	No
3 If you answered NO to question 2, is it because: A. you have not yet asked B. you have asked and not yet received an answer C. you have asked and been refused access. Note You will only be able to start the research when you have been granted access.	B

4. Research with Products and Artefacts

Question	Yes/No
1. Will the research involve working with copyrighted documents, films, broadcasts, photographs, artworks, designs, products, programmes, databases, networks, processes or secure data?	Yes

2. If you answered YES to question 1, are the materials you intend to use in the public domain?
 	
Notes 'In the public domain' does not mean the same thing as 'publicly accessible'.
 	
  – Information which is 'in the public domain' is no longer protected by copyright (i.e. copyright has either expired or been waived) and can be used without permission.
 	
  – Information which is 'publicly accessible' (e.g. TV broadcasts, websites, artworks, newspapers) is available for anyone to consult/view. It is still protected by copyright even if there is no copyright notice. In UK law, copyright protection is automatic and does not require a copyright statement, although it is always good practice to provide one. It is necessary to check the terms and conditions of use to find out exactly how the material may be reused etc.
 	
If you answered YES to question 1, be aware that you may need to consider other ethics codes. For example, when conducting Internet research, consult the code of the Association of Internet Researchers; for educational research, consult the Code of Ethics of the British Educational Research Association.
	No

Question	Yes/No
3. If you answered NO to question 2, do you have explicit permission to use these materials as data? If YES, please show evidence to your supervisor. PI should retain permission.	No
4. If you answered NO to question 3, is it because: A. you have not yet asked permission B. you have asked and not yet received and answer C. you have asked and been refused access. Note You will only be able to start the research when you have been granted permission to use the specified material.	A/B/C B

Adherence to SHU policy and procedures

Personal statement	
I can confirm that: – I have read the Sheffield Hallam University Research Ethics Policy and Procedures – I agree to abide by its principles.	
Student / Researcher/ Principal Investigator (as applicable)	
Name: Katie Shearn	Date: 05 05 2015
Signature:	

Please ensure the following are included with this form if applicable, tick box to indicate:

	Yes	No	N/A
Research proposal if prepared previously	☐	☒	☐
Any recruitment materials (e.g. posters, letters, etc.)	☐	☐	☐
Participant information sheet	☒	☐	☐
Participant consent form	☒	☐	☐
Details of any measures to be used (e.g. questionnaires, etc.)	☐	☐	☐
Details of any support materials provided to participants	☐	☐	☐
Debriefing materials	☐	☐	☐

Sheffield Hallam University

Request for major amendment of a protocol already approved by the Faculty Research Ethics Committee

Title of Research Protocol
Delivering positive youth sexual health services
(previous title *Delivering positive and preventative sexual health services*)

Name of chief investigator or of student and supervisor

Student: Katie Shearn
Director of Studies: Hilary Piercy

Is this research undergraduate, masters, doctoral or staff?

Doctoral

Date of original approval

12.05.2015

Brief summary of research

The World Health Organisation (2010) recognises that globally the sexual health programmes need to shift from treating sexual ill-health to promoting sexual well-being.

In the UK, there is some recognition that a broader framework for sexual healthcare is necessary (e.g. Wellings and Johnson, 2013), which is now echoed in policy (e.g. Department of Health, 2013).

However the transition from broad policy/research recommendations to action on the ground is under-theorised.

One avenue for research is to identify triggers and barriers operating in local sexual health services in providing positive sexual health services for young people. This would provide empirical data and deeper theoretical understanding, useful for the ongoing development of policy and practice.

This protocol refers to the initial element of the project which, in turn, will inform the development of subsequent stages.

Main research question

- To undertake a synthesis of evidence to identify and/or develop theories and provide empirical data illustrating what works to deliver positive youth sexual health services, for whom, under what circumstances and why?

Major Amendment Form FREC HWB 14102013

Summary of methodology and techniques

A realist informed approach, derived from the work of Pawson and Tilley (1997) will be used to undertake the investigation.

This initial element is primarily concerned with developing ideas and uncovering existing evidence about what works or doesn't to deliver positive, preventative sexual health services.

The initial phase will comprise a rapid realist synthesis of existing evidence and stakeholder interviews.

Realist Synthesis

The synthesis will include a range of sources which are relevant to the research question including published academic articles, grey literature such as national and local policy documents, best practice guidance, tender documents, and local unpublished evaluation reports.

Stakeholder Interviews

Stakeholder interviews will be used to understand what is happening currently and develop ideas about what would need to change, or be in place, to provide positive sexual health services for young people.

Sample and recruitment for interviews

Research will be conducted in 3 sites in England. These locations offer a range of: size of residential area; diversity of population; sexual health service models in operation (i.e. integrated hub and spoke, youth specific hub and spoke and youth provision including e-technology).

The proposed sample is outlined below with around 25-30 individuals.

Public health commissioners (minimum of 3 across sites)

Local counsellors (minimum of 2 across sites)

Director of services (minimum of 2 across sites)

Clinical professionals (minimum of 6 across sites)

Non-clinical professionals (minimum of 6 across sites)

Quota-based convenience sampling will be used to ensure the mix of roles are included as well as a good spread of key demographic and other factors such as length of time in post. The researcher has established good relationships with all three sites and has reassurances of their support in accessing individuals.

Consent, confidentiality and protection from harm

Participation in the study is completely voluntary. Participants will be fully briefed on the nature of the interview, their participation and likely impacts of the research. A tailored information sheet will be provided to assist this dialogue. Participants will have the opportunity to ask questions at any point and are free to withdraw from the study at any time.

The research data will be held confidentially and in accordance with the Data Protection Act. Services and individuals will remain anonymous in any publication of protocol or results. Where relevant, services will be described as a small/large town or city in the North of England, as appropriate. Any participating individual or organisation would be eligible to receive a copy of the results.

Outcomes, impacts and benefits

The purpose of this study is to contribute to the researcher's thesis for a PhD in Health and Wellbeing.

The study has been designed to develop the theory of what works to deliver good quality sexual health services for young people and what conditions or circumstances help or hinder the delivery of such services. It is not designed to find fault, rather the ambition is to uncover the mechanisms for delivering good quality work. It is hoped that such information can contribute to the development of policy, commissioning and practice.

Bibliography

DEPARTMENT OF HEALTH, 2013. A Framework for Sexual Health Improvement in England. London: Department of Health.

PAWSON, R. and TILLEY, T., 1997. Realistic Evaluation. London: Sage.

WELLINGS, K. and JOHNSON, A.M., 2013. Framing sexual health research: adopting a broader perspective. Lancet, 382, pp. 1759-62.

WORLD HEALTH ORGANISATION, 2010. Developing sexual health programmes: a framework for action. Geneva, Switzerland: WHO.

Nature of amendment

The overall aim of the project has been changed to ensure it accurately reflects the project ambitions. Instead of making a claim about 'what works', it now more accurately describes the ambition as developing robust programme theory.

The sites for fieldwork have been changed due to identification in the early part of the literature review of a useful case study where positive youth sexual health services have recently been developed.

The number of interviews has increased by 5-10 to incorporate more views in each case study site.

In your opinion, does the amendment give rise to any new ethical issues (e.g. requirement for new information sheets and consent forms)?

There are no new ethical issues to consider. However, since May I have revised the information sheets and participant consent forms slightly and enclose the latest iteration.

Date: 12052015

Research proposal number: HWB-HSC-35

Dear Katie SHEARN

This letter relates to your research proposal:

Delivering positive and preventative sexual health services

This proposal was submitted to the Faculty Research Ethics Committee with a standard SHREC 1 form. This indicates that your project is low risk. As such, it has been added to the register of projects and given a reference number. You do not need any further review from the Ethics Committee. You will need to ensure you have all other necessary permission in place before proceeding, for example, from the Research Governance office of any sites outside the University where your research will take place. This letter can be used as evidence that the proposal has been registered within Sheffield Hallam University.

The documents reviewed were:

SHUREC1 Shearn May 2015

Good luck with your project.

Yours sincerely

Punita Chowbey

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Telephone +44 (0) 114 225 5854 | Fax +44 (0) 114 225 4377
chscr@shu.ac.uk | www.shu.ac.uk/chscr

Email confirming major amendment

Dear Katie

Protocol: 2014-5/HWB-HSC-35

I have received your amendment to the protocol "Delivering positive and preventative sexual health services". I believe the amendment raises no further ethical concerns and am happy to provide approval for the protocol as amended. The amendment documents have been saved and added to your folder under the name:

SHEARN amendment Nov 2015.pdf

Best wishes

Punita CHOWBEY

Authorisation letter from NHS (redacted to preserve anonymity)

NHS Foundation Trust

NHS

17th February 2016

Project Authorisation
NHS Permission for Research to Commence

NIHR CSP ref:	Not Applicable	
REC ref:	SHU REC HWB-HSC-35	
MHRA ref:	CTA No: NA	EudraCT No: NA
Clinical Trial reg no:	Not Applicable	
Study title:	What works to deliver positive youth sexual health services, for whom, under what circumstances and why?	
Chief Investigator:	Katie Shearn (Sheffield Hallam University)	
Principal Investigator:		
Sponsor:	Sheffield Hallam University	
Funder:	Unfunded	

MANDATORY REPORTING OF RECRUITMENT
The Research Department is obliged to report study set up and recruitment performance for the Trust to NIHR and to report research activity for all studies to Trust Board. In order to meet these reporting requirements please be advised that it is now a *mandatory* condition of ▮▮▮▮roject authorisation that recruitment to *all* research studies* at▮▮▮▮ reported into EDGE (the Accrual Collation and Reporting Database). It is essential that recruitment is entered into EDGE *real-time* to enable directorates to accurately monitor performance. Please see item 2 of the 'Conditions of R&D Authorisation' for further details.

Please be informed that failure to report recruitment to EDGE may result in loss or delay in funding to the Trust and to the Directorate.

*Information regarding EDGE eligibility for reporting is detailed in the 'Conditions of R&D Authorisation'

Ref: ████044/AC

The Research Department has received the required documentation as listed below:

1.	Sponsorship Agreement	IRAS Form, D Form, Sheffield Hallam University, 05 Feb 2016
	Clinical Trial Agreement	Not Applicable
	Material Transfer Agreement	Not Applicable
	Funding Award Letter	Not Applicable
2.	Monitoring Arrangements	Not Applicable
3.	STH registration document	R & D Form, 03 Feb 2016
4.	Evidence of favourable scientific review	SHU ISR
5.	Protocol – final version	Version 4.0, 18 Nov 2015
6.	Participant Information sheet	Version 4.0, 18 Nov 2015
7.	Consent form	Version 3.0, no date
8.	Letter of indemnity arrangements	NHS Indemnity and SHU Insurance
9.	ARSAC certificate / IRMER assessment	Not Applicable
10.	Ethical review- Letter of approval from NHS REC or UREC	Sheffield Hallam University REC, HWB-HSC-35 12 May 2015 Nov 2015
11.	Site Specific Assessment	PI responsibilities email, 17 Feb 2016
12.	Clinical Trial Authorisation from MHRA	Not Applicable
13.	Evidence of hosting approvals - ████ Principal Investigator - Clinical Director - Research Finance - Data Protection Officer	17 Feb 2016 Feb 2016 Nov 2015 Sep 2015
14.	Honorary Contract/Letter of Access	Not applicable
15.	Associated documents	Not applicable

This project has been reviewed by the Research Department. NHS permission for the above research to commence has been granted on the basis described in the application form, protocol and supporting documentation on the understanding that the study is conducted in accordance with the Research Governance Framework, GCP and ████████████████ policies and procedures (see attached appendix).

Yours sincerely

Telephone +44 (0) 114 2265934
Fax +44 (0) 114 2265937

Participant Consent Form v3

Delivering Positive Youth Sexual Health Services

Please answer the following questions by ticking the response that applies

	YES	NO
1. I have read the Information Sheet for this study and have had details of the study explained to me.	☐	☐
2. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.	☐	☐
3. I understand that I am free to withdraw from the study within the time limits outlined in the Information Sheet, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.	☐	☐
4. I agree to provide information to the researchers under the conditions of confidentiality set out in the Information Sheet.	☐	☐
5. I wish to participate in the study under the conditions set out in the Information Sheet.	☐	☐
6. I consent to give information which will be audio-recorded and pseudonymised (so that I cannot be identified), and used in this research study, and also potentially used in journal articles related to this study.	☐	☐

Your signature will certify that you have voluntarily decided to take part in this research study.

If you change your mind about participating you may withdraw at any time prior to publication of my thesis and/or any academic papers without giving a reason. All information you have provided up to that time will be deleted.

Participant's Signature: _____ Date: _____

Participant's Name (Printed): _____

Contact details:

_____

Researcher's Name (Printed): KATIE SHEARN

Researcher's Signature: __ _____

Researcher's contact details:

☎ Telephone: 07727010877 ✉ email: katie.m.shearn@student.shu.ac.uk
c/o Health and Wellbeing Research Institute - Postgraduate Research Centre Sheffield Hallam University: Chestnut Court: Collegiate Crescent: Sheffield: S10 2BP

Please keep your copy of the consent form and the information sheet together.

Information for Participants - version 4

Delivering Positive Youth Sexual Health Services	

Chief Investigator: Katie Shearn	*Telephone:* 07727 010877 *Email:* katie.m.shearn@student.shu.ac.uk	Date:18.11.2015

Study Sponsor: Sheffield Hallam University

Dear _____

I am a PhD student at Sheffield Hallam University. I would like to invite you to take part in an evaluation study about the delivery of positive and preventative sexual health services for young people. This study forms part of my doctoral work which is concerned with the sexual wellbeing of young people. This document provides some detail about what my study is about, what your contribution might be and what I intend to do with the results. You are welcome to discuss the project with others before deciding whether to take part. If you wish to discuss any element of this project with me please do so using my contact information above.

Participant Name:

The purpose of the study

The purpose of this study is to contribute to my thesis for a PhD in Health and Wellbeing.

The study has been designed to understand what works to deliver positive sexual health services for young people and what conditions or circumstances help or hinder the delivery of such services. It is not designed to find fault, rather my ambition is to uncover the mechanisms for delivering good quality work. It is hoped that such information can contribute to the development of policy and commissioning practice.

Who is taking part?

The study aims to get the views of a range of people involved in the commissioning and delivery of sexual health services. This will include people with both clinical and non-clinical background, those who work daily with young people and those who manage or commission services.

The study is also looking to reflect a range of different delivery models, which is why Sheffield would be a useful case study alongside other areas in England.

Do I have to take part?

Your participation is completely voluntary. If you do agree to participate you could still decline to answer questions you don't want to. You are also free to withdraw at any time, including after you have completed the interview but before completion of the researcher's thesis or publication of results (see below for optional publication review).

What would I have to do?

You are invited to take part in an interview. The interview would last up to one hour and involve questions and conversation about what positive sexual health services are for young people, what works well in the delivery of such sexual health services and what, if anything, prevents the delivery of such services.

You don't need to prepare anything in advance although thinking broadly about these themes and examples of practice would be helpful.

The interview would be conducted in a location and time of your choice. Ideally this would be in a place where you are comfortable and can speak freely. The interview would be audio taped and transcribed word for word. Neither the recording nor the transcript would ever be made public.

You are welcome to discuss the project and your participation at any time with the researcher. Whilst this is the only formal interview as part of this study, in order to ensure accuracy, you may be asked to review the findings of the research at a later stage and provide feedback.

Where data protection allows, you may also be asked to provide policy or evaluation documents which relate to the delivery of positive services. Sufficient time and notice for these activities would be allocated but you would be under no obligation to continue assisting the project at this time.

What are the possible risks of taking part?

You may be concerned that data collected from you will implicate you or your organisation in some way.

Your organisation does not have to know that you have agreed to take part if you do not wish to disclose this. The researcher will not tell anybody else of your involvement unless you give permission to do so. Once checked for accuracy the audio recording of your interview will be destroyed. The transcription, which will be pseudonymised, will be stored on a secure server and password protected, meaning only the research team will have access to it.

The data collected during the discussion will mainly be used, alongside a range of other sources, to develop the researcher's thesis. If there are new findings they may be published in academic or trade journals. They may also be presented at relevant conferences. In all circumstances, any direct quotations or examples used could not be attributed to you or the organisation you work for as identifying information will be removed. Should you wish to, you would be welcome to review a draft of the work prior to publication.

What are the possible benefits of taking part?

To thank you for your time, the researcher would be happy to prepare a summary report of findings in Sheffield including how they relate to the overall picture of service delivery. The exact nature of this report could be discussed with you to ensure maximum usefulness.

What if there is a problem or I want to complain?

If you have any queries or questions please contact Katie Shearn

☎ Telephone: 07727010877   ✉ email: katie.m.shearn@student.shu.ac.uk
c/o Health and Wellbeing Research Institute - Postgraduate Research Centre
Sheffield Hallam University: Chestnut Court: Collegiate Crescent: Sheffield: S10 2BP

Alternatively, you can contact my academic supervisor:

Dr. Hilary Piercy

☎ Telephone: 0114 2255603 ✉ email: hwbhp@my.shu.ac.uk
c/o Sheffield Hallam University: 34 Collegiate Crescent: Sheffield: S10 2BP

If you would rather contact an independent person, you can speak to:

Punita Chowbey (Chair HSC Research Ethics Committee).

☎ Telephone: 0114 225 5733 ✉ email: p.chowbey@my.shu.ac.uk

c/o Sheffield Hallam University: 32 Collegiate Crescent: Sheffield: S10 2BP

Will my involvement be kept confidential?

In addition to the measures outlined above all documentation relating to the administration of the project will be kept in a site file which will be held securely on the university servers and accessed only by a password. This may be inspected by those in authority to ensure that correct procedures have been followed. These people will not pass your details on to anybody else.

The whole study is likely to last another two years but this element of the work may be completed within six months to a year. The researcher collecting the data will be totally responsible for keeping your data confidential. Anonymised data derived from the project, such as analysis files, will be kept securely for as long as it might be useful for future research.

Who has sponsored the study?

The sponsor of this study is Sheffield Hallam University. The sponsor has the duty to ensure that it runs properly and that it is insured.

Who has reviewed the study?

The study has been reviewed the Clinical Effectiveness Unit at ▮▮▮▮▮▮ and the Research Ethics Committee at Sheffield Hallam University. They check studies to ensure it is appropriate and to protect your safety, rights, wellbeing and dignity. The project has received approval from both of these groups.

I have read this information sheet and discussed it with the researcher.

Signature of Participant:……………………………

Date: ………………………
Please keep this information sheet.